executive committee of the directing council

PAN AMERICAN HEALTH ORGANIZATION

working party of the regional committee

WORLD HEALTH ORGANIZATION

92nd Meeting
Washington, D.C.
June 1984

Provisional Agenda Item 15

CE92/16 (Eng.)
9 May 1984
ORIGINAL: ENGLISH-SPANISH

SUBCOMMITTEE ON LONG-TERM PLANNING AND PROGRAMMING

The Subcommittee on Long-Term Planning and Programming of the Executive Committee of PAHO met on 11-13 April 1984. The Subcommittee members, including Canada, Cuba, Panama, United States of America, and Uruguay, examined issues on the agenda along with the corresponding documents. Those issues included Managerial Strategy for the Optimal Use of PAHO/WHO Resources in Direct Support of Member Countries; Evaluating the Strategies of Health for All by the Year 2000; Economic Crisis in Latin America and the Caribbean and its Repercussions on the Health Sector; Guidelines for the Promotion of TCDC/ECDC in the Health Sector with the Collaboration of PAHO; Program and Budget Process and Calendar Utilized by PAHO/WHO; and Other Matters. Following its review, the Subcommittee completed its report for submission to the Executive Committee.

Annexes:

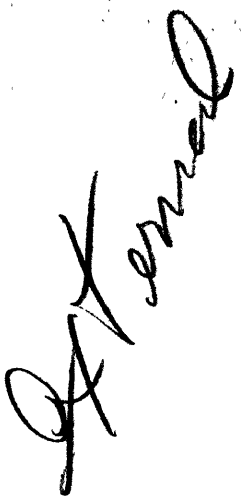
I. Report of the Subcommittee

II. Managerial Strategy for the Optimal Use of PAHO/WHO Resources in Direct Support of Member Countries

III. Evaluating the Strategies for Health for All by the Year 2000. Common Framework and Format

IV. National and International Financial and Budgeting Implications of the Regional Strategies and the Plan of Action for Health for All by the Year 2000 (The Economic Crisis in Latin America and the Caribbean and its Repercussions on the Health Sector)

V. Guidelines for the Promotion of TCDC/ECDC in the Health Sector with the Collaboration of PAHO



REPORT OF THE SUBCOMMITTEE

SUBCOMMITTEE ON LONG-TERM PLANNING AND PROGRAMMING OF THE EXECUTIVE COMMITTEE OF PAHO

Report to the 92nd Meeting of the Executive Committee

The Subcommittee met at the PAHO Headquarters in Washington, D.C., 11, 12 and 13 April 1984. The following Governments, all members of the Executive Committee, were present at the session: Canada, Cuba, Panama, United States of America, and Uruguay (see Annex for List of Participants).

OPENING OF THE MEETING

Dr. H. David Banta, Deputy Director, opened the meeting and welcomed the members of the Subcommittee. The Subcommittee was informed that the Delegation of Cuba experienced certain difficulties in attempting to travel to PAHO Headquarters. There was, therefore, the option of either continuing the meeting as scheduled or of suspending the session. The consensus of the Subcommittee was to suspend the session until the following day, when the Cuban Delegation was expected to be present.

The meeting was reopened on Thursday, 12 April, at which time the Director, Dr. Carlyle Guerra de Macedo, greeted the delegates. Among other things, he asked if the Subcommittee could meet on the morning of Friday, 13 April, for the purpose of a closed session to discuss Item 8 of the Agenda.

Subsequently, Dr. Banta gave a summary of the background of each of the items which had been included in the provisional agenda of the Subcommittee.

OFFICERS

The following persons were elected officers of the subcommittee:

Chairman:	Mr. Norbert Préfontaine	CANADA
Vice-Chairman:	Dr. Carlos Migues Barón	URUGUAY
Rapporteur:	Dr. Benigno Argote	PANAMA
Secretary ex officio:	Dr. José Romero Teruel	Pan American Sanitary Bureau

AGENDA

The provisional agenda was approved unanimously.

1) Item 1: Opening of the Meeting

2) Item 2: Election of the Chairman, Vice Chairman and Rapporteur

3) Item 3: Adoption of the Agenda

4) Item 4: Managerial Strategy for the Optimal Use of PAHO/WHO Resources in Direct Support of Member Countries

5) Item 5: Evaluating the Strategies for Health for All by the Year 2000

6) Item 6: National and International Financial and Budgetary Implications of the Regional Strategies and the Plan of Action for Health for All by the Year 2000

7) Item 7: Guidelines for the Promotion of TCDC/ECDC in the Health Sector with the Collaboration of PAHO

8) Item 8: The Program and Budget Process and Calendar Utilized by PAHO/WHO

9) Item 9: Other Matters

Item 4. Managerial Strategy for the Optimal Use of PAHO/WHO Resources in Direct Support of Member Countries

An identically titled document served as background for the discussion. It was presented by Mr. Mark Schneider, who described the differences between the current version of the background document and the version which was presented to the XXIX Meeting of the Directing Council in 1983. The majority of those differences reflected comments made during that meeting. In this version, the concepts of equity, efficiency and technical excellence have been further developed and explained. More precise definitions also have been included concerning the role of the Country Representative, the planning function, as well as the concepts of decentralization and administrative development.

The Subcommittee members considered the document and made several suggestions and recommendations. The document, for example, should be complemented with further analyses detailing the operational mechanisms. Likewise, flow charts or other illustrations of elements of the strategy would be useful, particularly describing the structural and administrative changes. The importance of the concept of flexibility in the management process was emphasized, along with the importance of its contribution to equity in the use of resources in the technical cooperation programs.

The participants agreed with the idea that PAHO Country Representatives (CR's) play a vital role in the Organization in that they represent the basic unit for the coordination of technical cooperation and for the joint administration of the Organization's resources in the countries. Likewise, it was recommended that the Bureau provide the necessary support to CR's in order to improve and update their technical and administrative capabilities.

The Subcommittee recognized that the goal of technical excellence cannot be fulfilled solely by the personnel of the Office; rather it also requires incorporating the ideas and scientific skills found outside the Organization. The Organization must facilitate the flow of talents, ideas and individuals comprising that technical excellence to the members countries.

The Subcommittee discussed the Organization's plan to publish in the near future a reference manual on sources of financial and technical resources from bilateral, multilateral and private entities. In this area, the Subcommittee also emphasized that the AMRO programming and evaluation system (AMPES) should develop as a practical instrument to transmit PAHO's programs to the countries. Furthermore, it was recommended that it would be useful for the Subcommittee to receive a more detailed explanation of the AMPES, its different components, and the steps underway to improve it.

Item 5. Evaluating the Strategies of Health for All by the Year 2000

Document DGO/84.1--which has been drafted in Geneva at the Office of the Director General of WHO--served as background for the discussion and was presented by Mr. Dixon. The Subcommittee noted that the presentation explained the steps that WHO in general and PAHO specifically intend to undertake in this area. The Subcommittee decided to include a summary of the presentation with the document for distribution to the member countries of the Executive Committee.

On the one hand, the document from Geneva was viewed as a useful instrument which, although it must be revised, could perform a catalytic role for national evaluations. Its revision should remove existing problems involving its adaptation and its operational applicability to the Region.

A matter of concern was whether this document had been tested at the country level. It was explained that the document resulted from a mandate of the Governing Bodies of WHO. It had undergone several revisions at the global level. Finally, it was noted that the document presents only suggested guidelines for the countries. Furthermore, it was pointed out that at various stages of the preparation of this document, PAHO's Secretariat had communicated to Geneva its reservations regarding the document.

Subcommittee members emphasized that the implementation of the document should be adjusted and adapted, and the format perhaps field tested. It was pointed out, however, that any such field tests should not delay the Region's ability to meet the global monitoring and evaluation timetable of the process of health for all.

Item 6. National and International Financial and Budgetary Implications of the Regional Strategies and the Plan of Action for Health for All by the Year 2000

The background document presented by Mr. Jiménez and Mr. Landmann served as a basis for the discussion. Although the available data from the countries did not include sufficient information to permit firm projections, negative repercussions of the crisis on the social sector in general, and in particular on the health sector, are becoming visible.

The Subcommittee noted the effort undertaken to produce the document. It was pointed out that other data contained in studies by the Economic Commission for Latin America (ECLA) also could be used to present additional information on countries not previously cited in the regional economic summaries.

The Subcommittee considered the recommendations contained in the background document, and emphasized the importance of an in depth review of the impact of technology on health costs. It was concluded that it is feasible and essential for the health sector of each country to undertake economic studies. The benefit from this analysis would not be limited to broadening the health sector's understanding of the impact of socioeconomic factors on health conditions. It would help as well to promote comunications between the health sector and the economic and financial sectors, and would facilitate the sector's being considered a priority within natural development plans. Given the need to improve information systems in order to permit the realization of economic studies, the Organization intends to support the countries in developing those systems and in carrying out studies in this area.

Finally, taking into consideration the decline in real income among the populations of the Region, it recommended that governments review the financing of the health sector in their countries. That review should be undertaken with the objective of moving toward the fulfillment of the principles of equity and solaridity, among other ways by extending the coverage of the social security system and promoting its integration into the public health system.

Item 7. Guidelines for the promotion of TCDC/ECDC in the health sector with the collaboration of PAHO

The document presented by Dr. José María Salazar, from the Secretariat, examines priority areas for action, and the role of PAHO in the promotion and support of the concept of TCDC/ECDC.

The Subcommittee endorsed the recommendations contained in the document, including the idea that a group of experts, at the regional level, should analyze and define specific and concrete proposals for technical cooperation activities among different countries. This effort should be supported by PAHO in order to stimulate the TCDC/ECDC process. The Subcommittee emphasized that, given all the work that has been carried out for several years in studying this concept, it was now time to design concrete actions at the country level. Strengthening UN mechanisms supporting TCDC/ECDC also was urged as a means to increase activities in this field.

Item 8. The Program and Budget Process and the Calendar Used by PAHO/WHO

In closed session, the Director informed the Subcommittee of the complexity of the PAHO budget formulation process, noting that he personally was responsible for coordinating the different processes. He was referring to the WHO budget allocation to PAHO and PAHO's own budget which includes the former. As a result, there are 25 distinct phases

required during the elaboration of the budget, six consultations with the Governing Bodies and the preparation of four documents. Therefore, it is necessary to make cost projections four years in advance, within an environment of uncertainty, exacerbated by the internal dynamics of the Region's economic crisis and aggravated by the absence of projections by the countries themselves of their needs. For these reasons, the original costs which served as the basis for the budget ceiling of WHO and of the Region, have diminished recently. These costs are therefore below, at the present time, the estimates being made by WHO.

However, the Director suggested that this situation also reflects the fact that PAHO's cost analysis is more refined than that of other regions, which makes cost comparisons with those regions difficult.

If the estimated excess amount of the WHO allotment were to be returned, it would reduce available funds to the Region. There would be a risk that if these initial calculations made during a period of uncertainty turn out to be mistaken, PAHO could not fund its existing programs.

The Director discussed possible alternatives of dealing with the situation. Although there was some support for the Director's proposals, the Subcommittee as a whole was not prepared to reach a consensus on this matter but urged the Director to continue examining various approaches. The two principal alternatives suggested by the Director were:

1. Seek from WHO approval for program growth in the countries.

2. Create a contingency fund which, without forming part of the country budgets, would permit reinforcing those programs in keeping with the needs produced by the current uncertain financial environment.

In terms of the priorities for country program growth, one would consider the attitude of a country in terms of changing its health practices in order to focus on HFA/2000. Three kinds of criteria should be included in this stage:

a) Analysis of the trend toward change within the countries and the Region;

b) Selection of problems, in relation to the mobilization of national resources, for their solution and cooperation among countries;

c) Importance of the problem within the country.

Item 9. Other Matters

Definition of the Functions of the Long-Term Subcommittee of the Executive Commitee in the Context of the New Management Approach of the Administration

The Director presented his views, which were discussed with the Subcommittee. The participants reached the basic conclusion that this body should retain its strictly advisory character, as a Subcommittee of the Executive Committee. As such, its functions should be directed, first, to assist the Committee in its analysis of important medium- and long-term strategic issues, and, second, to advise the Director with respect to issues related to the direction of the Organization.

The previously cited functions would include the following aspects:

- Analysis of the proceedings and of the planning objectives (short-, medium-, and long-term), trying to facilitate the articulation of the different stages of planning;

- Analysis of information systems, focusing principally on the need to define the PAHO and WHO systems at the country level;

- Discussion of the socioeconomic framework and of the long-term repercussions on the health sector;

- Analysis of PAHO budget processes and of the background and basis for their formulation;

- Study of aspects related to the development of medium- and long-term administrative systems, particularly those of personnel;

- Analysis of special or subregional programs, as well as some of those financed with extrabudgetary funds, concentrating principally on their formulation and evaluation.

Speakers emphasized the need to carefully define a limited number of issues for each meeting of the Subcommittee in order to avoid a superficial treatment of the different items. A restructuring of the Subcommittee was discussed in light of the new functions that might be assigned in the future. The Secretariat will prepare a study focussing on the composition, period of tenure of members and frequency of meetings.

PAHO Presence within Countries

Both the Director and the Subcommittee believe that the Country Office is vital for the administration of technical cooperation. It was emphasized that, in countries without permanent representative, mechanisms must be established to assure frequent and continuous contacts between the Organization, the Member Government and national institutions in order to convey the concept of a permanent presence in those countries.

ANNEX

LIST OF PARTICIPANTS

CANADA

Mr. Norbert Préfontaine
Mr. Percy Abols

CUBA

Dr. Ramón Prado

PANAMA

Dr. Benigno Argote

UNITED STATES OF AMERICA

Mr. Neil Boyer
Dr. Valerie Williams

URUGUAY

Dr. Carlos Migues Barón

The Pan American Sanitary Bureau was represented by the following Staff:

Dr. Carlyle Guerra de Macedo
Director

Dr. H. David Banta
Deputy Director

Dr. George Alleyne
Director, Area of Health Programs' Development

Dr. Luis Carlos Ochoa
Area Director, Health System Infrastructure

Dr. José Romero Teruel
Program Coordinator, Analysis and Strategic Planning

Dr. José María Salazar,
Program Coordinator, External Relations

Mr. Roger Dixon
Program and Operation Coordination

Mr. Wilburg Jiménez
Analysis and Strategic Planning

Mr. James Milam
Budget Section

Mr. Mark Schneider
Analysis and Strategic Planning

Mr. Robert Landmann
Analysis and Strategic Planning

MANAGERIAL STRATEGY FOR THE OPTIMAL USE OF PAHO/WHO RESOURCES IN DIRECT SUPPORT OF MEMBER COUNTRIES

MANAGERIAL STRATEGY FOR THE OPTIMAL USE OF PAHO/WHO RESOURCES IN DIRECT SUPPORT OF MEMBER COUNTRIES

I. INTRODUCTION

1. The Managerial Strategy for the Optimal Use of PAHO/WHO Resources in Direct Support of Member Countries has been prepared to provide a clear guide to the Secretariat in fulfilling its constitutional obligations as the executive arm of the Pan American Health Organization and of the World Health Organization in the Region of the Americas. The Managerial Strategy is based on these obligations which determine the Organization's fundamental mission and on the policy framework derived from the decisions of its Governing Bodies. The purpose of the Managerial Strategy is to help insure that PAHO/WHO resources are utilized in the most efficient and effective manner to achieve the goal of improving health conditions in the Americas.

II. TERMS OF REFERENCE

Political Framework

2. The PAHO/WHO Management Strategy responds to the special characteristics of the Organization and to the specific characteristics of the Region in which it operates within the framework of resolution WHA33.17 on the "Study of the Organization's Structures in the Light of its Functions" and the "Managerial Framework for Optimal Use of WHO's Resources in Direct Support of Member States, DGO/83.1.X."

3. The Pan American Health Organization has two complementary constitutional obligations. First, its Governing Body comprises the Regional Committee for the Americas of the World Health Organization. Second, its Governing Body also serves as the highest political decision-maker of the Organization in its independent constitutional status as an Inter-American Specialized Organization.

4. The Management Strategy has also been crafted with an awareness of the unique nature of the Western Hemisphere within the international arena. PAHO Member Countries span the most developed as well as those with vast unmet needs in every aspect of development. The present moment is one in which complex forces interact to yield new uncertainties for regional economic, social and political development. All nations in the Region today, in differing ways, stand at a crossroads where the decisions they make will shape events throughout the remaining years of this century. The health sector, now more than ever, is intimately and inextricably entwined in those decisions, affecting them and affected by them.

Preliminary version

5. The dominant features of the policymaking backdrop today include an economic and financial crisis unmatched since the Great Depression, with inevitable and still unknown political and social consequences. There also is a growing awareness within the public consciousness of a fundamental right of people to satisfy basic needs--particularly health--an awareness nourished by governmental commitment to Health for All. Finally, that backdrop includes population growth, building upon itself, changing features year by year, aging, and migrating from rural communities to urban centers.

6. The political framework for the Management Strategy includes not only a recognition of the unique characteristics of the Region but also the policy decisions of the Governing Bodies which have established the current goals and objectives for the Organization.

7. The Governing Bodies of PAHO and WHO and the Member Countries which comprise those entities have adopted the goal of Health for All by the Year 2000. In pursuit of that goal, they have approved the Global and Regional Strategies for the achievement of Health for All by the Year 2000, the Global and Regional Plans of Action for the Implementation of the Strategies, the Seventh General Program of Work, the goals of the International Drinking Water Supply and Sanitation Decade, the Five Year Plan of Action for Women in Health and Development, and the goal of providing immunization services to all children of the world by 1990.

8. Among the particularly relevant decisions of the Governing Bodies in this regard, which emphasize the demand for more efficient and active utilization of PAHO/WHO resources, were the following:

- Resolution X of the XXVII Meeting of the PAHO Directing Council, (September 1980) recommended that the Director strengthen the Organization's plans and programs to give increased support to the achievement of Health for All by the Year 2000. This resolution also recommended that Member Governments, in cooperation with the Secretariat, ensure that national health programs are appropriately consistent with the world-wide and Region-wide priorities of the Organization.

- Resolution XI of the XXVIII Meeting of the PAHO Directing Council (September 1981) approved the "Plan of Action" to implement the Regional Strategies to attain the objective of Health for All by the Year 2000. This resolution further urged the Governments to evaluate and adjust their national health plans in keeping with their own national strategies as well as the Regional Strategies and Plan of Action so as to contribute to the attainment of regional objectives and goals. The same resolution requested the Director to review and orient, with the participation of the Member Governments, the PAHO program of technical cooperation to ensure support for the development of national and regional processes of Health for All in the Year 2000.

- Resolution XII of the XXI Pan American Sanitary Conference (September 1982) requested the Director to encourage and support additional activities at the national level to implement the Plan of Action.

Basic Principles

9. A basic principle of the Management Strategy is that analysis, resources, and actions must be oriented toward the country, given that the primary unit of production in terms of health activities and of cooperation is the country itself. The guiding principle for the Organization in its future activities will be the focus on the particular characteristics of each country, its priorities, its resources and its needs.

10. A second principle is that Member Countries must have a more active participatory role in their individual relationship with the Organization. They are the primary actors in the definition of national needs and priorities and, together with the Organization, in the design of the country program so that it responds to those needs in the context of both national and regional priorities. Together with the Organization, they have co-equal responsibility in the administration of the Organization's cooperation and in assuring the efficient use of country program resources within their national frontiers. That increased participation at the country level by the governments also should serve as a stimulus for their increased involvement in the critical readjustment of the Organization's regional programs of technical cooperation. Ultimately, it is the government's responsibility to translate collective decisions within the governing bodies into commitments and implementing actions in each country.

11. A third principle will be to stimulate, support and encourage flexibility in management responses to changing conditions and circumstances at both the country and regional levels. Given the changing nature of problems within the health sector as well as the widely diverse circumstances of countries in which the various programs of the Organization are to be implemented, past management procedures and approaches must change. The new management procedures also will tend to vary over time and between countries.

12. A fourth principle will be the need to promote and support a mobilization of national will and of national resources both for strengthening the capabilities and self-reliance of each country and for stimulating cooperation between countries. This step of identifying national resources is essential to discover what can be offered to other countries and what is needed from other countries and from other external sources. Cooperation among countries will become a principle strategy in mobilizing resources for the achievement of national goals.

13. The Organization must become a catalyst at each step of the mobilization process, and it must pursue more active coordination with other international and bilateral technical cooperation agencies in the field of health. However, in this regard, as in other aspects of the strategy, the focus of the coordination must be the country, and the crucial actor in the process must be the individual government.

14. A fifth principle of the Management Strategy is the need to assure internal coordination among all of the components of the office in support of the Member Countries. Coordination requires linking entities to avoid duplication and contradictory actions as well as promoting complementary actions which yield the greatest possible impact. At the Regional Office level, there must be coordination between and among technical areas, between technical and support activities, and between policy, programming and operations activities. There must be coordination between the regional level and the country level in support of the countries. To a large extent, that latter role will be played by the Country Representative as the primary coordinator of all the Organization's activities and resources at the country level.

15. The new Management Strategy also demands that the Organization act to promote and support national activities aimed at the achievement of national and regional health goals through a more vigorous assertion of leadership than in the past. That same active attitude also must extend to external cooperation in the field of health, assisting countries in identifying potential external economic and technical cooperation and assisting them in the steps needed to obtain that cooperation in a form consistent with national needs and priorities and national and regional objectives.

16. The mechanism for the integration of resources and cooperation will continue to be the Ministries of Health. They also will remain the major entranceway in each country for the Organization and, through it, provide the Organization access to the broader health sector and to other sectors.

17. As a corollary to each of the principles of the Management Strategy and as fundamental values and objectives in themselves, the Organization will pursue equity, efficiency, excellence and sufficiency in the use of resources through its technical cooperation programs.

- Equity in the allocation of health resources within each country in order to meet the needs of high risk population groups and efficiency in the use of resources are both part of the regional objective defined in the Plan of Action for Implementing the Regional Strategy for Health for All as elements to ensure the specific contribution of the health sector to the reduction of social and economic inequalities.

- Technical excellence implies four basic components: first, that one has full competence in all of the technical aspects related to a specific field of knowledge; second, that one has the capability,

as a manager in that specialty, to identify the origins and sources of that technical knowledge; third, that one must be able to apply that knowledge in light of the different social and economic conditions of each country; and, finally, one must possess an attitude and behaviour that stems from a basic commitment to the goals of the Organization and which permits that knowledge to be applied in the face of the diverse pressures faced in each country.

- Sufficiency is a concept which acknowledges the limited material resources of the Organization, totalling barely 0.2% of all health expenditures in the region and approximately 10% of total external resources coming into the region in the health field. PAHO must become an active catalyst and multiplier, helping to mobilize the capabilities of the nations themselves, starting with the health sector but reaching out to other public and private resources as well, and identifying and helping to combine those resources with other external resources to produce the critical mass of technical, managerial and material skills sufficient to cope with each nation's health problems.

III. GUIDELINES FOR ACTION

Mission

18. The fundamental mission of the Organization revolves around the constitutional obligation to cooperate with Member Governments in solving the health problems in their respective countries. The basic components of that mission are the management of knowledge, which translates into the very essence of technical cooperation; the mobilization of national technological, scientific, human, institutional, and financial resources to enhance national capacities to resolve problems and to participate in the determination of the nature of technical cooperation; and, through the previous two elements, the contribution to the building of understanding, solidarity, and peace among people.

19. The components of the mission of the Organization and the policy framework derived from the decisions of its Governing Bodies determine the nature of its scientific-technical cooperation, its management structure, the definition of regional priorities, and the requirement that those priorities be translated into its program and budget.

Definition of Priorities

20. The definition of regional priorities in the use of resources rests on the determinations expressed in resolutions of the Governing Bodies and on the process of joint dialogue between the Organization and the Member Countries at the country level. That joint dialogue is not a single act but a continuous and permanent process, redefining priorities

in light of the changing demography, circumstances and capabilities of each nation and of the Region as a whole. The process will yield modifications in national priorities and in national demands on the Organization and, over time, should be reflected in new regional priorities as well.

Role of the Governing Bodies

21. The Governing Bodies of the Organization, under the Constitution, are the originators of the policies and priorities of the Organization and the arbiters of the conduct of the Organization's affairs. The Director and the Secretariat, as the executive arm of the Governing Bodies, carry out the Organization's Program of Technical Cooperation with the Member Governments in accord with those decisions of the Governing Bodies. Those decisions impose mutual obligations on the secretariat and on the countries themselves to carry out individually what was agreed upon collectively. Both should view themselves as engaging in a shared responsibility at the country level to insure that actions taken there are consistent with regional policies and priorities.

Role of the Country Office

22. The entire design of the management structure is aimed at being better prepared to convert into action the first principle of the management strategy which designated the country as the primary object of and the decisive force in determining the Organization's technical cooperation.

23. The role of the country office is to serve as the basic unit for the generation, coordination, execution and evaluation of scientific and technical cooperation of the Organization in the countries of the Region. It also is the administrative management arm of the Organization in the country.

24. The Country Office itself must possess an appropriate body of scientific and technical knowledge. It must develop the capacity to be critical in the assessment, organization and use of scientific knowledge, in order to understand fully the origin, implications, and implementation requirements of the resolutions of the Governing Bodies of PAHO/WHO. It also means developing the capacity to secure and utilize technologies appropriate to national conditions.

25. The country offices must be involved in resource mobilization which demands a continuing search for increased national potential, stimulating self-reliance as well as cooperation among countries. This will require the Country Office,in close partnership with the Ministry of Health, to form a broader network of intersectoral relations with other ministries related to health and to other sectors which impact on health, as well as to national centers of research and technical excellence.

26. As a key part of that resource mobilization responsibility, the Country Office must develop the political awareness to permit the realization of an effective, efficient and opportune understanding with national authorities, with bilateral and multilateral agencies, and with other national and international institutions related to the health sector.

27. Country Offices also must engage in a horizontal interchange of information, share expertise, promote teamwork,and generate a spirit of cooperation.

Role of the Regional Programs

28. The Regional Programs constitute a critical portion of the Organization's management of its scientific and technical knowledge in support of the goals of Health for All. The Regional Programs respond to the mandates of the governing bodies, the key priorities of the Plan of Action, and, most important, to the specific needs of the countries. Internally, they are grouped mainly in the two technical areas, one focusing on the specific subjects of health problems and the second concentrating on the health infrastructure's responsibility for implementing that knowledge.

29. The Regional and Subregional centers are critical components of the Regional Programs of the Organization, their resources devoted and their activities designed to assist in meeting the technical cooperation needs of the Member Countries. By concentrating technical expertise in fields of high priority, these centers constitute a rich potential for generating technical cooperation among and between the countries of the Region. They will promote the network concept with national institutions and develop systems for information and technology transfer. The dominant PAHO strategy will be to mobilize existing national centers within the various countries, to speed their attainment of a high level of expertise and see that they become more active in providing technical cooperation to the countries. The Pan American centers will be a central force in promoting this process and in developing the professional skills of those national centers. The Country Office will provide a linkage between national centers, regional centers, and national needs.

Structure of the Secretariat

30. The Secretariat has been reorganized to manage the resources of the Organization more effectively, not in the abstract, but in light of the specific tasks facing the Organization in the next several years. The principles which served as criteria for the reorganization were the following:

--First, the internal structure of the Organization should approximate as closely as possible the structure approved by the Governing Bodies in the Plan of Action and by the World Health Assembly in the Seventh General Program of Work, including the program classification system.

--Second, the structure should respond to the fundamental guide of the strategy which emphasizes the country as the primary focus of all the Organization's activities.

--Third, the structure should offer greater internal coherence, thereby enabling the Organization to function in support of country needs as a comprehensive, integrated institution and not merely as a composite of activities, projects or unrelated services.

--Fourth, the reorganization should emphasize the concept of flexibility so that natural alterations can occur within the major elements as changes occur in the countries, in health conditions, and in cooperation needs.

--Fifth, the new management structure should avoid additional costs and also cause the least possible disruption in the conduct of the routine activities of the Organization.

Intersectoral Linkages

31. The Country Office also has a critical role in strengthening the capacity of the health sector to reach out to involve other sectors in the definition of a solution to national health problems. The effectiveness of that endeavor to promote intersectoral action in support of health goals will depend in part on the degree to which there is coordination and coherence within the health sector itself. The Country Office has a permanent role in seeking to promote that sectoral cohesion, encouraging and working with the Ministry of Health. The Country Office also must play an active and dynamic role itself in working with the Ministry of Health to assess the impact of other sectors on health, to identify their potential resources, and to design strategies to mobilize those resources in support of intersectoral action to attain the goal of Health for All.

32. Aiding in the construction and strengthening of relations between the health sector and research centers as well as formal academic institutions is a corollary to expansion of intersectoral relations. The Country Office can help forge new linkages between the Health Ministry and those institutions to improve the process of defining national health problems and goals and to generate additional resources for their solution.

Interaction with other Agencies

33. Several agencies cooperate with the countries in developing health related projects. PAHO interacts with these agencies both at regional and country level to ensure maximum collaboration and the most productive use of all resources available.

IV. OPERATING MECHANISMS

Coordination

34. The coordinating mechanisms are designed to reflect the basic principles of the strategy and promote the guidelines for action. At the country level, and for PAHO as a whole, it is the Country Representative who has the primary role of coordinating the activities of the Organization. He is charged with coordinating the activities of the country office, managing the country program and assuring that the regional programs support national priorities.

35. Within the Regional Office, coordination is a responsibility of each staff member at every level of the Organization. The entire ethos of the new strategy is to encourage individuals to take the initiative in pursuing linkages with other programs to obtain the complementary actions which create the greatest positive impact. Technical officers with supervisory responsibilities for specific programs are being urged to explore the opportunities for collaborative actions with other program coordinators.

36. The division of the regional technical cooperation activities into two core areas, Health Systems Infrastructure and Health Programs Development, had a principal purpose in facilitating coordination among programs with a similar focus. Area Directors have instituted regular meetings to promote coordinated activities within their respective programs. By combining continuing communication between individual program coordinators within each area as well as promoting frequent contacts between the two areas, greater coordination of the overall technical cooperation of the Organization is to be achieved.

37. In addition to the operational coordination carried out at the level of the Area directors, the Office of Program Operations Coordination has the task of advancing coordinated programming of cooperation between the countries and the Regional Office. Health program analysts in that office have subregional geographic responsibilities and will serve to help facilitate the delivery of technical cooperation.

38. Several units with direct responsibility to the Director have a fundamental objective of serving as internal mechanisms for coordination by virtue of the multidisciplinary nature of their functions. The

activities they undertake affect all of the various technical areas and are undertaken with broad representation from those areas in ad hoc task forces. They include the Office of Analysis and Strategic Planning, the Office of External cooperation, the Office of Information Coordination and the Office of Research Coordination.

39. Four special advisory bodies to the Director have been established to enhance policy coordination. The Director's General Advisory Committee meets weekly and constitutes a forum for discussion of major events and trends requiring policy decisions. The Senior Staff Meeting unites coordinators from the technical and administrative areas to provide counsel to the Director on current problems, programs and policies affecting the technical cooperation of the Organization. A committee on staff development and a permanent committee on information have been established to assist in policy and program development in these areas. The activities of these entities will be communicated regularly not only within the headquarters but to all country representatives and their comments and suggestions will be solicited.

Member Country Participation in the Conduct of the Organization

40. Member Countries participate in the conduct of the Organization through a range of formal and informal interactions. The new emphasis of the Managerial Strategy is to generate a more active role for Member Countries in each of these areas. In the meetings of the Executive Committee, Directing Council, and Pan American Sanitary Conference, Member Countries are being asked to involve themselves more actively in defining the policy and examining the program of the Organization. Through more active use of special committees as well as more frequent use of subregional ministerial meetings, Member Country concerns are to be translated more rapidly into policy and program modifications. Ultimately, the countries themselves are responsible for monitoring how well the Organization manages its resources.

Joint Government/PAHO Policy and Program Reviews

41. Perhaps the most important innovation in achieving more active participation of the Member Countries in defining the programs of the Organization and in translating the principles of the new Management Strategy into practice is the Joint Government/PAHO policy and program review. This review incorporates the Office of the Director, the Country Representatives, and principal regional program coordinators as well as the Country Office technical program. The counterparts include the highest political and technical levels of Ministries of Health and other leading institutions of the health sector. These reviews have been initiated to ensure that future directions in PAHO/WHO technical cooperation conform to national policies and strategies and target specific national needs within a framework of Regional and Global Strategies of Health for All. The underlying premise behind these

reviews is the need for change in the past conduct of PAHO's cooperation in order to increase its effectiveness and relevance. A second premise, to be reflected in specific guidelines to country representatives, is that the country offices are the active force in monitoring the Organization's implementation of the agreements stemming from these reviews. These joint reviews and the expanded role of the Country Representatives, complemented by the planning and programming of the Organization's resources through AMPES, are designed to secure the optimal use of resources in attaining national, regional and global health goals.

Planning, Programming and Budget

42. The Organization's planning, programming and budgeting is an on-going and integrated process, although it has the following specific periods and cycles: long-term planning is directed towards the year 2000; medium-term planning occurs in periods of six years in accordance with the WHO Seventh General Program of Work; short-term planning focuses on the preparation of the two-year program and budget, the two-year operating budget and the annual program of technical cooperation (AMPES).

43. The long-term planning of the Organization is based on the National Health Strategies, the Regional Strategies for Health for All by the Year 2000 and the Plan of Action for their implementation. The last two documents constitute AMRO's contribution to WHO's Global Strategy and the Seventh General Program of Work, and, along with the Plan of Action for implementing the Global Strategy of Health for All, comprise the Organization's long-term plan for improving health conditions in the Americas. However, those documents require continuing review and updating as they are translated into operational activities. At the same time, the PAHO Classified List of Programs, which follows from the adoption of the Seventh General Program of Work, was approved recently by the PAHO Governing Bodies and is now an integral part of the Organization's planning, programming and budgeting procedures. Together, they will work towards ensuring the compatibility of national, regional and global goals in support of Health for All by the Year 2000.

44. The medium-term planning process at the country level takes place in the context of the long-term plans already adopted by the governing bodies, the joint examination of country and regional needs and the specific resolutions of the governing bodies. In that process, due consideration should be given to the impact of demographic and environmental factors on the health situation and an effort should be made to examine possible areas for joint action. At the regional level, long-term plans, relevant resolutions of the governing bodies, and the composite of country needs and requests should also be considered. The changing short and medium term demands from countries must be the major determinant in the on-going process of adjustment of regional programs.

45. For short-term planning and programming, the Organization will utilize the joint Government/PAHO policy and program reviews as a starting point. Negotiations with each specific country are carried out between the government authorities and the PAHO/WHO Country Representative. The methodology consists of an initial stage in which there is joint exploration of the country's health and socioeconomic situation, the national health goals and objectives, and the implications of regional mandates. A second stage involves an analysis of available national resources in the relevant program areas. A third stage involves allocation of PAHO country program services to help fulfill program objectives where domestic technical, physical and financial resources are insufficient. A fourth stage involves the proposed use of additional regional and external resources to offer further support for national priority programs.

46. Based on those reviews, the Organization will continue to utilize AMRO's Programming and Evaluation System (AMPES) as the key managerial tool for programming PAHO's technical cooperation. The PAHO Programming and Evaluation system (AMPES) has been revised to include a series of specific phases to strengthen the system of programming of the Organization's resources consistent with defined national policies and activities and with the collective priorities promulgated by the Governing Bodies. The revisions in the system are designed to simplify its procedural aspects and increase its effectiveness in programming regional resources in support of country needs. The regional programming through AMPES has to be based on the mandates of governing bodies, the medium-term plan, but most crucially, the changing demands from the countries. The resultant document not only constitutes the program of technical cooperation in light of country needs and priorities and PAHO's governing mandates but the composite for all countries and for the region represents the short-term plan of technical cooperation of the Organization.

Management Information System

47. An integral part of the PAHO Management Strategy is the development of an Information System. Reliable, timely and relevant information is required at all stages of the managerial processes and at all levels of the Organization to support management decision-making. That information will be the basis for on-going monitoring of technical cooperation activities to permit appropriate actions when programs veer from their critical path.

48. The Management Information System also will contain country health statistics and that data will become progressively more complete as national information systems develop over time. That information will form part of the data base for monitoring and evaluation of the progress toward Health for All. It will enable continuing analysis and comparisons at the regional level which will be communicated to the countries themselves.

Development of Administrative Procedures

49. The policy of the Administration is to achieve genuine decentralization and bureaucratic simplification of administrative procedures and decision making. To comply with this orientation, Area Offices are being eliminated, Country Offices revitalized and the relationship with the Regional Office strengthened.

50. In order for decentralization to operate in a flexible manner, more adequate financial and administrative mechanisms are required. Such mechanisms include decentralization in the management of fellowships, contractual services, travel authorization, hiring of national experts as short-term consultants, utilization of expertise present in other country offices, increased authority to make local payments and grant authority for meeting unique situations.

Personnel Development

51. The Plan of Action approved by the Governing Bodies identifies several non-traditional areas in the health sector for personnel development as well as new approaches to old problems. The underlying personnel strategy will be to pursue the maximum personal and career development of each staff member. Along with that goal, there is new emphasis on active participation by all staff members in critical analysis of the work of the Organization. Active participation by staff members in defining the problems and identifying alternative solutions and their implications is a fundamental requirement for the well-being of the Organization. Participation in that process will be required of the Country Representatives, of all Country Office staff, and of all Regional Office staff.

52. The primary element in the technical cooperation that PAHO provides to its Member Governments is and will continue to be the technical expertise of its human resources. Two general strategies will be followed to revitalize PAHO's technical staff in accord with the shifting realities of the countries and in keeping with the dynamic nature of technological change in public health. In the first instance, the composition of the technical staff will be readjusted gradually to new requirements as new posts are created or vacancies filled. Second, staff will be offered opportunities to update their technical skills through training and career development activities.

53. The same mechanisms for pursuing staff development within the Organization will be integrated into the technical cooperation activities themselves, providing similar opportunities for national participation in those staff development activities.

Research

54. The research policy is one of the mechanisms by which the Organization intends to achieve optimal use of its resources. Much of the research to be conducted will be of an evaluative nature and many of the Organization efforts are designed to identify areas for research, to promote research in those critical fields and to act as a regional clearinghouse for disseminating the results. No single criterion will suffice in terms of the kinds of research activities to be supported given the diversity of need and research capability in the different countries. Thus, the Organization will work with countries in emphasizing their own particular research needs, which may range from operational research directed at problems in health service delivery to those involved with basic research into biological and genetic questions of significant complexity.

55. In each of the technical and scientific fields, the basic function of the Organization will be one of promotion and coordination, although there will be research projects which PAHO Centers and personnel will conduct and others where direct financial support may be possible. A key objective of the evaluative research will be to decide if a particular technology is appropriate. Ultimately, the research policy will consist in designating the gaps in knowledge which impede solutions to national health problems and to cooperate with the countries to carry out in a coordinated manner the research necessary to fill those gaps.

Network of National Centers of Technical Excellence

56. The establishment of networks of collaborating centers of excellence in each nation is a mechanism for furthering several goals of the Organization. Such national centers can help expand the level of excellence in the techncial cooperation of the Organization. Experts from those centers participate in the technical cooperation programs of the Organization in the host country but they also can serve as resources for other countries as well. They can be the dominant manpower source serving as the instrument for cooperation among countries. Those centers also can be a setting for staff development of PAHO personnel. They can be a source of important links to other institutions in the health sector, to academic institutions and to other sectors. The national networks also can be engaged to jointly study critical problems at the national level, and together with their counterparts, examine problems in other countries as well.

Organizational Mobilization of Resources

57. The mobilization of resources for regional support to national and intercountry activities is a vital operating mechanism of the Management Strategy. That process occurs both at the country and regional office levels. At the country level, an essential base for optimum use of

national resources in the program of cooperation is a well-defined and active national health planning process. Applying PAHO/WHO resources to assist governments in developing this process could produce a significant multiplier effect for the effective and efficient use of national resources devoted to national health programs. That same mutual planning process can be the instrument for spurring the process of technical cooperation among countries.

58. Part of that process is the Organization's effort to identify centers of excellence and other technical resources available within other developing countries of the Region. Another critical PAHO role is to act as a catalyst to bring those resources to bear on national problems--both in their identification through joint studies and in their solution through joint programs.

59. Finally, at both the country and regional level, the Organization has a vital role to play in assisting the countries in seeking additional financing from other bilateral and multilateral financing institutions. It is identifying prospective donor agencies and, their requirements, and will assist countries in the preparation of proposals for submission to those agencies. Countries in each instance, close consultation between the country office and the regional office will insure that proposed international cooperation conforms to national health programs and national and regional health priorities.

Monitoring and Evaluation

60. Monitoring and evaluation within the Organization will occur at both the country level and the regional office level. At the Country level, PAHO will collaborate with the countries in developing their own capacity to monitor the use of their resources in pursuit of program objectives and goals. By providing the necessary information in a progressively more reliable and more timely manner, decision-makers will be able to identify unforeseen obstacles, and to adjust programs accordingly. Since the very process of insuring a more adequate utilization of national resources contributes to a more effective utilization of PAHO/WHO resources, the enhancement of the national capacity for monitoring and evaluation will be a continuing priority of the Organization.

61. The Organization is committed to support the complementary objective of the monitoring and evaluation processes at country level. In accordance with the Plan of Action for Implementing the Regional Strategy for Health for All, monitoring and evaluation of national progress toward the goals of Health for All is to be a catalyst for advancing the national process of planning and management. As it permits an evaluation of progress achieved toward the national and regional goals of Health for All, it provides national health managers with the information needed to improve existing programs or to develop new programs

62. A regional responsibility is the consolidation and analysis of the contributions from Member Countries' own monitoring and evaluation in order to obtain a regional assessment of progress toward the goals of Health for All by the Year 2000. That regional monitoring and evaluation of progress toward the goals of HFA/2000 will constitute the regional contribution to the global monitoring and evaluation process. It also will facilitate decision-making within PAHO in order to adjust and reorient the Organization's policies and programs. It will yield vital information that will allow the Organization to enhance the effectiveness of our technical cooperation, to mobilize international financing, to target TCDC as well as to identify new problems that appear during the process of implementing the Plan of Action. The regional assessment also will have the added function of providing to the Member Countries composite information of regional progress which can be utilized by them in their own adjustment of policies, strategies, plans and programs.

63. Regional monitoring and evaluation of PAHO's own activities also will constitute a permanent task. At every level of the Organization monitoring of imputs and products of each program will be combined with efforts to evaluate the impact of those activities.

V. Conclusion

64. The Managerial strategy offers a basic statement of the framework, principles, guidelines and operating mechanisms which PAHO will use to pursue its responsibilities to its regional and global governing bodies and to the people of the Americas. It incorporates changes in approach, procedures and practices which hopefully conform more closely to the current needs of Member Countries. It contains within it a commitment to flexibility based on a determination to reflect and respond to the changing needs of the Member Countries. That same commitment to change will require regular reviews in order to ensure that its own managerial principles and practices continue to promote the optimal use of PAHO/WHO resources in support of the Member Countries and the goals of Health for All by the Year 2000.

EVALUATING THE STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000

COMMON FRAMEWORK AND FORMAT

PAHO MONITORING AND EVALUATION PLANS

(Presentation by Roger A. Dixon, PASB)

Regional Monitoring and Evaluation System. The Plan of Action for implementing the Regional Strategies of Health for All by the Year 2000 (HFA/2000) and the Managerial Strategy for the Optimal use of PAHO/WHO Resources in Direct Support of Member Countries call for the establishment of a monitoring and evaluating system. Monitoring is systematically following up on activities to see if actions are being implemented as planned. Corrective actions can be taken to redirect activities which deviate from plan or plans may be changed to fit the new realities. Evaluation focuses on the impact or results of the activities and the efficiency and effectiveness of the procedures used.

The regional monitoring and evaluation system called for in the above mentioned documents is to operate at two levels: the regional level which is to be organized by the Secretariat of PAHO/WHO and the country level which is the responsibility of the Member Governments. There are minimum goals and obligatory indicators which are to be used as measures of progress toward Health for All by the Year 2000.

The American Region Programming and Evaluation System (AMPES) is the regional level system designed to facilitate the programming, monitoring and evaluation of technical cooperation of the Organization with the Member Governments. The AMPES includes three stages: programming, execution and evaluation. Programming consists of identifying technical cooperation activities, allocating resources and stipulating delivery times. Programming, inter alia, requires documentation of the health situation, the basic indicators and the national health programs at the country level and a description and analysis of the health situation at the regional level. Execution includes delivering technical cooperation to Member Governments and monitoring timeliness and appropriateness of the delivery. Evaluation is to be completed annually in the form of Annual Evaluation Reports compiled by the Country Representatives (CR) and the Program Coordinators (PC).

Evaluating the Strategies for Health for All by the Year 2000. Common Framework and Format (CFF). The CFF was approved by the Global Programme Committee (GPC) in February 1984 in response to the World Health Assembly mandate to monitor and evaluate the progress toward HFA/2000. The stated rationale for the document is to assist the Member Governments to review their commitment to HFA/2000 and determine what has been accomplished.

Two activities are emphasized in the CFF. First, Member Governments are encouraged to compare their current efforts against the monitoring report completed last year. Second, Member Governments are encouraged to review their strategies to see where improvements can be made in their health delivery systems.

The CFF is to be completed by March 1985 at the country level. Then each WHO Region is to complete country summaries and a regional summary based on the information received from the countries. A mock-up of a summary country review is to be prepared at WHO headquarters and sent to the Regions by the end of July 1984. The country review mock-up and the formats for the regional and global summaries will be discussed at the next meeting of the Programme Development Working Group (PDWG), scheduled for the fall of 1984.

The final report, will contain a global synthesis (estimated at 150 pages), regional syntheses (estimated at 35 pages per region) and country summaries (estimated at five pages per country). The report will be published in 1986 in the six official WHO languages.

The CFF contains 85 questions grouped under 26 headings. Basically there are three types of questions in the CFF. One type focuses on statistical data, a second type on the development of strategies and mechanisms for implementing HFA/2000 and a third type on obstacles encountered in redirecting health strategies at the country level. Many of the first type and some of the second can be answered at PAHO Headquarters using basic data previously received from the countries and mentioned in PAHO Statistics Office (PHS) and the country narratives from AMPES. The third type is more appropriately dealt with at country level.

Recommendation No. 1

To complete the CFF the following actions are recommended:

. Field Test

- PAHO staff will complete partially the CFF for several countries using basic data obtained from PAHO's Statistics Office and other sources including the country narratives from the AMPES.

- PAHO staff will discuss the partially completed CFF with the Country Representatives and representatives from the Member Governments and assist the Member Governments in completing the CFF.

- Member Governments will be requested to finalize the CFF and return an endorsed copy to PAHO.

. Revise the process based on the results of the field test.

. Discuss the revised process at the Directing Council Meeting in the Fall.

. Implement the process for completing the CFF in all countries in the Region.

Recommendation No. 2

Establish a Regional Monitoring and Evaluation System based on the AMPES.

The Regional Monitoring and Evaluation System would have five major components.

. Technical cooperation to the Member Governments on how to monitor and evaluate. Planning seminars, which include monitoring and evaluation, are now being conducted by PAHO regional programs. The only additional requirement would be to ensure that all aspects of the Regional Monitoring and Evaluation System are integrated into the technical cooperation activities.

. Programming as now done in the AMPES. Here it will be necessary to revise only slightly the country narrative guidelines to ensure that all global and regional indicators are called for in specific terms.

. Monitoring PAHO/WHO funded activities and providing timely feedback to top management on priority technical projects and administrative systems. A procedure should be established to identify milestones in the AMPES which will form the basis of periodic progress reports to the Director's Office. Country Representatives and Program Coordinators would report progress against the agreed upon milestones. This will require a slight revision in the operational programming portion of AMPES and place greater emphasis on follow-up of planned activities.

. Evaluation. The Annual Evaluation Report done by the Country Representatives and the Annual Evaluation Report done by the Program Coordinator should have a prescribed format which correlates with the country narratives so that they are more useful for comparative analysis. A formal review process should be established to evaluate about one-third of the PAHO/WHO technical programs each bienium regarding their impact, efficiency and effectiveness. The reviews would be accomplished by special working groups drawn from PAHO regional and field staff and representatives from the Member Governments.

. Report generation would be a by-product of the system. Properly implemented this system would generate a base of information which could be used to meet PAHO's reporting requirements.

Next steps

- Complete the field test for the CFF.

- Integrate discussion of the Regional Monitoring and Evaluation System and the CFF into the planning seminars being conducted by PAHO regional programs.

- An agenda item on monitoring and evaluation would be added to the Directing Council meeting in September 1984. The Secretariat would report on the Regional Monitoring and Evaluation System and progress in completing the CFF. National delegations could report on their own evaluation processes.

WORLD HEALTH ORGANIZATION

EVALUATING THE STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000

- Common Framework and Format -

This document consists of a framework and format to help you evaluate on a continuing basis the effect of your strategy on your people's health and its impact on the socioeconomic development of your country.

It is first and foremost for your use; it is not a WHO questionnaire. However, you did agree as a Member State of WHO to inform your Regional Committee of your findings by March 1985 in order to make it possible to build up regional and global evaluations.

DGO/84.1
Geneva, 31 January 1984

List of Contents

INTRODUCTION

1. When you adopted the Global Strategy for Health for All by the Year 2000 in the World Health Assembly and the Plan of Action for implementing it, you agreed with all other Member States of WHO to monitor the progress of your national strategy and to evaluate the effect it was having on the health of your people. The purpose of this Evaluation Framework is to help you do the latter on a continuing basis. But evaluation cannot be undertaken in a vacuum. It forms part of a broader managerial process for health development which includes the formulation of policy; the development and implementation of a strategy to give effect to that policy, including the allocation of resources; a plan of action to carry out the strategy; its monitoring and evaluation; and information support to all parts of the process. However, monitoring and evaluation can be useful entry points to this broader managerial process. WHO is ready to help you strengthen your managerial capacity, including your monitoring and evaluation capacity, if you want it to.

2. The above is stressed to make it clear that this Evaluation Framework is not a WHO questionnaire. It is for your use, to facilitate the systematic evaluation of your strategy by you, and for you to learn from the experience and use the lessons learned to improve your current activities and to promote better planning by you, through careful selection of alternatives for further action.

3. To carry out any evaluation it is necessary to collect and analyse relevant information. This can be done in a variety of ways, for example through the process of monitoring which you started in 1983. Just as you presented a report on the findings of your monitoring to the Regional Committee in 1983, you are now being asked to present a report on the findings of your evaluation to the Regional Committee in 1985. In this way, the evaluation of the regional strategy will become possible, as well as the ultimate evaluation of the Global Strategy based on the evaluation of all the regional strategies. You agreed to that

too when you adopted the Global Strategy for Health for All and approved the Plan of Action for implementing it. Moreover, you also agreed that these reports would form the basis of the regional health situation reports to be published in each of the six WHO regions, and of the Seventh Report on the World Health Situation of which these regional reports will form a part.

4. At first glance this Evaluation Framework may appear complex and lengthy. However, the difficulty lies not so much in the Framework as in the evaluation process itself. This Framework is intended to help you to carry out such a process, step by step. You may find it useful to glance through the whole of it first of all to get the feel of it, and then use it systematically, item by item, on a continuing basis - not just as a one-time affair. WHO is ready to help you in this if you want to. It has also issued two publications which you may find helpful: "Health Programm Evaluation" and "Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000", the first appearing as "Health for All" Series No. 6 and the second as "Health for All" Series No. 4.

5. To make the process as practical as possible, each item in this Framework consists of two complementary parts. The lefthand pages are organized by the main items for evaluation, each item being subdivided into a number of questions. For each question a cross-reference is made to the related component of evaluation that appears in the publication "Health Programme Evaluation" mentioned above - that is: relevance, adequacy, progress, efficiency, effectiveness and impact. So the lefthand pages are made up of the issues being evaluated, questions to guide you in evaluating, and a reference to place each question in its proper context in the evaluation process. Each righthand page complements each lefthand page in that it consists of points relating to the questions on the lefthand page. These points are extracted from WHO's "Health for All" Series. (A complete list of these publications is to be found on page 75.) For example, if you look at the lefthand page 18 you will see that it consists of questions related to health

systems based on primary health care. If you turn to the righthand page 19 you will see that it consists of points that illustrate the essential characteristics of primary health care and of health systems based on it. They have been extracted from the Report of the International Conference on Primary Health Care in Alma-Ata and from the Global Strategy for Health for All. These points on the righthand page are meant to help you by drawing your attention to a kind of ideal situation that Member States envisaged collectively. In reality, at this stage the situation in your country may fall short of that ideal. If it does, this should not discourage you. Evaluation is not meant to lead to mere criticism by you or by others; it is meant to lead to action for improvement by you.

6. A word about your report to the Regional Committee. Please present it as a separate document and not in the body of this Common Framework; it was not constructed with space for that purpose. Please indicate on each sheet of your report the number of the item in the Common Framework being reported on. For example, where your report deals with matters related to health manpower please write "Item 8: HEALTH MANPOWER". Also please give your report a covering page with the name of your country, the date of completion of the report, and the period covered (e.g. 1978-1984). Finally, please do not hesitate to contact the WHO Programme Coordinator in your country or, in the absence of one, the Regional Director, for any further clarification you may require. In doing so, please remember once again, the purpose of this Framework is to help you evaluate your strategy, not merely to supply information to WHO.

Item 1: EVALUATION PROCESS

Evaluation is a continuing process, not a one-time exercise. This being the case, some kind of mechanism is required to gather and analyze the necessary information in a systematic manner.

1.1 WHAT PROCESS HAVE YOU ESTABLISHED TO MONITOR AND EVALUATE YOUR STRATEGY AND WHAT MECHANISM HAVE YOU SET UP TO THIS END ?

(Progress)

1.2 IF YOU HAVE NOT ESTABLISHED AN EVALUATION PROCESS AND RELATED MECHANISM, WHAT ARE YOUR PLANS TO DO SO ?

(Progress)

The extracts on the opposite page illustrate the type of process you might use for evaluating your strategy.[1]

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1 "Global Strategy for Health for All", "Health for All" Series, No. 3, Section VII, page 73, paragraph 1.

"Health Programme Evaluation, Guiding Principles", "Health for All" Series, No. 6, Section II, page 11, para. 7, and page 15, paragraph 17.

Points to be considered with respect to Item 1

(1) Governments will want to know if they are making progress with the implementation of their strategies, and whether these strategies are having the desired effect in improving the health status of the people. To this end they will consider introducing at the earliest stage a process of monitoring and evaluation that is appropriate to their needs as part of their managerial process for national health development. Whatever the precise nature of the process, it should include monitoring progress in carrying out the measures decided upon, the efficiency with which these measures are being carried out, and the assessment of their effectiveness and impact on the health and socioeconomic development of the people.

(2) The purpose of evaluation in health development is to improve health programmes and the services for delivering them, and to guide the allocation of human and financial resources in current and future programmes and services. It should be used constructively and not for the justification of past actions or merely to identify their inadequacies.

(3) It is essential to perceive evaluation as a decision-oriented tool, and to link the evaluation process closely with decision-making, whether at the operational or the policy level. The very process of carrying out an evaluation can be just as important as the conclusions drawn, since involvement in the process itself often induces a better understanding of the activities being evaluated, and a more constructive approach to their implementation and to any future action required.

(4) As for the responsiblity for evaluation, the principle whereby evaluation should be conducted as an integral part of the various steps of the overall managerial process implies that individuals and groups responsible for the development and application of that process at the various policy and operational levels also carry responsibility for its evaluation.

Item 2: HEALTH POLICIES

2.1 HAVE YOU COMPARED SYSTEMATICALLY YOUR EXISTING HEALTH POLICIES WITH THOSE COLLECTIVELY DEFINED FOR HEALTH FOR ALL ? WHICH AREAS (IF ANY) REQUIRE FURTHER STRENGTHENING ?

(Relevance)

2.2 HAS "HEALTH FOR ALL" RECEIVED ENDORSEMENT AS POLICY AT THE HIGHEST OFFICIAL LEVEL ? (Global Indicator No. 1)

(Relevance)

2.3 HAVE YOU FORMULATED ADDITIONAL OR REVISED EXISTING HEALTH POLICIES SINCE YOU REPORTED ON THIS IN 1983 ? IF YES, DESCRIBE.

(Progess)

2.4 WHAT OBSTACLES, IF ANY, HAVE IMPEDED THE DEVELOPMENT OF NATIONAL HEALTH POLICIES FOR THEM TO BE IN LINE WITH THE POLICY OF HEALTH FOR ALL AND WHAT MEASURES DO YOU INTEND TO TAKE TO OVERCOME THESE OBSTACLES ?

(Progress)

The principles on the opposite page and on page 11 indicate what a national policy for Health for All might consist of and what information would respond to Global Indicator No. 1, which is quoted on page 11.[1]

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1 "Formulating Strategies for Health for All", "Health for All" Series, No. 2, Section III, page 14, para. 17 and page 16, paragraphs 24 and 25.

"Global Strategy for Health for All", "Health for All" Series, No. 3, Section II, pages 34-35, paragraph 9.

Points to be considered with respect to Items 2.1, 2.3 and 2.4:

(1) A national health policy is an expression of goals for improving the health situation, the priorities among those goals, and the main directions for attaining them.

(2) Sound health policies contribute to overall socioeconomic policies; thus, if the country's overall development policy gives priority, for example, to rural development, urbanization, or industrialization, the health policy has to give preferential attention to these priorities.

(3) Health is a fundamental human right and a world wide social goal.

(4) The overall social goal of health for all has to be broken down into more concrete social policies aimed at improvement of the quality of life and maximum health benefits to all. If the gap between "haves" and "have-nots" is to be reduced within and among countries, there will be a need in most countries to formulate and put into effect concrete measures for more equitable distribution of resources. In many countries this will imply the preferential allocation of health resources to those in greatest social need as an absolute priority, as a step towards attaining total population coverage.

(5) The existing gross inequality in the health status of people is of common concern to all countries and must be drastically reduced. An equitable distribution of health resources, both among countries and within countries, leading to universal accessibility to primary health care and its supporting services, is therefore fundamental to the Strategy.

(6) People have the right and the duty to participate individually and collectively in the planning and implementation of their health care. Consequently, community involvement in shaping its own health and socioeconomic future, including mass involvement of women, men and youth, is a key factor in the Strategy.

(7) Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and other social measures. The political commitment of the State as a whole, and not merely the ministry of health, is essential to the attainment of health for all.

(8) Countries must become self-reliant in health matters if they are to attain health for all their people. National self-reliance implies national initiative, but not necessarily national self-sufficiency. Where health is concerned no country is self-sufficient; international solidarity is required to ensure the development and implementation of health strategies and to overcome obstacles. Such international health solidarity must respect national self-reliance.

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Item 2: HEALTH POLICIES (continued)

Item 2.2:

Opposite are Global Indicator No. 1 and points to be considered with respect to the endorsement of the policy for "Health for All" mentioned in item 2.2[1]

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1 "Global Strategy for Health for All", "Health for All" Series, No. 3, page 75.

"Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000", "Health for All" Series, No. 4, pages 18 and 19.

"Managerial Process for National Health Development: Guiding Principles", "Health for All" Series No. 5

Points to be considered with respect to Items 2.1, 2.3 and 2.4 (continued)

(9) In conformity with the recognition by the United Nations General Assembly of health as an integral part of development, the human energy generated by improved health should be channelled into sustaining economic and social development, and economic and social development should be harnessed to improve the health of people.

(10) Health for all by the year 2000 cannot be achieved by the health sector alone. The coordinated efforts will be required of other social and economic sectors concerned with national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, and communications. Ministries of health or analogous authorities have an important role in stimulating and coordinating such joint action for health.

Global Indicator No. 1 and Points to be considered with respect to Item 2.2

Global Indicator No. 1 reads:

"Health for all has received endorsement as policy at the highest official level."

The following points can give an indication, whether endorsement exists. If the answer is "yes", the type of endorsement should be described.

(1) The Constitution of the country contains a statement on the right of citizens in respect of health.

(2) A declaration of commitment to health for all has been made by the head of the state, the cabinet or party committees.

(3) If a regional health charter has been established, the country has endorsed it.

(4) There have been significant changes during the past four years in the policy for the allocation of resources (budget, manpower or facilities) in favour of primary health care and in particular in favour of underserved population groups: for example .....

(5) A systematic managerial process has been adopted for national health development, including measures for preparing and carrying out national strategies and plans of action through policy formulation, programming, programme budgeting, operational management, monitoring, evaluation and information support, in accordance with the principles described in: Managerial Process for National Health Development: Guiding Principles, WHO, 1981 ("Health for All" Series, No. 5). See also Item 6 on page 24.

Item 3: NATIONAL "HEALTH FOR ALL" STRATEGIES

3.1 DOES YOUR HEALTH STRATEGY REFLECT YOUR HEALTH POLICY ? HAVE YOU COMPARED SYSTEMATICALLY YOUR EXISTING HEALTH STRATEGY WITH THOSE DEFINED FOR HEALTH FOR ALL ? WHICH AREAS (IF ANY) REQUIRE FURTHER STRENGTHENING ?

(Relevance)

3.2 HAVE YOU UPDATED YOUR STRATEGY AND PLAN OF ACTION SINCE 1983 ? IF YES, DESCRIBE THE MODIFICATIONS.

(Progress)

3.3 IF YOU HAD NOT DEVELOPED A STRATEGY AND PLAN OF ACTION BY 1983, HAVE YOU DONE SO SINCE THEN ?

(Progress)

3.4 WHAT OBSTACLES, IF ANY, HAVE IMPEDED THE DEVELOPMENT OF NATIONAL HEALTH STRATEGIES IN LINE WITH THE STRATEGIES FOR HEALTH FOR ALL AND WHAT MEASURES DO YOU INTEND TO TAKE TO OVERCOME THESE OBSTACLES ?

(Progress)

The points on the opposite page and on page 15 illustrate what a national strategy and plan of action might consist of.[1]

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1 "Formulating Strategies for Health for All", "Health for All" Series, No. 2, Section III, pages 14-20, paragraphs 17, 21-35.

Points to be considered with respect to Item 3:

National Health Strategies and Plans of Action

A national strategy, which should be based on the national health policy, includes the broad lines of action required in all sectors involved to give effect to that policy. A national plan of action is a broad intersectoral master plan for attaining the national health goals through implementation of the strategy. It indicates what has to be done, who has to do it, during what time frame, and with what resources. It is a framework leading to more detailed programming, budgeting, implementation and evaluation.

NATIONAL STRATEGIES

(1) The strategies should incorporate the systematic identification and use of suitable entry points for fostering health development, ways of ensuring the involvement of other sectors bearing on health, the range of political, social, economic, managerial and technical factors, as well as obstacles and constraints and ways of dealing with them.

(2) Political Commitment
The introduction or strengthening of the development process needed to attain health for all will require unequivocal political commitment to bring about the reforms that are essential to convert this goal into a reality. This will most likely have to be set in motion by political decisions taken by the government as a whole, and permeating all sectors, at all levels throughout the country, and not merely by the ministry of health or the health sector alone.
National political commitment will be reinforced by technical cooperation among countries and by international political support.

(3) Community Involvement and Participation
Measures have to be taken to ensure free and enlightened community involvement and participation, so that notwithstanding the overall responsibility of governments for the health of their people, individuals, families and communities assume greater responsibility for their own health and welfare, including self-care.

(4) Administrative Reform
The strengthening and adaptation of administrative structures and systems at all levels and in all sectors, not only the health sector, may be required.

Item 3: NATIONAL "HEALTH FOR ALL" STRATEGIES (continued)

Points to be considered with respect to Item 3: (continued)

(5) Financial Implications
In most countries there will be a need to reallocate resources. In addition, in many countries it will be necessary to increase the national health budget to the greatest possible extent in order to provide the population with essential health care.
Although most of the resources for national health development come from the country concerned, there will nevertheless be a need for substantial and continuing international support for developing countries. The nature of this support must be subject to decisions of the government of the developing country concerned.
It is essential to consider the costs of programmes and services and how they can be borne. These might include government direct and indirect financing, social security and health insurance schemes, local community solutions and the use of external loans and grants.

(6) Enabling Legislation
In some countries it may be necessary to legislate in order to introduce the necessary reforms.

NATIONAL PLANS OF ACTION

(7) What has to be done ? The national plan of action has to specify the policies to be followed, the objectives to be attained and related targets, quantified to the extent possible. It includes the political, social, economic and administrative dispositions and the technology required, together with any necessary legislation and managerial mechanisms and processes.

(8) Who has to do it ? The ministry of health or equivalent governmental authority is responsible for promoting and sustaining the development of plans of action. To do so effectively, it has to involve all levels of the health system, including all health workers, as well as the other social and economic sectors concerned.

(9) Time frame The implementation of plans of action is a long-term process for which it is difficult to specify a definitive precise timetable in advance. Nevertheless, it is useful to prepare tentative, rough timetables and to refine them progressively, realizing that implementation will depend on a variety of political social, economic, managerial and technical circumstances, including the extent to which resources can be made available in accordance with requirements.

(10) Resources Broad allocations and ways of financing have to be defined at the intial stages of formulation of plans of action. Without this, plans cannot be materialized.

Item 4: INTEGRATION WITH NATIONAL SOCIOECONOMIC PLAN

4.1 HAS YOUR NATIONAL HEALTH STRATEGY BEEN FULLY INCORPORATED INTO YOUR NATIONAL SOCIOECONOMIC PLAN ? IF NOT FULLY, WHAT ASPECTS HAVE BEEN REFLECTED ?

(Relevance)

4.2 IF IT HAS NOT AT ALL, WHAT OBSTACLES HAVE IMPEDED THE INCORPORATION OR REFLECTION OF THE NATIONAL STRATEGY FOR HEALTH INTO THE NATIONAL SOCIOECONOMIC PLAN AND WHAT MEASURES DO YOU INTEND TO TAKE TO OVERCOME THEM ?

(Progress)

The points opposite illustrate the relationship between health and socioeconomic development.[1]

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1 "Global Strategy for Health for All", "Health for All" Series, No. 3, Section II, pages 35-37, paragraphs 10-12.

Points to be considered with respect to Item 4:

(1) The improvement of health not only results from genuine socioeconomic development as distinct from mere economic growth, it is also an essential investment in such development. In recognition of these intimate interrelationships and in compliance with the fundamental policies presented above, the Strategy will be based on the mutual reinforcement of health development policy and socioeconomic development policy. Full account will be taken of the extent to which the achievement of health goals will also be determined by policies that lie outside the health sector, and in particular policies aimed at ensuring universal access to the means to earn an acceptable income, whatever their nature. In many countries the conquest of poverty will be the overriding priority.

(2) But merely to increase incomes will not guarantee health. While there is a close relationship between health and income at the very lowest income levels, as incomes begin to rise health hazards associated with economic development begin to emerge. Health authorities will have to display vigilance in identifying and introducing elements that are essential for health development in national, regional, and global socioeconomic development plans. This involves making economic planners and political decision-makers aware of the health implications of alternative development strategies, identifying those aspects of development schemes which can either promote or threaten health, and ensuring that safeguards to health are incorporated into their design.

(3) Health authorities and governments will also assure economic planners and political decision-makers that endeavours to improve health in conformity with the fundamental policies for health for all outlined above are an investment in human development. Health authorities will use the very Strategy for health for all, based on social justice and on equity in the distribution of resources for health, as an example to be followed by other sectors. They will insist on seeing evidence that investments in economic development will indeed bring about improvements in the quality of life and standard of living of people. Other sectors will be encouraged to take appropriate action to minimize hazards to health and to take full account of health goals as part of their own sector goals.

Item 5: HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE

5.1 HAVE YOU REVIEWED SYSTEMATICALLY YOUR HEALTH SYSTEM AND HAVE YOU MADE FURTHER ADJUSTMENTS TO IT AS NECESSARY SO THAT IT REFLECTS THE ESSENTIAL CHARACTERISTICS OF A HEALTH SYSTEM BASED ON PRIMARY HEALTH CARE OUTLINED IN THE ALMA ATA DECLARATION AND REPORT ? DESCRIBE.

(Relevance)

5.2 WHAT IS THE PROPORTION OF THE POPULATION FOR WHOM PRIMARY HEALTH CARE IS AVAILABLE ? (Global Indicator No. 7)

(Adequacy)

5.3 WHAT OBSTACLES, IF ANY, HAVE IMPEDED THE NEEDED ADJUSTMENT OF YOUR EXISTING HEALTH SYSTEM AND WHAT MEASURES DO YOU INTEND TO TAKE TO OVERCOME THEM ?

(Progress)

The points opposite and on page 21 illustrate the essential characteristics of Primary Health Care and of health systems based on it. Global Indicator No. 7 and points that could be considered in gathering the information in response to item 5.2 are also given on pages 21 and 23.[1]

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1 "Alma-Ata 1978: Primary Health Care, "Health for All" Series, No. 1, Section VII, page 4, paragraph 3.

"Global Strategy for Health for All", "Health for All" Series, No. 3, Section III, pages 39-42, paragraphs 2 and 6, and pages 75 and 76.

"Development of Indicators for Monitoring Progress Towards Health for All", "Health for All" Series No. 4, pages 28-32, paragraphs 77-86 and pages 57-63, paragraphs 183-214.

Points to be considered with respect to Item 5:

(1) Primary Health Care includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

(2) While no universal blueprint of a health system can be imposed on countries, and much remains to be done to work out the most appropriate ways of developing health systems in different national circumstances, the following principles have been defined that are applicable to all health systems based on primary health care:

- The system should encompass the entire population on a basis of equality and responsibility.

- It should include components from the health sector and from other sectors whose interrelated actions contribute to health.

- Primary health care, consisting of at least the essential elements included in the Declaration of Alma-Ata, should be delivered at the first point of contact between individuals and the health system.

- The other levels of the health system should support the first contact level of primary health care to permit it to provide these essential elements on a continuing basis.

- At intermediate levels more complex problems should be dealt with, more skilled and specialized care as well as logistic support should be provided, and more highly trained staff should provide continuing training to primary health care workers, as well as guidance to communities and community health workers on practical problems arising in connexion with all aspects of primary health care.

- The central level should coordinate all parts of the system, and provide planning and management expertise, highly specialized care, teaching for specialized staff, the expertise of such institutions as central laboratories, and central logistic and financial support.

(3) To develop such health systems countries will take into account the following:

- Action to be taken in the health sector will be identified, planned and coordinated.

- Action to be taken in other sectors will be identified, and the responsible authorities approached with a view to implementation.

- Ways will be devised of involving people and communities in decisions concerning the health system and in taking responsibility for self-care as well as family community care.

- Central planning will aim at enabling communities of different types and sizes to work out their own primary health care activities.

- A supportive referral system will be devised and put into effect, particular attention being paid initially to the first referral level.

Item 5: HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE (continued)

Points to be considered with respect to Item 5: (continued)

- A logistic system will be organized and operated for the whole country.

- Health manpower will be planned, trained and deployed in response to specific needs of people as an integral part of the health infrastructure.

- Appropriate health care facilities will be planned for, designed, constructed and equipped so that they are readily available, accessible and acceptable to all the population.

- Health technology will be selected that is scientifically sound, adaptable to various local circumstances, acceptable to those for whom it is used and to those who use it, and maintainable with resources the country can afford.

Global Indicator No. 7 and points to be considered with respect to Item 5.2

Global Indicator No. 7 reads:

"Primary health care is available to the whole population, with at least the following:

- safe water in the home or within 15 minutes' walking distance, and adequate sanitary facilities in the home or immediate vicinity;
- immunization against diphtheria, tetanus, whooping-cough, measles, poliomyelitis, and tuberculosis;
- health care, including availability of at least 20 essential drugs, within one hour's walk or travel;
- trained personnel for attending pregnancy and childbirth, and caring for children up to at least 1 year of age."

At least the following sub-indicators should be reported with the year to which they refer. It will be useful if the figures are available separately for urban and rural areas. For national monitoring and evaluation further geographical breakdowns may be required.

(1) The proportion of the population to which safe drinking water is available in the home or within 15 minutes' walking distance. Safe water supply should include treated surface waters and untreated but uncontaminated water such as that from protected boreholes, springs and sanitary wells. Other sources of doubtful quality should be considered unsafe and not included in the estimate of coverage.

(2) The proportion of the population to which adequate facilities for hygienic waste disposal are available in the home or immediate vicinity. Facilities are considered adequate if they effectively prevent contact with and access to excreta by humans, animals and insects.

Item 5: HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE (continued)

(3) The proportions of infants under 1 year of age who have been fully immunized against diphtheria (3 doses), tetanus (3 doses), whooping-cough (3 doses), measles (1 dose), poliomyelitis (3 doses) and tuberculosis (1 dose). If the target population includes older children, the age limit used should be specified. In addition, the proportion of pregnant women immunized against tetanus (2 doses) should also be reported.

(4) The proportion of the population to which first-level contact for appropriate treatment of common diseases and injuries, including the regular supply of at least 20 essential drugs, is available within one hour's walk or travel by the means commonly available in the community.

(5) The proportion of women who were attended during pregnancy and at childbirth, and the proportion of children cared for up to at least 1 year of age, by trained personnel. The criteria used to judge the adequacy of training of the attendant should be described.

Item 6: MANAGERIAL PROCESS AND MECHANISM

6.1 WHAT MANAGERIAL PROCESS AND RELATED MECHANISM HAVE YOU SET IN MOTION TO DEVELOP, IMPLEMENT AND UPDATE YOUR STRATEGY AND PLAN OF ACTION ? DESCRIBE.

(Adequacy)

6.2 WHAT OBSTACLES, IF ANY, HAVE IMPEDED TAKING THE NECESSARY MANAGERIAL MEASURES AND WHAT DO YOU INTEND TO DO TO OVERCOME THEM ?

(Progress)

The points opposite indicate the managerial measures required to develop and implement a national strategy and plan of action for Health for All.[1]

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1 "Global Strategy for Health for All", "Health for All" Series, No. 3, Section IV, pages 59 and 60, paragraphs 14 and 15.

"Managerial Process for National Health Development, Guiding Principles", "Health for All" Series, No. 5, page 14, paragraph 13.

Points to be considered with respect to Item 6:

(1) To permit them to develop and implement their strategies, countries that have not already done so will establish a permanent, systematic, managerial process for health development. Whatever the precise nature of the process, it will lead to the definition of clearly stated objectives as part of the national strategy and, wherever possible, specific targets. It will facilitate the preferential allocation of health resources for the implementation of the Strategy, and will indicate the main lines of action to be taken in the health and other sectors to implement it. It will specify the detailed measures required to build up or strengthen the health system based on primary health care for the delivery of countrywide programmes. The managerial process will also specify the action to be taken so that detailed programmes become operational as integral parts of the health system, as well as the day-to-day management of programmes and the services and institutions delivering them. Finally, it will specify the process of evaluation to be applied with a view to improving effectiveness and increasing efficiency, leading to modification or updating of the Strategy as necessary. Health manpower planning and management will be an inseparable feature of the process. For all the above, the support of relevant and sensitive information will be organized as an integral part of the health system.

(2) Ministries of health will establish permanent mechanisms to develop and apply their managerial process and to provide adequate training to all those who need it. These may include mechanisms in ministries themselves, as well as networks of individuals and institutions in the health and other sectors, including academic institutions, to collaborate in the managerial research, development and training efforts required for health development.

(3) Continuity is essential to the managerial process for national health development. In order to ensure it, ministries of health may need to establish or strengthen mechanisms to provide political and technical support, as well as effective coordination within the health sector, with other sectors, and with communities. Ministries of health usually have the main responsibility for defining national health policies, formulating health programmes, and designing, operating, and controlling health systems. To be as effective as possible, ministries of health should form an integral part of the policy-making mechanism concerned with socioeconomic development at the highest government level; at the same time they should maintain close contact with other ministries and government authorities dealing with socioeconomic development.

Item 7: COMMUNITY INVOLVEMENT

7.1 WHAT ADDITIONAL POLICIES AND MECHANISMS HAVE YOU DEVELOPED FOR INVOLVING COMMUNITIES IN PLANNING AND IMPLEMENTING YOUR NATIONAL HEALTH STRATEGY ? ARE THESE ADEQUATE ?
(Global Indicator No. 2)

(Adequacy and Progress)

7.2 IN WHAT WAYS ARE COMMUNITIES INVOLVED IN HEALTH MATTERS ? GIVE EXAMPLES.

(Progress)

7.3 WHAT MEASURES HAVE YOU TAKEN TO INCREASE YOUR PEOPLE'S UNDERSTANDING OF THEIR HEALTH PROBLEMS AND WAYS OF SOLVING THEM ?

(Progress)

7.4 WHAT HAVE BEEN THE MAIN OBSTABCLES IN INVOLVING COMMUNITIES AND WHAT MEASURES DO YOU INTEND TO TAKE TO OVERCOME THEM ?

(Progress)

7.5 HAVE YOU REVIEWED THE ROLE OF NON-GOVERNMENTAL ORGANIZATIONS IN YOUR HEALTH STRATEGY ? WHAT STEPS DO YOU INTEND TO TAKE TO INVOLVE THEM FURTHER ?

(Progress)

Opposite and on page 29 are Global Indicator No. 2 and points that illustrate ways of involving communities.[1]

1 "Global Strategy for Health for All", "Health for All" Series, No. 3, Section V, pages 65 and 66, paragraphs 2-4, 6-7 and page 75.

Global Indicator No. 2 and Points to be considered with respect to Item 7:

Global Indicator No. 2. reads:

"Mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning."

(1) Ministries of health will explore appropriate ways of involving people in deciding on the health system required and the health technology they find acceptable, and in delivering part of the national health programme through self-care and family care and involvement in community action for health.

(2) The following are some of the measures that will be considered to promote community involvement:

(a) delegation of responsibility, authority and resources to the community to establish primary health care in the community in a way that is linked to the real-life situation of the people in that community;

(b) creation of community health councils, composed of representatives of a cross-section of the people in the community, to develop and control primary health care;

(c) fostering individual responsibility for self-care and family care, adopting a healthy life-style, and applying the principles of good nutrition and hygiene;

(d) delegation of responsibility and resources to communities to carry out agreed components of health programmes, such as insecticide spraying against malaria and ensuring adequate nutrition for underprivileged children;

(e) developing mechanisms for people to participate at the national level in decision-making on the country's health system and health technology through accepted social and political channels;

(f) ensuring people's representation in national or intermediate-level councils;

(g) election of members of the public to the governing bodies of health institutions.

(3) In addition to the orientation and training of health workers, other people with community responsibility, such as civic and religious leaders, teachers, community workers, social workers, and magistrates, will be provided with information on the national health strategy and the part they could play in supporting it.

Item 7 COMMUNITY INVOLVEMENT (continued)

Points to be considered with respect to Item 7: (continued)

(4) Voluntary organizations and Non-governmental Organizations will be given full encouragement to participate in health-promoting activities, first aid and other health care following agreed courses of action and distribution of responsibilities.

(5) Ministries of health will launch countrywide health educational activities through health personnel and the mass media and in the educational institutions of all types, with the aim of enlightening the whole population on the prevailing health problems in their country and community and on the most appropriate methods of preventing and controlling them.

Item 8: HEALTH MANPOWER

8.1 HAS A PLAN BEEN DRAWN UP TO DEVELOP HEALTH MANPOWER IN RESPONSE TO THE NEEDS OF THE STRATEGY ?

(Relevance and Progress)

8.2 DOES SUCH A PLAN INCLUDE THE DEPLOYMENT OF HEALTH TEAMS FOR PRIMARY HEALTH CARE AND DOES IT SPECIFY THE ROLE AND FUNCTIONS OF DIFFERENT CATEGORIES OF HEALTH WORKERS SUCH AS THE MEDICAL AND NURSING PROFESSION AND OTHER CATEGORIES OF HEALTH WORKERS ? GIVE EXAMPLES OF MAJOR CHANGES INTRODUCED.[1]

(Adequacy)

8.3 DOES THE HEALTH MANPOWER PLAN GIVE SUFFICIENT ATTENTION TO ORIENTING AND TRAINING HEALTH WORKERS ACCORDINGLY AND TO INTRODUCING THE NECESSARY INSTITUTIONAL CHANGES ?

(Adequacy)

Questions continued on page 32

The points opposite and on page 33 illustrate what needs to be taken into account to develop a relevant plan for health manpower development and to orient and train health workers.[2]

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1 Paragraph (4) on the opposite page contains a relevant extract from the Summary Records of the Seventy-first Session of the Executive Board, when it discussed in 1983 the role of nursing in the primary health care team and requested that countries might be asked to pay particular attention to this issue when evaluating health manpower as an important component of their strategy for health (document EB71/1983/REC/2, page 153).

2 "Alma-Ata 1978: Primary Health Care", "Health for All" Series, No. 1, page 26, paragraph 9.

"Global Strategy for Health for All", "Health for All" Series, No. 3, Section III, page 41, paragraph 6.(7) and page 44, paragraph 15; Section IV, page 58, paragraph 10 and Section V, page 66, paragraph 5.

Points to be considered with respect to Item 8

HEALTH MANPOWER PLANNING

(1) Health manpower will be planned, trained and deployed in response to specific needs of people as an integral part of the health infrastructure.

(2) Ministries of health, together with other ministries concerned such as ministries of labour and education, will plan health manpower in specific response to the needs of the health system, with a view to placing at the disposal of the system the right kind of manpower in the right numbers at the right time in the right place.

(3) Governments give high priority to the full utilization of human resources by defining the technical role, supportive skills, and attitudes required for each category of health worker according to the functions that need to be carried out to ensure effective primary health care, and by developing teams composed of community health workers, other developmental workers, intermediate personnel, nurses, midwives, physicians, and, where applicable, traditional practitioners and traditional birth attendants.

(4) When evaluating the deployment of health teams to fulfil their role in carrying out the strategy, governments might assess and report on areas relative to the role of nurses in primary health care:

(a) the role of nurses as seen by the public, various management levels and professional groups;

(b) barriers to effective utilization of nurses - attitudinal, employment practices, strategy elements;

(c) changes required in the strategy to ensure that nurses play their proper role and have maximum impact;

(d) the role of nurses in reaching policy and management decisions;

REORIENTATION AND RETRAINING

(5) To secure the support of the health professions, ministries of health will consider ways of involving them in the practice of primary health care and in providing support and guidance to communities and community health workers. To this end they will approach the professional organizations of medical doctors, nurses, and other health professions, providing them with information, and holding dialogues with them, and impressing upon them their social responsibilities. They will also consider ways of providing tangible incentives.

Item 8: HEALTH MANPOWER (continued)

8.4 IN WHAT WAY HAS THE PLAN CONTRIBUTED TO BALANCED TRAINING ("PRODUCTION"), INCLUDING MANAGERIAL CAPABILITIES, AND THE REQUIRED DISTRIBUTION AND OPTIMAL UTILIZATION OF HEALTH MANPOWER ?

(Adequacy)

8.5 WHAT FACTORS HAVE CONTRIBUTED TO PROGRESS ?

(Progress)

8.6 WHAT HAVE BEEN THE MAIN OBSTACLES IN THE IMPLEMENTATION OF YOUR PLAN AND WHAT MEASURES DO YOU INTEND TO TAKE TO OVERCOME THEM ?

(Progress)

Points to be considered with respect to Item 8:

(6) Full attention will be given to the reorientation and retraining as necessary of existing health workers, including measures to enable them to assume an active role in community health education. Consideration will also be given to the development of new categories of health workers, to the involvement and reorientation as necessary of traditional medical practitioners and birth attendants where applicable, and to the use of voluntary health workers.

Item 9: RESOURCE MOBILIZATION AND UTILIZATION

9.1 WHAT MEASURES HAVE BEEN TAKEN TO REALLOCATE HUMAN, MATERIAL AND FINANCIAL RESOURCES FOR THE IMPLEMENTATION OF YOUR STRATEGY ?

(Adequacy and Progress)

9.2 WHAT EFFORTS HAVE BEEN MADE TO MOBILIZE INTERNAL AND EXTERNAL MATERIAL AND FINANCIAL RESOURCES ?

(Adequacy)

9.3 HAVE THESE MEASURES PROVED ADEQUATE ? IF NOT, WHAT HAVE BEEN THE MAIN OBSTACLES AND WHAT MEASURES DO YOU INTEND TO TAKE IN ORDER TO OVERCOME THESE OBSTACLES ?

(Adequacy)

Questions continued on page 36

The points opposite illustrate how financial and material resources might be mobilized.[1]

1 "Global Strategy for Health for All", "Health for All" Series, No. 3, Section V, pages 67 and 68, paragraph 10.

Points to be considered with respect to Items 9.1, 9.2 and 9.3:

Ministries of health will:

(1) review the distribution of their health budget and in particular allocations to primary health care and intermediate and central levels, to urban and rural areas, and to specific underserved groups;

(2) reallocate existing resources as necessary - or, if this proves impossible, at least allocate any additional resources - for the provision of primary health care, particularly for underserved population groups;

(3) include an analysis of needs in terms of costs and material in all consideration of health technology and of the establishment and maintenance of the health infrastrucutre;

(4) consider the benefit of various health programmes in relation to the cost, as well as the effectiveness of different technologies and different ways of organizing the health system in relation to the cost;

(5) estimate the order of magnitude of the total financial needs to implement the national strategy up to the year 2000;

(6) attempt to secure additional national funds for the strategy if necessary and if they are convinced that they can prove that they have made the best possible use of existing funds;

(7) consider alternative ways of financing the health system, including the possible use of social security funds;

(8) identify activities that might attract external grants or loans;

(9) in developing countries take action so that their governments request such grants and loans from external banks, funds and multilateral and bilateral agencies;

(10) in high-income countries, take action to influence the agencies concerned to provide such grants and loans;

(11) present to their government a master plan for the use of all financial and material resources, including government direct and indirect financing; social security and health insurance schemes; local community solutions in terms of energy, labour, materials and cash; individual payments for service; and the use of external loans and grants.

Item 9: RESOURCE MOBILIZATION AND UTILIZATION(continued)

9.4 WHAT PERCENTAGE OF THE GROSS NATIONAL PRODUCT IS SPENT ON HEALTH ? (Global Indicator No. 3)

(Adequacy)

9.5 WHAT PERCENTAGE OF THE NATIONAL HEALTH EXPENDITURE IS DEVOTED TO PRIMARY HEALTH CARE ? (Global Indicator No. 4)

(Adequacy)

9.6 HAVE RESOURCES FOR PRIMARY HEALTH CARE BEEN DISTRIBUTED IN SUCH A WAY AS TO REACH SOCIALLY AND GEOGRAPHICALLY DISADVANTAGED AND UNDERSERVED GROUPS ? (Global Indicator No. 5)

(Adequacy)

Opposite and on page 39 are Global Indicators Nos. 3, 4 and 5, as well as points with respect to items 9.4 - 9.6.[1]

1 "Global Strategy for Health for All", "Health for All" Series, No. 3, Section VII, pages 75 and 76

Global Indicator No. 3 and points to be considered for item 9.4

Global Indicator No. 3 reads:

"At least 5% of the gross national product is spent on health."

(1) Ideally the calculation of the percentage of the gross national product spent on health should include the items listed below. In case all of these cannot be estimated, explanation should be provided as to which items have been included in the health expenditure figure. It is hoped that all countries will be able to report at least public expenditure;

(a) outlays on health provided through the Ministry of Health and other governmental and public agencies, e.g. ministries of labour, education, defence, etc., and compulsory social security or health insurance organizations;

(b) outlays on measures to improve nutritional status and prevent nutritional imbalances or shortages;

(c) outlays on development, operation and maintenance of drinking water supply and hygienic waste disposal systems by governmental or municipal authorities, or other contracted enterprises;

(d) outlays on educational services directed at improving health, promoting healthy habits and self-care;

(e) outlays on training and education of health workers and on research related to health and disease;

(f) expenditure incurred through voluntary health insurance schemes;

(g) other private expenditures in cash or in kind, such as payments for private health care, private expenses for drugs, payments to traditional practitioners, etc.

(2) Health expenditure should not include the costs of the social effects of illness, such as the losses in earnings and productivity incurred directly or indirectly through illness or incapacity, and payments made to individuals compensating for lost earnings.

(3) Expenditure data and gross national product should be expressed in the national currency and the year to which the expenditure data refer should be specified.

(4) If possible, reallocation and change in distribution should be given in percentages.

Global Indicator No. 4 and Points to be considered with respect to Item 9.5

Global Indicator No. 4 reads:

"A reasonable percentage of the national health expenditure is devoted to primary health care, i.e. first-level contact, including community health care, health centre care, dispensary care and the like, excluding hospitals. The percentage considered "reasonable" will be arrived at through country studies."

Item 9: RESOURCE MOBILIZATION AND UTILIZATION (continued)

Opposite are Global Indicator No. 5 and points that could be considered in gathering information in response to Item 9.6.[1]

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1 "Global Strategy for Health for All", "Health for All" Series, No. 3, page 75

"Development of Indicators for Monitoring Progress Towards Health for All", "Health for All" Series, No. 4, page 20, paragraphs 43 and 44.

(1) Expenditure data on primary health care should cover its eight elements as described on page 19, under point (1) for Item 5. To the extent available, such data should include both public and private expenditure. Administration and other overheads attributable to primary health care should also be included besides direct expenditure. An explanatory note should be provided as to what items have been covered in the expenditure figure given. The year to which the figure relates should be specified.

(2) This health care implies primary health care of a promotive, protective, preventive, curative and rehabilitative nature. Ideally, such data should include both public and private expenditure. As indicated above, an explanatory note should be provided as to what items have been included in the expenditure figure given. Reallocation and change in distribution should be given in percentages.

Global Indicator No. 5 and points to be considered with respect to Item 9.6

Global Indicator No. 5 reads:

"Resources are equitably distributed."

(1) Distribution of resources devoted to primary health care (PHC) should be analysed according to population groups, in terms of:

(a) expenditure;

(b) manpower (e.g. physicians, nurses, community health workers, traditional practitioners and birth attendants, as appropriate to the country's situation), and

(c) facilities (e.g. PHC centres).

(2) Choice should be made of the population groups which are relevant to the country's health policy, such as geographical units and socioeconomic groups. It is recommended that at least the urban/rural distribution of resources can be considered in this connection. The following format of presentation is suggested for each relevant item of resource, though countries may wish to adapt it to suit their specific requirements. Comparisons with the norms will be useful if they have been established. Government's views should be stated on the equity of the resource distribution based on these data.

Resource Item: ..... Year: ....

Population Groups	Population Size	Resources		PHC Resources per capita[1]	Norm (if established)
		Total	For PHC		
Whole Country					

[1] For resource items such as manpower and facilities, it will be more convenient to compute population per resource (e.g. population per PHC centre).

Item 10: INTERNATIONAL TRANSFER OF RESOURCES

For developing countries:

10.1 HAVE YOU MADE A SYSTEMATIC ANALYSIS OF YOUR NEEDS FOR EXTERNAL SUPPORT ? PLEASE DESCRIBE.

(Progress)

10.2 WHAT PERCENTAGE OF THE EXTERNAL RESOURCES NEEDED HAVE YOU RECEIVED ? PLEASE INDICATE THE AREAS THAT RECEIVED SUPPORT ? (Global Indicator No. 6)

(Adequacy)

10.3 WHICH OF YOUR PRIORITY NEEDS DID NOT RECEIVE ADEQUATE SUPPORT ?

(Adequacy)

For high-income countries:

10.4 WHAT SUPPORT HAVE YOU PROVIDED FOR THE IMPLEMENTATION OF THE HEALTH STRATEGIES OF DEVELOPING COUNTRIES ? PLEASE INDICATE IN TERMS OF US DOLLARS AND BROAD AREAS SUPPORTED.

(Adequacy)

Global Indicator No. 6 and the points opposite should be taken into account in connection with the international transfer of resources.[1]

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1 "Global Strategy for Health for All", "Health for All" Series, No. 3, Section VII, page 75, paragraph 6.

Global Indicator No. 6 and points to be considered with respect to Items 10.1, 10.2 and 10.3

Global Indicator 6 reads:

"The number of developing countries with well defined strategies for health for all accompanied by explicit resource allocations, whose needs for external resources are receiving sustained resource support from more affluent countries."

Countries receiving support should provide information on the amount of external resources received, financial and other. The period to which the information refers should be specified. The amount of external resources should be compared with the total amount required, if such needs have been assessed. It should be explained what kind of support was received. Countries might try to quantify this information to the degree possible. They may also report on the extent to which resources offered could be absorbed in activities related to the Strategy or otherwise.

Points to be considered with respect to Item 10.4

High-income countries should express the resources provided bilaterally to the national strategies for health for all of developing countries as a percentage both of their GNP and of the total resources provided bilaterally for all purposes to developing countries. They should also indicate the broad areas of support such as the essential element of Primary Health Care, health management, health manpower development, hospitals and the like.

Item 11: INTERCOUNTRY COOPERATION

11.1 HOW HAS YOUR COUNTRY COOPERATED WITH OTHER COUNTRIES IN THE IMPLEMENTATION OF THE NATIONAL STRATEGY FOR HEALTH FOR ALL ? DESCRIBE THE EXTENT AND NATURE.

(Adequacy)

11.2 DO YOU CONSIDER THAT THIS COOPERATION HAS BEEN ADEQUATE ?

(Adequacy)

11.3 WHAT ARE THE MAIN FACTORS THAT GAVE RISE TO FRUITFUL COOPERATION ?

(Adequacy)

11.4 WHAT ARE THE MAIN OBSTACLES TO SUCH COOPERATION AND WHAT MEASURES DO YOU INTEND TO TAKE TO OVERCOME THEM ?

(Adequacy)

The points opposite illustrate areas in which intercountry cooperation might be particularly useful.[1]

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1 "Global Strategy for Health for All", "Health for All" Series, No. 3, Section VI, page 71, paragraphs 4, 5 and 7.

Points to be considered with respect to Item 11:

(1) Developing countries will consider participating in TCDC/ECDC in cooperative activities and joint ventures such as, for example, the exchange of information and experience on all aspects of their strategies, training, collaborative research, use of one another's experts, joint programmes for the control of certain diseases, production, procurement and distribution of essential drugs and other essential medical equipment and supplies, development and construction of health infrastructural facilities, and the development and application of low-cost technology for water supply and waste disposal.

(2) Developed countries, too, will consider intensifying cooperative activities, for example, in such areas as the assessment of clinical, laboratory and radiological technology and of the usefulness of selective health screening for early detection of disease, research on prevalent noncommunicable diseases and mental health, control of environmental hazards, including the long-term health effects of chemicals in the environment, prevention and control of alcohol and drug abuse, accident prevention, and the care of the elderly.

(3) Cooperation among developed and the developing countries will be mutually beneficial in implementing national strategies and will be indispensable for implementing the Global Strategy.

Item 12: COORDINATION WITHIN THE HEALTH SECTOR

12.1 WHAT ACTION HAS BEEN TAKEN TO ENSURE BETTER COORDINATION WITHIN THE HEALTH SECTOR ? DESCRIBE.

(Progress)

12.2 WHAT ARE THE MAIN FACTORS THAT GAVE RISE TO IMPROVED COORDINATION WITHIN THE HEALTH SECTOR ?

(Adequacy)

12.3 WHAT WERE THE MAIN OBSTACLES AND WHAT MEASURES DO YOU INTEND TO TAKE TO OVERCOME THEM ?

(Adequacy)

The points opposite illustrate how better coordination within the health sector might be attained.[1]

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1 "Global Strategy for Health for All", "Health for All" Series, No. 3, Section III, page 42, paragraph 7.

Points to be considered with respect to Item 12:

To achieve coordination within the health sector countries will pay attention to the following:

(1) collaboration between the various health services, programmes and institutions, including those for education and in other fields, following agreement on allocation of responsibilities in order to make the most efficient use of resources. These may include services and institutions belonging to government, social security, the private sector, nongovernmental and voluntary organizations active in the health sector, for example Red Cross or Red Crescent societies and the like, and women's and youth organizations;

(2) collaboration between the various levels of the health system and programmes following agreement on the distribution of functions and resources;

(3) collaboration within and among the various categories of health workers following agreement on the division of labour.

Item 13: INTERSECTORAL COLLABORATION:

13.1 HAS YOUR HEALTH STRATEGY TAKEN INTO ACCOUNT THE POTENTIAL CONTRIBUTIONS BY OTHER SECTORS TO HEALTH DEVELOPMENT, INCLUDING PREVENTIVE MEASURES ? WHAT WERE THE MAIN AREAS IDENTIFIED ? GIVE EXAMPLES OF SIGNIFICANT INVOLVEMENT OF SECTORS OTHER THAN HEALTH.

(Progress and Adequacy)

13.2 WHAT MEASURES HAVE BEEN TAKEN TO ENSURE INTERSECTORAL ACTION ?

(Adequacy)

13.3 WHAT WERE THE MAIN OBSTACLES AND WHAT MEASURES DO YOU INTEND TO TAKE TO OVERCOME THEM ?

(Adequacy)

The points opposite illustrate how improved intersectoral coordination and collaboration could be attained.[1]

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1 "Global Strategy for Health for All", "Health for All" Series, No. 3, Section III, page 43, paragraph 8.

"Alma-Ata 1978: Primary Health Care", "Health for All" Series, No. 1, page 22, paragraph 49.

Points to be considered with respect to Item 13:

(1) To foster intersectoral action, countries will devise ways of ensuring adequate cooperation between ministries of health or analogous authorities and other ministries concerned. The role of the ministry of health will include spearheading and coordinating action. The following possibilities will be explored in particular:

(a) the establishment of multisectoral national health councils comprising personalities representing a wide range of interests in the fields of health and political, economic and social affairs, as well as the population at large, to explore jointly policy questions affecting health and socioeconomic development; including both the positive and negative effects on health of measures aimed at economic growth;

(b) the establishment of interministerial committees, or the use of existing interministerial committees for social affairs, in which the health representatives will take initiatives to promote the action in other sectors that the implementation of the strategy requires;

(c) the establishment of arrangements between ministries of health and other ministries and sectors concerned in relation to such specific fields as nutrition, water, housing, education, communications, the protection of the environment, the production and import of drugs and equipment, and use of the mass media;

(d) the improvement of communication between the health sector with other relevant sectors, for example through national, district or local health development councils or committees dealing with health and related socioeconomic policy and planning.

(e) the delegation of responsibility and authority to communities to organize their own primary health care or selected elements of it, as well as to intermediate levels of the health system to provide support to primary health care; and the use of this process as an example to encourage administrative reforms in other sectors with a view to facilitating intersectoral coordination at the different administrative levels.

(2) Intersectoral coordination with emphasis on peripheral district and provincial level will be encouraged by taking the following into account:

(a) the general administrative system of a country is important for ensuring coordinated contributions to development from different sectors concerned. There has been a tendency to concentrate entirely on the central administrative level. Only recently attention has been focussed on local levels. The importance of decentralization to intermediate levels, such as provincial or district levels, has to be stressed. These levels are near enough to communities to respond sensitively to their practical problems and needs; they are equally near to the central administrative level to translate government policies into practice;

(b) They are particularly useful for harmonizing the activities of the various sectors that jointly promote development. The intermediate administrative levels serve thus as important pivots for coordinated development. To fulfil this role, they have to be strengthened in many countries, particularly by deploying to them the manpower required in the various sectors.

Item 14: HEALTH COMPONENT IN ECONOMIC DEVELOPMENT SCHEMES

14.1 WHAT ACTION HAS BEEN TAKEN AND WHAT MECHANISM HAS BEEN ESTABLISHED TO INCORPORATE, WHERE NECESSARY, A HEALTH COMPONENT IN ECONOMIC DEVELOPMENT SCHEMES AND/OR TO TAKE INTO ACCOUNT HEALTH CONSEQUENCES ON THE POPULATION OF SUCH SCHEMES ? (e.g: AGRICULTURAL, INDUSTRIAL, ENERGY) GIVE SPECIFIC EXAMPLES.

(Adequacy and Progress)

14.2 IF THE RESULTS ACHIEVED WERE SATISFACTORY, WHAT FACTORS CONTRIBUTED TO THAT ?

(Adequacy)

14.3 IF NOT, WHAT ARE THE MAIN OBSTACLES AND WHAT MEASURES DO YOU INTEND TO TAKE IN ORDER TO OVERCOME THEM ?

(Adequacy)

The points opposite illustrate how preventive health measures can be introduced into economic development schemes.[1]

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1 "Alma-Ata 1978: Primary Health Care", "Health for All" Series, No. 1, page 48, paragraph 38.

Points to be considered with respect to Item 14:

(1) Many agricultural and industrial activities can have side effects that are detrimental to health. To mention a few:-

(a) irrigation schemes can create the right conditions for the breeding of mosquitos that transmit malaria;

(b) artifical lakes and irrigation schemes can lead to the proliferation of the snails that carry schistosomiasis;

(c) industrialization can lead to the pollution of air, soil, and water with toxic chemicals and the accompanying urbanization can provoke psychosocial problems.

(2) It is therefore wise to incorporate preventive measures in industrial and agricultural projects which pose particular health hazards. Such measures can be included in irrigation schemes and man-made lakes, safety precautions can be taken to reduce industrial accidents and pollution, potential carriers of disease can be identified wherever there are large population movements.

(3) Special attention can be given to protecting the physical and mental health of migrant workers.

Item 15: WHO COOPERATION

15.1 WHAT SUPPORT HAS YOUR COUNTRY REQUESTED FROM THE WORLD HEALTH ORGANIZATION FOR THE PREPARATION, IMPLEMENTATION AND EVALUATION OF YOUR NATIONAL STRATEGY AND PLAN OF ACTION ? TO WHAT EXTENT HAVE YOU RECEIVED SUCH SUPPORT ?

(Adequacy)

15.2 WHAT ARE THE MAIN FACTORS THAT CONTRIBUTED TO PRODUCTIVE COOPERATION WITH THE ORGANIZATION ?

(Adequacy)

15.3 WHAT WERE THE MAIN PROBLEMS ENCOUNTERED AND WHAT MEASURES DO YOU INTEND TO TAKE IN ORDER TO OVERCOME THEM ?

(Adequacy)

The points opposite illustrate the type of support that WHO should be providing you.[1]

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1 "Plan of Action for Implementing the Global Strategy for Health for All", "Health for All" Series, No. 7, pages 22 and 23.

Points to be considered with respect to Item 15:

(1) The Regional Director and his staff will provide support to governments in preparing and implementing national strategies. WHO Programme Coordinators and National Programme Coordinators, as well as other WHO staff in the country concerned, will provide support to governments in formulating, initiating and monitoring the implementation of national strategies and plans of action for health for all, particularly through the application of the managerial process for national health development (MPNHD), and, where applicable, in seeking external resource support.

(2) WHO's technical cooperation activities carried out under its General Programme of Work Covering a Specific Period should lead to self-sustaining national health programme development, particularly in building up the health infrastructure and delivering appropriate health technology through it.

Item 16: EFFICIENCY OF IMPLEMENTING THE STRATEGY

16.1 DO YOU CONSIDER THAT THE RESULTS OBTAINED SO FAR FROM IMPLEMENTING YOUR STRATEGY ARE REASONABLY POSITIVE IN RELATION TO THE EFFORTS EXPENDED ?

(Efficiency)

16.2 WHAT MAIN FACTORS ACCOUNTED FOR THE EFFICIENCY OF IMPLEMENTATION ?

(Efficiency)

16.3 WHAT ARE THE MAIN SHORTCOMINGS AND WHAT MEASURES DO YOU INTEND TO TAKE TO OVERCOME THEM ?

(Efficiency)

Opposite are points that could be considered with respect to efficiency.[1]

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1 "Health Programme Evaluation, Guiding Principles", "Health for All" Series, No. 6, page 17, paragraph 21(4) and pages 37-39, paragraph 57.

Points to be considered with respect to Item 16:

Item 16 relates solely to the component of efficiency and it is therefore pertinent to expand on the meaning of efficiency at this juncture.

(1) Efficiency is an expression of the relationships between the results obtained from a health programme or activity and the efforts expended in terms of human, financial and other resources, health processes and technology, and time. The assessment of efficiency is aimed at improving implementation, and adds to the review of progress by taking account of the results of monitoring. Under this heading, a check is also made on such matters as the appropriateness of existing plans of operations, work schedules, methods applied, manpower used, and the adequacy and use of finacial resources, with a view to improving them, if necessary, at the least cost.

(2) The assessment of efficiency consists of an analysis of the results obtained in relation to the efforts made and the resources used. The question is: could these results have been obtained in better and more economical ways ? A differentiation should be made between technical efficiency and cost efficiency. The following issues should be raised:

(a) Operational level - assess whether the activities are being conducted at the right operational level, e.g., local, district or central.

(b) Methods - analyse whether the methods employed are proving to be useful for the solution of the problem.

(c) Manpower - analyse whether the best combination of available manpower is being deployed in sufficient numbers for the solution of the problem. Analyse the efficiency of the manpower in terms of skill and effort in comparison with what could be expected.

(d) Finances - judge the adequacy of the financial resources made available for the implementation of the programme or the management of the service or institution. Make a cost analysis to assess how economically the results have been achieved.

(e) Facilities - review the suitability of the geographical location of buildings and the adequacy of buildings, vehicles, equipment and supplies, where applicable.

(f) Collaboration - describe the results of collaboration with other social or economic sectors and institutions, voluntary agencies, bilateral and multilateral agencies, etc.

(g) Managerial control - analyse factors not mentioned above such as the degree of adequacy of the time allotted for the implementation of the activities, the correctness of the sequence of activities, the appropriateness and timeliness of logistic support, and the degree to which major activity results were being reached. Indicate problems encountered and describe corrective action envisaged or taken.

(h) Cost-efficiency - this is an important aspect of the analysis of any programme, service or institution.

Item 17: EFFICIENCY OF THE UTILIZATION OF HEALTH SERVICES

17.1 HAS THE STRATEGY GIVEN RISE TO BETTER AND MORE PRODUCTIVE USE BEING MADE OF HEALTH SERVICES AND FACILITIES ? GIVE A FEW SALIENT EXAMPLES.

(Efficiency)

17.2 WHAT ARE THE MAIN FACTORS THAT GAVE RISE TO BETTER UTILIZATION ?

(Efficiency)

17.3 WHAT WERE THE MAIN OBSTACLES AND WHAT MEASURES DO YOU INTEND TO TAKE IN ORDER TO OVERCOME THEM ?

(Efficiency)

The points opposite and on page 57 illustrate how health services might be optimally utilized.[1]

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1 "Global Strategy for Health for All", "Health for All" Series, No. 3, Secion III, page 44, paragraphs 10-13 and pages 45 and 46, paragraphs 18 and 19.

"Health Programme Evaluation: Guiding Principles", "Health for All" Series, No. 6, pages 40 and 41, paragraphs 63 and 64.

Points to be considered with respect to Item 17:

(1) The functions of the mechanisms and institutions in the health and related sectors will be reviewed, particularly at the first referral level, and staff will be motivated and retrained as necessary to provide support and guidance to communities and community health workers.

(2) A system of referral of patients and problems will be developed so that the first referral level is not overloaded with problems that could be dealt with by primary health care in the community, and so that patients and problems are referred back to those who sent them, accompanied by information on action taken and guidance for further action.

(3) Ministries of health will review transport and communication facilities together with local authorities and representatives of the other ministries concerned, to permit the referral system to function efficiently.

(4) Ministries of health will review their logistic system to ensure regular and timely distribution of supplies and equipment, as well as the availability of transport and its maintenance, starting with facilities in communities and working centrally through intermediate and central levels.

(5) Ministries of health, together with ministries of public works in some countries, will review the distribution of existing health care facilities and will work out and continually update national master plans of requirements for health centres and dispensaries and for first-referral hospitals. Accessibility to those most in need will be the foundation of the master plans.

(6) Ministries of health will review the functions, staffing, planning, design, equipment, organization, and management of health centres and first-referral hospitals, in order to prepare them for their wider function in support of primary health care. Before investing in buildings, the cost of running them will be considered.

(7) One measure of the efficiency of a health service is the correct use of its component parts; for example, the use by the population of a health centre for preventive and simple curative services and use of the appropriate hospital only on referral from the health centre; another example could be the use of the most appropriate hospital in that it is nearest to the community concerned and provides clinical services at the right degree of specialization.

Item 17: EFFICIENCY OF UTILIZATION OF HEALTH SERVICES (continued)

Points to be considered with respect to Item 17: (continued)

(8) The following are a number of examples of the assessment of the efficiency of institutions:

(a) Health centres - the comparison of the number of immunizations provided in a given period as compared with an accepted norm; the coordination between an immunization time schedule and the vaccine supply; the number of women provided with the required antenatal examinations over a given period of time as compared with an accepted norm.

(b) Hospitals - the number of outpatients cared for per health worker. For inpatient care, the ratio of staff to beds; the percentage of bed occupancy; the average duration of stay by clinical department; the bed turnover rate; the number of inpatient days for a given size of population; the number and types of laboratory or radiodiagnostic examinations for a given size of population; medical audit, e.g., the comparison with certain norms of the statistics for the care of a given condition, such as average length and frequency distribution of stay, types of care provided, results of care, the number of patients returning for the same condition, and the frequency of their return.

(9) The cost-efficiency of institutions should be measured in terms of the amount of service provided in relation to the costs. For example, the efficiency of including a trained nurse/midwife in the staff of a health centre without obstetric beds has to be measured in terms of the cost divided by the number of women provided by her with the accepted range of antenatal and postnatal care; the efficiency of having such a midwife for deliveries has to be measured in terms of the cost divided by the number of deliveries. The comparison of the cost-efficiency of different hospitals has to be assessed in terms of the costs divided by the total number of inpatient days, but great care has to be taken in arriving at conclusions in order to take into account variations between hospitals in the provision of different kinds of diagnostic and therapeutic inpatients and outpatient care. It is often more fruitful to assess the cost-efficiency of the same institution over a number of given periods of time.

Note: It is realized that to obtain country-wide information for all the above issues may be very difficult, as well as costly and time consuming. It may be necessary therefore to resort to sample surveys.

Item 18: QUALITY OF HEALTH CARE

18.1 WHAT ACTION HAVE YOU TAKEN TO IMPROVE THE QUALITY OF CARE PROVIDED BY THE HEALTH SYSTEM ? AND HOW DO YOU MEASURE (OR ASSESS) SUCH QUALITY ?

(Efficiency)

18.2 WHAT ARE THE MAIN FACTORS THAT GAVE RISE TO THE IMPROVEMENT IN QUALITY OF CARE ?

(Efficiency)

18.3 WHAT ARE THE MAIN FACTORS IMPEDING THE QUALITY OF CARE AND WHAT MEASURES DO YOU INTEND TO TAKE TO OVERCOME THEM ?

(Efficiency)

Opposite are points that illustrate how to go about assessing the quality of care, as well as the difficulties involved in doing so.[1]

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1 "Health Programme Evaluation: Guiding Principles", "Health for All" Series, No. 6, page 41, paragraph 65.

"Developing of Indicators for Monitoring Progress towards Health for All", "Health for All" Series, No. 4, page 27, paragraph 76.

Points which may be considered with respect to Item 18:

(1) Quality of care is an important component of efficiency, but is usually very difficult to assess objectively. Ideally, indicators of coverage should be supplemented by indicators of quality of care, although utilization is also a reflection of the quality of care.

(2) Quality control, however, is complex and requires a profile of a number of indicators which should be chosen for the specific conditions of the country. As the main purpose of quality control is to improve health care through better management and supervision, the existing situation should be assessed in comparison with the established norms and desired situation. Thus, for example, the assessment of health care facilities may be based on a review as to whether the facilities are adequately accommodated; staffed with personnel fully trained for the tasks required; provided with the necessary equipment, supplies, transport; etc.

(3) For the assessment of a particular type of care, a review may cover such aspects as the current practice regarding timeliness of the first care level; frequency of care; types of risk and disease screening; preventive and curative service; counseling on personal hygiene and nutrition; referrals to secondary and tertiary care levels; etc., as compared with the norms.

Item 19 : HEALTH RESEARCH

19.1 HAVE YOU REVIEWED THE SCOPE AND CONTENT OF YOUR ACTIVITIES IN THE FIELD OF BIOMEDICAL, BEHAVIOURAL AND HEALTH SYSTEMS RESEARCH WITH A VIEW TO GIVING PRIORITY TO PROBLEMS REQUIRING SOLUTION AS PART OF YOUR STRATEGY FOR HEALTH FOR ALL ? WHAT WERE THE RESULTS OF YOUR REVIEW ?

(Relevance)

19.2 WHAT MECHANISMS HAVE YOU ESTABLISHED OR STRENGTHENED AIMED AT FACILITATING THE COORDINATION OF HEALTH RESEARCH IN YOUR COUNTRY AND TO DISSEMINATE THE RESEARCH FINDINGS TO THOSE WHO COULD PROFITABLY USE THEM ?

(Progress)

19.3 WHAT MEASURES HAVE YOU TAKEN TO BRING TOGETHER RESEARCH WORKERS AND HEALTH POLICY MAKERS AND PLANNERS IN JOINT ENDEAVOURS ?

(Efficiency)

19.4 DESCRIBE HOW - IF AT ALL - YOU HAVE USED RESEARCH FINDINGS IN DEVELOPING AND IMPLEMENTING YOUR STRATEGY ?

(Efficiency)

19.5 WHAT OBSTACLES ARE IMPEDING HEALTH RESEARCH IN YOUR COUNTRY AND WHAT MEASURES DO YOU INTEND TO TAKE TO OVERCOME THEM ?

(Efficiency)

The points opposite illustrate how health research could be supportive to your strategy.[1]

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1 "Global Strategy for Health for All", "Health for All" Series, No. 3, pages 61 and 62, paragraphs 19-22).

Points to be considered with respect to Item 19

(1) Research is often considered a luxury of the affluent and yet its successful pursuit and the application of its findings are often the source of affluence. Governments will review the scope and content of their activities in the field of biomedical, behavioural and health systems research, with a view to focusing them on problems requiring solution as part of their strategies for health for all. The identification of such problems is one of the many concerns of the managerial process for national health development. The ultimate aim will be to reach national self-reliance in health research, but governments will first identify those research activities which they can carry out using national resources, those for which international collaboration is required, and those for which it is better to rely on the efforts of countries endowed with greater resources for health research.

(2) Attention will be given to the allocation of resources to relevant health research, to the training of young scientists and the related question of career structures for health research workers, to the balance between work in health research and in health services, and to the wide dissemination of research results to different audiences so that they can be speedily applied.

(3) Consideration will be given to establishing or strengthening health research councils to facilitate the coordination of health research activities within the country, to increasing the interest of medical research councils in the broad problems of health, or to creating health research sections in general scientific research councils.

(4) Mechanisms for bringing together researchers and planners, such as national health development networks, will be used to ensure that research designs meet the requirements of decision-makers and that results are actually used.

Item 20: HEALTH STATUS

It is realized that there are many factors affecting the health status of a population and it may be difficult to see changes resulting from the implementation of the Strategy. Nevertheless, the following questions are asked to identify as much as possible the effectiveness of the Strategy.

20.1 IS THE NUTRITIONAL STATUS OF CHILDREN (0-5 YEARS) ADEQUATE•? (Global Indicator No. 8)

(Effectiveness)

Opposite are Global Indicator No. 8 and points that could be considered in gathering information in response to Item 20.1.[1]

1 "Global Strategy for Health for All", "Health for All" Series, No. 3, pages 75 and 76.

"Development of Indicators for Monitoring Progress Towards Health for All", "Health for All" Series, No. 4, pages 32 and 33, paragraphs 97-101.

Global Indicator No. 8 and points to be considered with respect to Item 20.1

Global Indicator No. 8 reads:

"The nutritional status of children is adequate, in that:

- at least 90% of newborn infants have a birth weight of at least 2500 g;
- at least 90% of children have a weight for age that corresponds to the reference values given in Annex 1 to Development of Indicators for Monitoring Progress Towards Health for All by the year 2000 ("Health for All" Series, No. 4).

Two proportions to be reported are:

(1) The proportion of newborn infants having birthweight of at least 2500g. The measurement of the weight should preferably be taken within the first hours of life, before significant postnatal weight loss has occurred. The data source (e.g. civil registration, surveys, deliveries at hospitals, etc.) and the year of reference should be specified. If data are based on part of the country, the representativeness of data should be indicated.

(2) The proportion of children under 5 years of age having a weight for age that corresponds to the reference values "median-2SD" given in Annex 1 to Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000, ("Health for All" Series, No. 4). The data source (e.g. a sample survey), year of reference and representativeness should be described. If they relate to children of a particular age, e.g. 2 years to 5 years, this should be specified.

Item 20: HEALTH STATUS (continued)

20.2 WHAT IS THE INFANT MORTALITY RATE FOR ALL IDENTIFIABLE SUBGROUPS ? (Glocal Indicator No. 9)

(Effectiveness)

Opposite are Global Indicator No. 9 and points to be considered in gathering information in response to Item 20.2.[1]

1 "Development of Indicators for Monitoring Progress Towards Health for All", "Health for All" Series, No. 4, page 34, paragraph 103 and pages 67 and 68, paragraphs 236-241.

Global Indicator No. 9 and points to be considered with respect to Item 20.2

Global Indicator No. 9 reads:

> "The infant mortality rate for all identifiable subgroups is below 50 per 1000 live-births."

In addition to the national rate, the variation in the rate observed among population groups, e.g. geographical areas or socioeconomic groups, should be reported, if figures are available. The year to which the figures relate, the data source (e.g. civil registration, sample surveys, etc.) and the data representativeness should be described. The following tabular presentation is suggested:

Year: .....

Population Groups	Number of Live Births	Number of Infant Deaths	Infant Mortality Rate
Whole Country			

Item 20: HEALTH STATUS (continued)

20.3 WHAT IS THE LIFE EXPECTANCY AT BIRTH ?
(Global Indicator No. 10)

(Effectiveness)

Opposite are Global Indicator No. 10 and points to be considered in gathering information in response to Item 20.3.[1]

1 "Development of Indicators for Monitoring Progress Towards Health for All", "Health for All" Series, No. 4, page 35, paragraphs 108 and 109, and pages 70-74, paragraphs 253-259.

Global Indicator No. 10 and points to be considered with respect to Item 20.3

Global Indicator No. 10 reads:

"Life expectancy at birth is over 60 years."

(1) A simple procedure for computing life expectancy is illustrated in Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000, cited on the lefthand page. Life expectancy cannot be established with precision for a country with a population of less than 1 million, if based on data for a single calendar year. For such a country, data for a few years (say, 2-5 years) should be combined for the computation. For a country with a population less than 200 000, even such combination of data would not suffice. In such a case the average age at death may be used as a proxy indicator.

(2) The figure of life expectancy may be reported separately for male and female, if available. The year to which the data refer, the data source (e.g. death rate based on a complete count, sample registration, estimate, etc.) and the data representativeness should be described.

Item 20 : HEALTH STATUS (continued)

20.4 WHAT ARE THE MAIN DISEASES AFFECTING THE HEALTH STATUS OF YOUR POPULATION ? (MORTALITY AND MORBIDITY CAUSED BY THESE DISEASES)

20.5 WHAT ARE THE MAIN DIFFERENCES, IF ANY, IN MORTALITY AND MORBIDITY AS COMPARED WITH THE SITUATION AT THE BEGINNING OF THE PERIOD UNDER REVIEW ?

(Effectiveness)

Opposite is an extract that could be useful with respect to Items 20.4 and 20.5. Suggestions are also made as to how the data may be presented.[1]

1 "Development of Indicators for Monitoring Progress Towards Health for All", "Health for All" Series, No. 4, pages 36 and 37, paragraphs 113-116.

Points to be considered with respect to Items 20.4 and 20.5

1. Mortality rates can be computed for specific diseases such as communicable diseases. The rates for diseases for which immunization exists are particularly useful, as they indicate the magnitude of the preventable mortality. As countries begin to extricate themselves from the burden of communicable diseases, they are liable to be increasingly beset by such other problems as cancer, cardiovascular diseases, accidents, suicides and mental diseases, this being to some extent an effect of the different age structure of the population. Even if the principle of high selectivity is accepted, the calculation of specific death rates is problematic, since mortality figures would have to be based on accurate diagnoses in relation to the international classification of diseases. This may require the support of pathology facilities in hospitals, and even were they available, deaths outside the hospital service would not be covered.

2. Morbidity can be described in terms of the incidence and/or prevalence of certain diseases or disabilities. It is usually expressed as a rate : the number of cases of disease per 1000 persons at risk. The most accurate way of assessing morbidity rates is through epidemiological surveys, but reporting cases through health systems surveillance does provide some indication of the relevant magnitude of the disease incidence as well as trends in control or prevention, and it can provide information on morbidity patterns in different parts of the country. If a country wishes to use morbidity indicators, it is suggested that it select the five or six most prevalent diseases and institute as a first step an appropriate method of monitoring the incidence or prevalence of one or two that it considers most important.

PRESENTATION

3. Please list, in the order of public health importance, the main 5 to 10 diseases causing mortality and the main 5 to 10 diseases accounting for morbidity. For the purpose of this ranking, it is suggested that the 2-digit categories of the Basic Tabulation List (see International Classification of Diseases, 1975 Revision, Volume 1, pages 746-755) be used if convenient. Data may be presented in the following format:

(a) MAIN DISEASES CAUSING MORTALITY. Reference year: .....
Data source: .....

Disease	Death rate [1]
1. ..... 2. ..... etc.	....

(b) MAIN DISEASES ACCOUNTING FOR MORBIDITY. Reference year: .....
Data source: .....

Disease	Incidence Rate[1]	Prevalence Rate[1]
1. ..... 2. ..... etc.	....	....

1 If available, please provide breakdowns according to age groups: (especially for children under 5 years of age)

Item 21 : SELECTED SOCIAL AND ECONOMIC INDICATORS

Although the figures for Global Indicator No. 11 concerning literacy and Global Indicator No. 12 concerning the gross national product cannot be attributed to the direct effects of the Strategy, it is nevertheless useful to consider them in this context.

21.1 WHAT IS THE ADULT LITERACY RATE - FOR WOMEN AND FOR MEN ? (Global Indicator No. 11)

21.2 WHAT IS THE GROSS NATIONAL PRODUCT PER HEAD ? (Global Indicator No. 12)

Opposite are Global Indicators Nos. 11 and 12 and points to be considered in gathering information in response to Items 21.1 and 21.2[1]

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1 "Development of Indicators for Monitoring Progress Towards Health for All", "Health for All" Series, No. 4, page 24, paragraph 61 and pages 22-23, paragraphs 53-55.

Global Indicator No. 11 and points to be considered with respect to Item 21.1

Global Indicator No. 11 reads:

"The adult literacy rate for both (but separately) men and women exceeds 70%."

The proportion of men and women (separately) aged 15 years or over who are able to read and write at least in one language should be reported. The year to which the data refer, the data source (e.g. population census, a sample survey, etc.) and the data representativeness should be described.

Global Indicator No. 12 and points to be considered with respect to Item 21.2

Global Indicator No. 12 reads:

"The gross national product per head exceeds US $500."

The gross national product per head should be expressed in the national currency. It may also be expressed in terms of US dollars, if available. The year to which the figure relates should be specified.

Item 22: REGIONAL INDICATORS

Some regions have agreed to use a number of indicators in addition to the twelve global ones.

22.	PROVIDE INFORMATION ON THE NATIONAL VALUES FOR REGIONAL INDICATORS AGREED UPON BY YOUR REGIONAL COMMITTEE (IF ANY) ?

Item 23: DEMOGRAPHIC INFORMATION

	VALIDATE OR UPDATE THE FOLLOWING DEMOGRAPHIC INFORMATION (OR VALUE OF):		
23.1	TOTAL POPULATION	:	(Year: .....)
23.2	CRUDE BIRTH RATE PER 1000 POPULATION	:	(year:.....)
23.3	CRUDE DEATH RATE PER 1000 POPULATION	:	(year:.....)
23.4	NATURAL INCREASE RATE OF POPULATION PER 1000:	:	(year:.....)

Item 24: NATIONAL INDICATORS

24.	IN ADDITION TO THE ABOVE, PROVIDE INFORMATION ON ANY ADDITIONAL INDICATORS YOU HAVE FOUND USEFUL.

Points to be considered with respect to Item 22:

If applicable, the regional office will provide in an addendum the specific indicators agreed upon in their respective region.

Points to be considered with respect to Item 23:

WHO will provide you with the latest values of the demographic information available to it and indicate the source.

Item 25: SATISFACTION WITH RESULTS

25.1 WHAT METHODS HAVE YOU USED TO ASSESS THE DEGREE OF COMMUNITY SATISFACTION WITH THE RESULTS OF THE STRATEGY AND WHAT DID THIS ASSESSMENT REVEAL ?

(Effectiveness)

25.2 TO WHAT EXTENT ARE YOU SATISFIED WITH THE RESULTS OF THE STRATEGY ? DESCRIBE.

(Effectiveness)

Item 26: EFFECTIVENESS AND IMPACT OF THE STRATEGY

26.1 SUMMARIZE YOUR ASSESSMENT OF THE MAIN EFFECTS OF THE STRATEGY IN REDUCING HEALTH PROBLEMS AND IMPROVING THE HEALTH STATUS OF THE PEOPLE IN YOUR COUNTRY.

Your description should include the most important achievements and shortcomings, the lessons you would draw from the information you have concerning the indicators of health status and any other relevant information. You may find it useful to recapitulate the main lines of action you are taking or intend to take; the main obstacles you are encountering and the measures you intend to apply to overcome them through health systems based on Primary Health Care.

(Effectiveness)

26.2 IN THE LIGHT OF THE ABOVE AND ANY OTHER INFORMATION, INCLUDING THE ECONOMIC AND SOCIAL INDICATORS YOU HAVE USED, ASSESS THE IMPACT THAT THE HEALTH STATUS OF YOUR PEOPLE IS HAVING ON THEIR QUALITY OF LIFE AND ON THE SOCIOECONOMIC DEVELOPMENT OF YOUR COUNTRY.

(Impact)

ANNEX

List of the WHO "Health for All" Series

No. 1 - Alma-Ata 1978: Primary Health Care (1978)

No. 2 - Formulating Strategies for Health for All by the Year 2000 (1979)

No. 3 - Global Strategy for Health for All by the Year 2000 (1981)

No. 4 - Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000 (1981)

No. 5 - Managerial Process for National Health Development: Guiding Principles (1981)

No. 6 - Health Programme Evaluation: Guiding Principles (1981)

No. 7 - Plan of Action for Implementing the Global Strategy for Health for All
and:
Index to the "Health for All" Series, Nos. 1-7 (1982)

No. 8 - Seventh General Programme of Work, covering the period 1984-1989 (1982)

NATIONAL AND INTERNATIONAL FINANCIAL AND BUDGETING IMPLICATIONS OF THE REGIONAL STRATEGIES AND THE PLAN OF ACTION FOR HEALTH FOR ALL BY THE YEAR 2000

(THE ECONOMIC CRISIS IN LATIN AMERICA AND THE CARIBBEAN AND ITS REPERCUSSIONS ON THE HEALTH SECTOR)

EXECUTIVE COMMITTEE
PAN AMERICAN HEALTH ORGANIZATION

NATIONAL AND INTERNATIONAL FINANCIAL AND BUDGETING IMPLICATIONS OF THE REGIONAL STRATEGIES AND THE PLAN OF ACTION FOR HEALTH FOR ALL BY THE YEAR 2000

THE ECONOMIC CRISIS IN LATIN AMERICA AND THE CARIBBEAN AND ITS REPERCUSSIONS ON THE HEALTH SECTOR

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FINANCIAL AND BUDGETARY IMPLICATIONS AT THE NATIONAL AND INTERNATIONAL LEVEL OF THE REGIONAL STRATEGIES AND THE PLAN OF ACTION OF HEALTH FOR ALL BY THE YEAR 2000

INTRODUCTION

A. BACKGROUND

1. During the 86th Meeting of the Executive Committee of the Pan American Health Organization in June 1981, emphasis was placed on the need to continue studying financial conditions that could affect attainment of the goals of health for all by the year 2000 both in the individual countries of Latin America and the Caribbean, and the Region as a whole. It was also decided to review the related efforts of the Pan American Sanitary Bureau.

2. During the sixties and seventies, growth in the Regional economy and funding for social programs, including those for health, continued to be steady. The Gross Domestic Product (GDP) grew an average of 7.2% annually from 1970 to 1974, 4.8% a year from 1975 to 1978, and 6.5% in 1979.

3. Despite this growth, in the document on strategies of health for all by the year 2000 it was concluded that: "it is... apparent that a new type of economic development, different from and more dynamic than the present type, will be needed. For Latin American and the Caribbean, an economic growth rate of 7.5% a year has been targeted by the United Nations. This represents an intensification of growth and a technological transformation of the Region's economy in comparison with trend projections which would indicate a growth rate of 6.3% per year for the area as a whole. Growth at 7.5% a year for the Region as a whole is necessary in order for the rate of employment to increase at the growth rates predicted for the economically active population."1/

4. In 1980, the Regional GNP grew at a slower rate than in the past, and in some countries the decline was sharply downward. Growth that year was 5.9% above the level of the previous year, but a mere 1.5% in 1981, after which it decreased to a negative 1.0% in 1982 and dived to a minus 3.3% in 1983. According to figures of the Economic Commission for Latin America (ECLA), the avarage annual growth of Latin America since 1981 has been a negative 2.8%.

5. This situation gave ample grounds for the concern felt by the Executive Committee of the Pan American Health Organization, which was reflected in its decisions at the June 1982 Meeting, and by the XXI Pan

American Sanitary Conference the following September. Those decisions were based on documents prepared by the Pan American Sanitary Bureau, and on the specific recommendations made by the Executive Committee's Subcommittee on Long-Term Planning and Programming.

6. The XXI Pan American Sanitary Conference approved a proposal made to it by the Executive Committee of the Directing Council in its 88th Meeting of 29 June 1982, as follows:

THE EXECUTIVE COMMITTEE,

Having considered the preliminary background document prepared for the Subcommittee on Long-Term Planning and Programming of the Executive Committee, which describes the financial and budgetary implications of the Regional Strategies and Plan of Action;

Noting that the document was prepared with the cooperation and participation of specialized personnel from other international agencies;

Bearing in mind that the document was prepared in keeping with the concerns expressed at the 86th Meeting of the Executive Committee; and

Recognizing that the document contains important implications for the capacity of the Member Governments and the Organization to achieve the goals of Health for All by the Year 2000,

RESOLVES:

To recommend to the XXI Pan American Sanitary Conference, XXXIV Meeting of the Regional Committee of the World Health Organization for the Americas, that it adopt the following Resolution:

THE XXI PAN AMERICAN SANITARY CONFERENCE,

Having considered the document prepared for the Subcommittee on Long-Term Planning and Programming of the Executive Committee, which describes the financial and budgetary implications of the Regional Strategies and Plan of Action;

Bearing in mind Resolution XI of the XXVIII Meeting of the Directing Council, which adopted the Regional Plan of Action for Health for All by the Year 2000 and Resolution WHA35.23, in which the World Health Assembly adopted the global Plan of Action for implementing the global strategy for Health for All by the Year 2000; and

Noting the revisions and recommendations made by the Subcommittee on Long-Term Planning and Programming and by the 88th Meeting of the Executive Committee,

RESOLVES:

1. To express appreciation to the Director for the study on the financial and budgetary implications of the Regional Strategies and Plan of Action.

2. to urge Member Governments to examine the implications and recommendations contained within the study and consider actions to enhance the likelihood that resources will be available and will be used in the most efficient and effective manner to permit the attainment of Health for All by the Year 2000.

3. To request the Director:

a) To continue to examine the international economic environment and national and international resource allocations to the health and related sectors and to inform the 92nd Meeting of the Executive Committee in 1984 of any significant changes affecting the attainment of Health for All by the Year 2000;

b) To advise those Member Governments which may request it on ways to implement the outcome of these studies.[2/]

7. Upon his election as Director of the Pan American Sanitary Bureau in September 1982, Dr. Carlyle Guerra de Macedo noted the effect that the crisis could have on health financing in the Region, indicating that:

"In the economic sector, it is noteworthy that, despite the diversity of systems and stages of development, the national economies will, in general, continue to experience strong pressures as a result of their entry into the world economy. In almost all the countries, internal development policies will be strongly conditioned by the need to bring the balance of payments into equilibrium. In the short and medium term, it is probable that low economic growth rates will continue to prevail and that employment, income and the production structure will change but little. A need for economic austerity measures can be foreseen, and they will affect the health sector as well."[3/]

8. The present Report on the results of the work done by the Pan American Sanitary Bureau is made in compliance with section 3 (a) of Resolution XX. Its preparation has been made easier by the spirit of participation promoted by the present Direction, which has yielded valuable contributions from different staff members at PASB Headquarters and in the various countries, which have participated in preparing data for the Report itself. Contributions have also been made by local staff members of the PAHO/WHO Country Offices.

End Notes, Introduction

1/ Pan American Health Organization and World Health Organization, Health for All by the Year 2000: Strategies, PASB, Washington, D.C., 1980, p. 9.

2/ Resolution XX of the XXI Pan American Sanitary Conference, September 27, 1982.

3/ Dr. Carlyle Guerra de Macedo, Declaration of Principles, Pan American Health Organization/World Health Organization, Washington, D.C., September 1982, p. 2.

CHAPTER I. CAUSES AND EFFECTS OF THE PRESENT SOCIOECONOMIC CRISIS IN LATIN AMERICA AND THE CARIBBEAN

9. The majority of the countries in Latin America and the Caribbean are experiencing the worst socioeconomic recession in 50 years. The causes of that recession are both historical and structural, but they have been aggravated severely by developments since 1981.

10. The crisis was aggravated in 1973 when the OPEC member countries began increasing the price of oil from what was then US$2.91 a barrel. An enormous increase of 160% in 1975 was followed by others that brought the price to US$35 a barrel in January 1983, or 12 times above the starting price in 1973. Since last year the international price has held at US$29 a barrel.

11. The drop of US$6.00 a barrel in 1983 has relieved to some extent the financial situation of the net importing countries, but has also created economic problems for the net exporting countries in the Region, including Mexico, Ecuador, Venezuela and Trinidad and Tobago.

12. The prices of oil and oil products affect the costs of other goods and services, including inorganic fertilizers, pesticides, automotive, aviation and marine fuels, some synthetics used in textiles, bunker oil for the manufacture of cement, and energy for industrial use, home heating and lighting not generated by water or other means.

13. These mounting increases in oil prices triggered a spiral of inflation that struck at a wide range of activities, and also affected the international financing system by shifting to the net exporting countries large volumes of monetary resources which they deposited in or invested through banking institutions. Net importing countries turned to these same institutions for loans to cover balance-of-payments deficits. Interest rates, at first 6% to 7% a year, soared to around 20%; however, when general rates of inflation declined in the more industrialized countries, interest rates did not recede to their original level, but have remained at about 14% to 15% a year.

14. Since 1981 the socioeconomic crisis has been deepened by other factors such as:

a) A deterioration of the international terms of trade with increases in the costs of most imports from the more industrialized countries--owing to the inflationary spiral--and a drastic decline in the value of the principal exports of the countries in the Region to markets in the more developed countries. In addition, customs restrictions in the form of quotas and duties have been imposed on imports of some of them;

b) An increase in Latin America's external indebtedness. In 1981 this indebtedness totaled US$258 billion, from which it increased 12% in 1982 to US$289 billion, and another 20% over the 1981 figure to 310 billion in 1983;

c) The rise of international interest rates has sharply increased the amount of interest due on the Region's external indebtedness. The amount of interest payments as a percentage of the value of exports of goods and services, has evolved as follows since 1977:

1977	12.4%	1979	17.4%	1981	26.4%	1983	35.0%
1978	15.5	1980	19.9	1982	38.3		

d) An abrupt loss of parity of the currencies of many countries in the Region relative to other international currencies, and to the United States dollar in particular;

e) An increase in price indices and rates of inflation in countries where inflation had traditionally been moderate, including Costa Rica, Ecuador and Mexico, and steep increases in those where inflation had historically been high, especially Argentina, Bolivia, Brazil, Peru and Uruguay;

f) A real drop in fiscal revenue and increase of public expenditures;

g) A rising trend of public budget deficits, especially over the last three years in many of the countries in the Region;

h) A decline in private production activity and in public services, with increasing unemployment and limited opportunities of employment for those who otherwise should be joining the ranks of the economically active population;

i) Cutbacks in most public programs, especially those for social purposes, owing to the priority given to the economic and infrastructural sectors as part of fiscal and monetary measures taken to meet the service on the external debt, which affects most areas of national activity, and

j) Declines in the per capita gross domestic product and the standard of living, particularly of the middle and low middle classes and the more deprived strata of society;

k) Exclusion of more people from the monetary economy and restrictions on access to essential goods and services such as education, food, health and housing, and to employment opportunities, which limits their sharing in the benefits of social security.

15. There is a close interrelationship between many causes and effects, and many effects are themselves the causes of fresh problems, which are exacerbated by inflexibilities and dependence on external factors. For example, the extremely unfavorable trend of the terms of international trade caused by the imbalance between exports and imports has been compounded since 1981 by rising real international interest rates. In 1983, a massive recession of the net flow of foreign private capital into the Region also has occurred, and the combination has meant difficulties in renegotiating both the public and the private external debt.

16. This whole situation has been referred to by the Economic Commission for Latin America (ECLA) as one of "overadjustment" imposed by the "financial depression," which in the last year has grown more intense. It underscores even more the dependence of the less developed countries on those that are wealthier and more advanced. This is aggravated by the uncertainty and internal conflicts that trouble some of the developing countries, the hegemony of the great world powers, which polarize East and West, and the varying extent to which all the countries in the Region are dependent on the more industrialized nations for their science, technology and financing.

17. It is now clearer that medium and long-term solutions for the problems of the Latin American and Caribbean countries will not be found only in internal adjustments of the moment, though some of these are also necessary. Those countries will have to undertake major political, social and economic structural changes, as has been suggested in widely differing international forums and documents, among them the Second Development Strategy of United Nations, the New International Economic Order, and the Strategies and Plan of Action of Health for All by the Year 2000.

REPERCUSSIONS OF THE SOCIOECONOMIC CRISIS IN LATIN AMERICA

18. The economic growth of a country is measured by a variety of indicators, the one in widest international use being the gross domestic product (GDP), which is the value of the goods and services produced within a national or regional economy net of foreign transfers.

19. According to ECLA, the Latin American GDP declined 2.8% from 1981 to 1983; over those three years the economic trend was downward, from a growth of 1.5% in 1981 to a decline of 1.0% in 1982 and further decline of 3.3% in 1983.

20. A more representative and sensitive socioeconomic indicator of the effects of the socioeconomic crisis of the last three years is the per capita GDP. From 1980 to 1983 this indicator dropped 9.5% at market prices of 1970, according to the same ECLA source.

21. During the same period the only countries which experienced growth in per capita GDP were Panama, at 3.5%, and the Dominican Republic, at 2.5%, as may be seen in the following table containing data from ECLA. ECLA also shows similar data on Cuba which indicate a consistent increase in its Gross Social Product, defined, in contradistinction to Gross Domestic Product, as the "... sum of gross production in the agricultural, industrial, mining, energy, transportation, communication and commerce sectors."**

Table 1-01

PER CAPITA GROSS DOMESTIC PRODUCT IN U.S. DOLLARS AT MARKET PRICES OF 1970 IN 1980, 1981, 1982 AND 1983, AND TOTAL CHANGES IN AMOUNTS AND PERCENTAGES FOR LATIN AMERICA AND THE INDIVIDUAL COUNTRIES DURING THE PERIOD 1981-1983*[1/]

Country	1980	1981	1982	1983	Change during 1981-1983 Amount	Percentage
Argentina	1.345	1,245	1,159	1,166	US$ 179	-13.3
Bolivia	382	368	326	297	- 85	-22.2
Brazil	958	919	908	844	- 114	-11.9
Chile	1.047	1,088	916	897	- 150	-13.3
Colombia	824	823	816	802	- 22	- 2.7
Costa Rica	974	904	801	778	- 196	-20.1
Dominican Republic	601	611	606	616	+ 49	+ 2.5
Ecuador	732	742	729	883	- 52	6.7
El Salvador	432	380	350	335	- 72	22.4
Guatemala	561	549	515	489	- 11	12.9
Haiti	148	145	142	137	- 37	- 7.2
Honduras	357	346	332	320	- 65	-10.3
Mexico	1.366	1,436	1,391	1,301	- 3	- 4.8
Nicaragua	341	359	342	338	- 40	- 0.9
Panama	1.154	1,176	1,214	1,194	+ 30	+ 3.5
Paraguay	633	665	632	603	- 105	- 4.7
Peru	690	698	683	585	- 15	-15.2
Uruguay	1.423	1,412	1,281	1,200	- 223	-15.6
Venezuela	1.268	1,230	1,197	1,135	- 133	-10.5
Latin America	1.007	997	965	911	- 96	- 9.5

*No data are supplied for Cuba or for the English-speaking Caribbean.

**See ECLA Report E/CEPAL/G.1279, 20 December 1983, Tables 2 and 3, pp. 32 and 33, paragraph 4, as well as the explanatory note on p. 15.

22. Eleven countries posted loses of per capita GDP greater than the regional average of 9.5%, three of these indices declining by more than 20%. These losses over those three years may be presumed to have reduced the standard and general quality of life of the population, particularly among those strata less financially able to cope with prevalent critical conditions.

23. Some evidence of this is supplied by two UNICEF studies, one done in Chile and the other in São Paulo state, Brazil. The one on Chile concluded in translation, that:

"The sharp economic recession of 1975-1976 was accompanied by a drastic curtailment of public expenditure in all the social sectors...the first recessive cycle saw a substantial drop in public expenditures in the health sector for investments and outlays for the acquisition of goods needed for the operation of the system.

"Moreover, investment outlays made no recovery in any year after those considered in this study. To the contrary, they continue to decline until in 1979 they level off at 3% of the public expenditures for health. This figure, about 350 million pesos of 1978, comes to barely 25% of the amount that had been invested in the early years of the decade. Outlays for personnel also fell during the first year of recession, recovered and then fell again with fluctuations after 1980. The tendency of outlays for the procurement of goods is similar. In no year of the period did they again reach the level of 1978.

"The paucity of investment in the sector and the decline in outlays for the procurement of goods have in all probability resulted in a deterioration of the plant and equipment for health and, in consequence, of the quality of care. This is borne out by frequent reports to this effect throughout the period by physicians and other personnel of the sector...

"A reduction of investment in health on this scale made it possible to maintain the levels of health care services in the short run at the expense of programs for the acquisition of equipment, maintenance and expansion of installed capacity. Another contributing factor was the drop in real remuneration to the staff employed in the sector. It may be noted that, in the health sector, about 40% of the total expenditure had gone traditionally for personnel remunerations."2/

24. The study on Sao Paulo also reveals a downtrend of expenditures for health, which by 1982 had dropped 18% since of 1978. The report asserted that:

"The decline in real value of health expenditures is more evidence (for education). Separation of recurrent from capital costs does not change the circumstances, in spite of the loss of capital expenditures for the Ministry of Health which has been seen to be particularly severe.

"...Thus we have a general overview of a decline, or at least of stagnation in health and education expenditures. However, it is not possible to draw the conclusion that this has caused a reduction in services in these areas, either on the part of the state or local government. The major part of expenditures is for salaries, and their stagnation or decline is a result mostly of "salary constriction," to which most public sector employees have been submitted over the past few years. Sooner or later, of course, such a salary policy will affect the quality of services provided."3/

25. It may be that the cases of Chile and São Paulo are not generalizable to other countries in the Region if their governments give priority to the financing of health programs or have developed a greater operating capacity. Either situation could check the decline in per capita GDP.

26. If this has happened, a proper answer is being given to the question posed by UNICEF: "...how can we sustain social progress without an increase in funding?"4/ For this international agency, the solution or "...very probably...the watchword for this decade in favor of social progress should be to 'make the most of the available resources.'"5/

27. On the need to improve the management of national health services so that they will make more efficient use of the available human, financial and material resources and become more productive, while maintaining the effectiveness required for HFA/2000, a number of specific recommendations will be presented in Chapter IV, below.

28. Economic development and the growth of a country's economy do not necessarily imply immediate attainment of the goals of social development; to the contrary, priority has to be given to programs for that purpose and to financing for them. For example, Saudi Arabia has one of the highest per capita GNPs in the world - estimated at US$12,600 in 1981 - and yet had a very high infant mortality of 111 children under one year per 1,000 live births. According to UNICEF data, in Costa Rica and Cuba, with lower per capita GNPs - US$1,430 and US$1,410, respectively, in 1981 - there were 27 and 19 deaths of infants under one year per 1,000 live births.6/

29. Infant mortality in the same age group was 12 per thousand in the United States of America, with a per capita GNP of US$12,820, and the USSR, with a per capita GNP in the equivalent of US$4,550, had 27 per thousand, in both cases owing to policies and practices applied to the country's health programs.

30. The fact that social development is not an automatic or secondary consequence of economic development, but requires an explicit administrative policy decision of government, was addressed in the document of the Ninth Session of the Committee of High-Level Experts (CEGAN) of ECLA, in which it is said, in translation, that:

...economic development per se does not guarantee social development unless steps are taken that promote equity in the distribution of wealth and access for the less privileged to the goods and services of society.7/

INTERRELATIONSHIP OF CAUSES AND EFFECTS

31. In the web of causality in which the range of socioeconomic factors is enmeshed, some of which are particularly exacerbating in time of crisis, they are all so closely interwoven and interdependent that no decision can be taken in isolation. For example, seeking to improve their balance of payments, many countries in the Region have given preference to production and exportation of nontraditional goods that are in greater demand and face less competition in the markets of the more developed countries. This has also been necessary in some cases as a requirement of the domestic adjustment process to which governments have submitted under standby agreements entered into with the International Monetary Fund. The purpose of such agreements is to enable a country to earn more foreign exchange with which to purchase the goods and services it needs for domestic production and service its foreign debt, and to meet the population's demands for food, medicines and other products.

32. As a result of this unprecedented effort, in 1983 Latin American exports exceeded imports of goods and services by US$31,170 billion. According to ECLA data this performance is all the more impressive when considering that it was accomplished on the strength of increases over previous years in the volume of products exported, the prices of which, in most cases, reamined low on international markets. Eight countries earned more from their exports than they spent on their imports, and so enjoyed trade surpluses, while the trade balances of eleven continued in deficit. In 1983 the value of total exports was US$87 billion against imports of US$56 billion.

33. Another effect of that interdependence has been that some items in the popular diet have become scarce as lands previously under cultivation for sugarcane, cassava, tubers, vegetables, pastures, etc., have been diverted exclusively to sugarcane for conversion into fuel alcohol or into products for export alone.

35. Net payments of profits and interest abroad have increased considerably as follows:

US$19 billion in 1980	US$37 billion in 1982
US$29 billion in 1981	US$34 billion in 1983

The reason for the drop of US$3 billion in 1983 is that amortizations were made on the principal of these debts, which has obviously also lowered in the Region's international reserves.

35. According to figures of the Bank for International Settlements in Basel,8/ new loans by international private commercial banks to Latin America, not counting those to Ecuador and Venezuela, have declined considerably since 1981 as follows:

US$21 billion in the second half of 1981
US$12 billion in the first half of 1982
US$300 million in the second half of 1982
US$3.7 billion in the first half of 1983

These loans in 1983 were obtained from international private commercial banks as a result of IMF intervention under standby agreements in effect between the debtor governments and that international agency.

36. Between August 1982 and December 1983, reschedulings of their foreign debts were requested by Argentina, Bolivia, Brazil, Chile, Costa Rica, Cuba, the Dominican Republic, Ecuador, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Peru, Uruguay, and Venezuela.

The number of countries that have had to resort to these negotiations is yet more evidence of the similarity of the situations in which they find themselves as a consequence of the crisis.

37. Another unfavorable development during 1983 was a dwindling flow of capital to Latin America, which was about US$30 billion less than the outward flow of payments of interest and principal on the Region's foreign debt.

In this regard, ECLA says that:

"...as in 1982, [in 1983] Latin America, instead of receiving a transfer of real funds from abroad, made transfers of funds to the rest of the world. This prolonged a situation which, given the relative state of development of the Region, may be described as perverse.

"However, this transfer was very considerable: 20 billion dollars in 1982 and almost 30 billion in 1983, or 19.0% and 27.0% of the value of the exports of goods and services and 2.5% and 4.0% of the gross domestic product, respectively, in those two years. Viewed from another standpoint, this reversal of the flow of net financial payments between 1981 and 1983 was equivalent to a drop of about one-third in the terms of trade."9/

38. Another effect of the influx of foreign capital has been a decline in its trend; the growth of this influx was 7% from 1982 to 1983 and 12% from 1981 to 1982, and so in both years was less than the average growth of 23% per annum during the period of 1977-1981. Even so, at the end of 1983 the foreign debt of Latin America totaled about US$310 billion.

39. The net inflow of capital began dropping in 1981 from US$38 billion to US$16.6 billion in 1982, and to US$4.5 billion in 1983. The causal effect of this was to reduce the surplus on current account from about US$40 billion in 1981 to US$36.4 billion in 1982, and to US$8.5 billion in 1983, the lowest level since 1974.

40. In a recent presentation Mr. Antonio Ortiz Mena, President of the Inter-American Development Bank, illustrated his comments on the net flow of capital with the charts on the pages that follow.

Figure 1.01

External resources: the net flow turns negative

Latin America obtained an additional net external inflow of capital amounting to $20-$22 billion annually in the five years up to 1981. Then, debt service soared, and the region suddenly began to lose international reserves--over $10 billion in 1982.10/

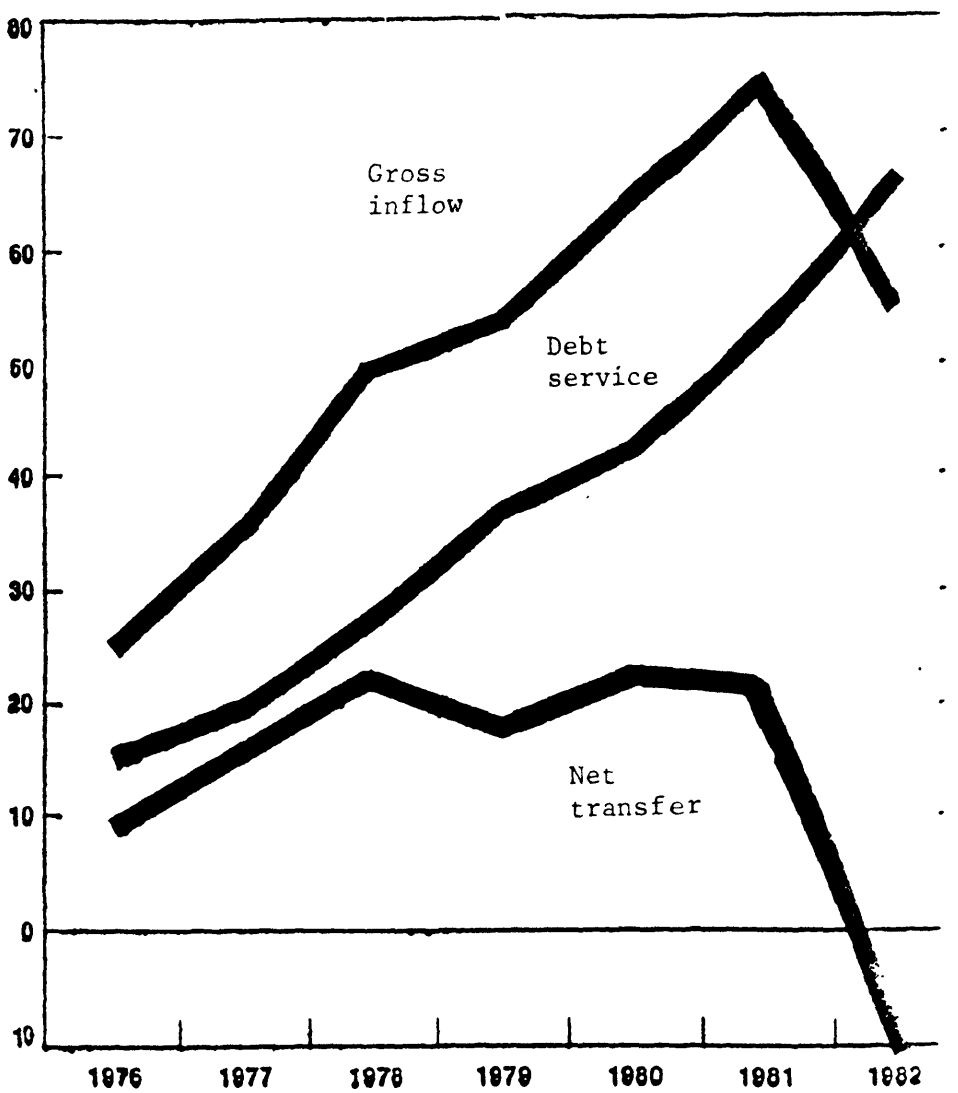


Figure 1.02

The rising cost of borrowing

Latin America had to borrow heavily to pay its oil bills. The region had good access to the private Eurocurrency market, but maturities for loans grew increasingly shorter. 11/

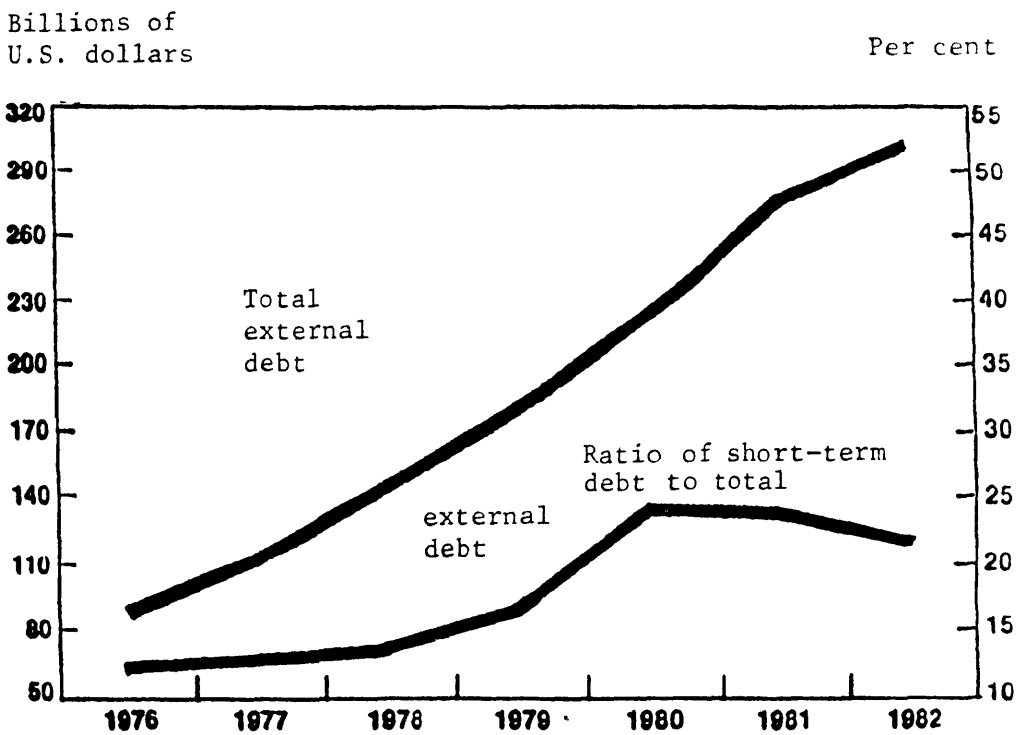
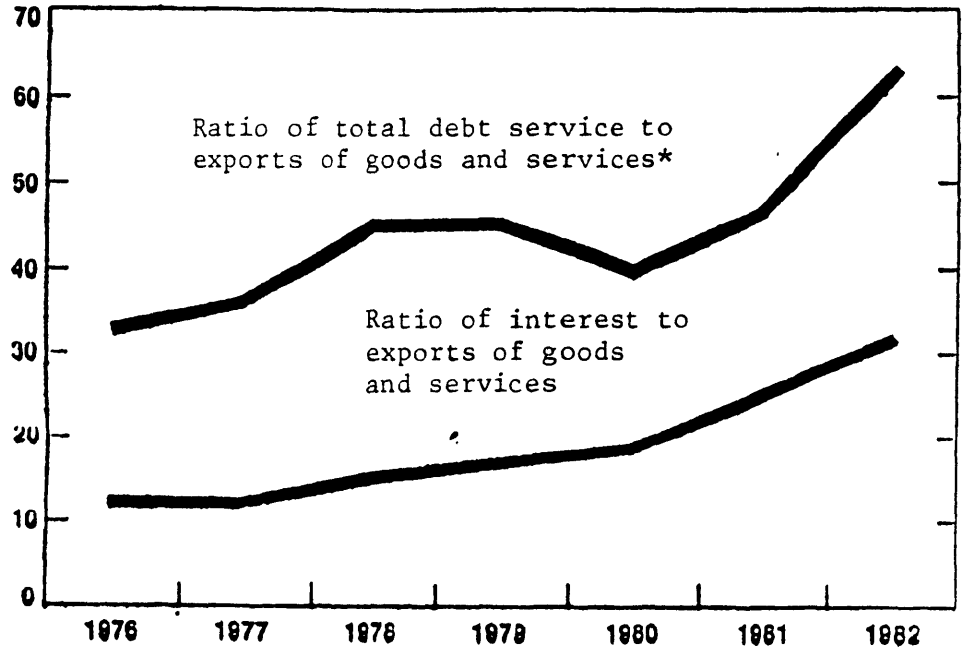


Figure 1.03

Servicing the debt: an increasing burden

By making extraordinary efforts, some countries have achieved favorable balances in their trade accounts. But the surpluses are being wiped out by the increasing service on their external debt. 12/

Per cent



41. Mr. Ortiz Mena indicated that the present crisis originated in 1971, when the United States of America decided to change the Bretton Woods International Monetary System, according to the terms of which United States dollars earned by other countries from their sales to the U.S. were convertible in to gold. When the flow of gold abroad increased, the United States set the value of its currency through the financial market by a "floating" system, and surpluses were handled through the uncontrolled parallel system by central banks, thereby giving rise to the so-called "Eurodollars."

42. These surpluses were invested as loans in countries having projects that guaranteed satisfactory monetary returns at terms usually of 10 to 15 years and at reasonable interest rates.

43. As indicated in paragraph 2, the first sudden increase in oil prices took place in 1973, when they quadrupled, followed by a second considerable increase in 1979. "Eurodollars" then became "petrodollars," as international financial surpluses shifted to countries that were net oil producers and exporters.

44. As early as 1973, the financial conditions of international lending also began to change with a hardening or worsening of the terms of loans, which contracted to five and seven years. There were also changes in interest rates for private corporations, which rose from 7.5% a year in 1972 to 8.1% in 1973, 9.5% in 1974, 9.6% in 1975, 7.9% in 1976, 8.4% in 1977, 9.3% in 1978, 11.3% in 1979, 14.4% in 1980, 15.5% in 1981, 12.2% in 1982, and 11.1% in 1983.13/

45. Charges on international private commercial loans have always been higher than on those granted domestically on the basis of the prime rate, which in March 1984 is 11.5%. The former carry surcharges for other costs of financial intermediaries, which at present run to about one and three-quarters of the LIBOR (London Interbank Offered Rate), plus commissions and financial insurance, which raise these costs to about 14% or 15% a year. Poorer nations in other regions of the world are authorized loans at lower interest and longer grace and amortization terms.

46. International interest rates went up when the rate of inflation rose in the wealthier and more industrialized countries, but did not follow it back down, among other reasons because of the high fiscal deficit of the United States of America; the government covers this deficit by borrowing on financial markets, which keeps the interest rate at about 11.75% a year.

47. When the financial situation hardened, net oil importing countries had to continue borrowing abroad, many of them to invest sizable amounts in hydroelectric works that in the long run would make them less dependent on oil energy. They also invested heavily in new, nontraditional energy

generation techniques, such as those using biomass and thermal energy, and the manufacture of fuel alcohol and diesel oil from agricultural products.

48. Like liquids under the law of communicating vessels in physics, different macroeconomic factors operate interdependently. Thus, in countries whose tax systems are based largely on customs levies, fiscal revenue diminishes appreciably when the imports that generate those levies decline. There is then a shift to other fiscal policies based more on direct taxes such as those on property, rent, appreciation, inheritances and consumption, among others.

49. Capital movements and foreign investment are used to solve balance-of-payments problems (income outflow of foreign exchange). To improve the international trade balance, imports are cut back and greater exports promoted, particularly those of nontraditional products that may have less competition in the markets to which they are shipped.

50. Increasing these nontraditional exports usually brings no additional income into the treasury, because it is precisely by exempting them from taxation that they are encouraged to increase. Drastic reductions of imports have brought down fiscal revenue and product stocks, including medicines and foods not produced locally.

51. With lower public receipts and increased difficulties and costs of replacing them through accumulation of new external indebtedness, real outlays at constant prices have been reduced. These constant prices are obtained by subtracting the inflationary component from current prices so as to obtain a time series of historically comparable figures in which the trend is apparent.

52. Another device has been printing money, that is, increasing the supply of money without regard for real national output, which accelerates inflation and causes further losses of purchasing power of the currency.

53. In many countries this course has led to sudden and steep devaluations of the national currency relative to stronger international currencies, which has been sought as another means of encouraging exports.

54. In some countries some of these factors have been indexed as a means of averting their secondary effects and make their fiscal and monetary policy decisions more flexible.

55. In some countries of the Region the public deficit has risen steeply relative to GDP and has worked against some of the corrective measures attempted in the internal adjustment process, particularly under standby agreements negotiated and signed between governments and the

IMF. These agreements establish targets for reduction of the fiscal deficit relative to the GDP, which compels some countries to give priority to programs that contribute more directly to economic recovery in the short run. The result is an increase in the relative weight of budgetary allocations for typically economic activities.

56. In the overall development process, the economic and social aspects are two sides of the same coin, and hence inseparable, as has been said by the Director-General of the World Health Organization and the Executive Director of the United Nations Children's Fund, in a statement on primary health care:

"Any distinction between economic and social development is no longer tenable. Economic development is necessary to achieve most social goals and social development is necessary to achieve most economic goals. Indeed, social factors are the real driving force behind development. The purpose of development is to permit people to live economically productive and socially satisfying lives. Social satisfaction and economic productivity will be interpreted in widely different ways according to the social and cultural values prevailing in each society. Everywhere people themselves realize that their motivation in striving to increase their earnings is not greater wealth for its own sake but the social improvement that increased purchasing power can bring to them and their children, such as better food and housing, better education, better leisure opportunities, and, last but not least, better health. Only when they have an acceptable level of health can individuals, families and communities enjoy the other benefits of life. Health development is therefore essential for social and economic development, and the means for attaining them are intimately linked. For this reason, actions to improve the health and socioeconomic situation should be regarded as mutually supportive rather than competative. Discussions on whether the promotion of health only consumes resources or whether it is an economically productive factor contributing to development, belong to the academic past."14/

57. Hence, in addition to the purely economic effects of monetary and fiscal factors, others deriving from production and employment have to be considered; these other effects are both economic and social in nature and have been affected by the downward trend of the GDP as reflected in the following figures estimated by ECLA in constant United States dollars of 1970:

350 billion in 1981
347 billion in 1982
335 billion in 1983

58. This decline is the outcome of widely diverse factors, including some of an economic nature stemming from the recession-cum-inflation,

(which did not occur during the Great Depression of the Thirties), which have adversely affected activity in many lines of production in both the public and private sector; that is, the decline of this activity has also curtailed opportunities for employment and worsened visible unemployment and equivalent unemployment (visible plus invisible unemployment).

59. The figures for urban unemployment are as follows, in mean annual rates for 1983:[15/]

Argentina	4.9%	Costa Rica	9.8%
Bolivia	12.6	Mexico	12.5
Brazil	6.8	Paraguay	9.4
Chile	19.7	Peru	8.8
Colombia	11.0	Uruguay	15.7

60. No country in Latin America or the Caribbean has unemployment insurance such as that available in the more developed countries, which makes the situation in the Region even worse. In recent decades, as the economic situation in the Region improved, governments in Latin America and the Caribbean undertook programs for construction of infrastructure works, housing and social development as a means to generation of full employment. Some of these activities were supported by external financing, and others added to the fiscal deficit and aggravated the countries' monetary problems by being financed by printing money, which was regarded as the lesser evil.

61. In addition, bureaucratic job slots were created for the generation of employment, especially for unskilled labor. In the internal adjustment process to which the countries have submitted in their search for ways out of the economic crisis, these measures have had to be curtailed. Even so, several governments have continued or even expanded programs of minimum employment, as in Chile, or of food subsidies or distribution, as in Brazil.

62. Other countries have been unable to do this, having to direct those internal adjustments called for in their standby agreements with the IMF toward a drastic contraction of demand, for which they have had to reduce the supply of money in circulation and public expenditures not only of the central government, but of the decentralized agencies as well, a course that in many countries has greatly increased the government's consolidated public debt. This is what has happended in Peru, where, according to the Inter-American Development Bank,[16/] the six most important public enterprises accounted for 86% of the public sector's operating deficit in 1982. According to the same source, in Venezuela 69% of public sector expenditures were generated by the decentralized agencies.

63. The adverse effects of the socioeconomic crisis in the labor area have been severe, particularly for the young people entering the labor force each year--estimated at 9 million--because 43.2% of the present population of Latin America and the Caribbean is between 15 and 44 years old. Most of this age group is economically active inasmuch as only a small percentage of the segment between 15 and 24 years of age is enrolled in regular institutions of secondary, vocational and higher education.

64. ECLA's Economic Projections Center is of the view that, as a result of the prevailing situation, the demand and employment opportunities for young people and women is lower than in past decades, and that preference for jobs is given to adult male heads of family. The Center also considers that earlier unemployment calculations are now unrealistic and that the rates are higher than initially estimated. It also suggests that purchasing power of wages will steadily decrease in the next two years. This may also adversely affect future per capita GDP figures and equitable distribution of national income in most of the countries of the Region.

65. Other damage done by the socioeconomic crisis can be measured by the changes that have taken place in prices to the average consumer and urban worker (very few countries have similar indexes for the rural consumer owing to measurement difficulties), and also by modifications of wages and salaries. Changes in prices are measured by a predetermined "basic basket" of goods and services on which family income is spent, including such basic items as food, housing, education, health, and lesser expenditure items for apparel, recreation, etc.

66. According to ECLA figures,[17/] between December 1982 and December 1983 consumer prices rose throughout the region an average of 130.4%. In the countries of traditionally high inflation this average was 153.6%, and in those of traditionally moderate inflation it was 15.7%. The first group comprises Argentina, Bolivia, Brazil, Chile, Colombia, Mexico, Peru and Uruguay, among which the figures in excess of the group average are those of Argentina, Bolivia and Brazil, where retail prices rose 401.6%, 249.0%, and 175.2%, respectively

67. For the countries with moderate inflation, the group average of 15.7% was exceeded by Ecuador with a rata of 65.9% and Trinidad and Tobago with 16.7%. Costa Rica managed to drastically reduce the high inflation set off in 1981, during which year the index of prices to the average consumer and worker rose 65.1% above the 1980 level and 81% in 1982, essentially because of a sudden change in the parity of the national currency in 1981. The Costa Rican colon was devalued from 8.60 to 60.0 in that year, from which it then depreciated in 1982 to 45 colones to the United States dollar, and where it has, currently stabilized. The devaluations of Mexico, Venezuela and Bolivia have also

abruptly changed the rate of exchange of their currencies with the United States dollar. The Mexican peso dropped from 12.5 to the United States dollar in 1976 to 154 in 1982; the bolívar from about 4.5 to the dollar to 11; and the Bolivian peso plummeted from 25 to one U.S. dollar in 1981 to 2,200 to one on the parallel market today, although the official rate is 500 to the dollar.

68. The level of the exchange rate is the outcome of a variety of factors, including the monetary reserves held by a country, which in turn are determined by the components of its balance of payments. In turn, the exchange rate affects price changes just as these impact efforts by employees to have their wages and salaries increased to offset losses in purchasing power. In times of crisis, prices tend to change faster than wages, so that when adjustments are made the gap is usually wider than the changes that have taken place in the market value of the goods.

69. Although short-run adjustment programs tend to keep inflation in check by containing demand, when they fail to do this those who suffer most are people who depend on fixed incomes from wages, salaries, pensions and investments at fixed interest rates which have not been indexed to national rates of inflation. Also hard hit are low and moderate income people, who are less able to protect themselves from situations created by decisions made at levels and in spheres to which they have no access.

70. Loss of monetary parity and the deterioration of international reserves have made it difficult for some countries to buy medicine and drugs, equipment, and replacement parts, for their health programs when those items are of foreign origin and the national monetary authorities restrict the release of foreign exchange for these and others.

71. The above measures of the status of the Regional economy are examples only and by no means constitute a comprehensive analysis of all causes and effects of the present crisis made. Besides, there is no precise dividing line between political and social indicators, such as those described on Chapter 2, which discusses the situation in seven selected countries in the Region.

EXTERNAL AND INTERNAL STRUCTURAL AND SHORT TERM CAUSES AND EFFECTS

72. The term structural is frequently used to describe and define the permanent causes, factors and effects of overall development, while cyclical describes the same aspects but for the short term only. The former are over the long term, while the latter transitory usually lasting less than four years.

73. Those who have studied the origins of the current socioeconomic crisis blame it essentially on structural causes, citing rises in oil

prices as a trigger of the developments of the last decade. These causes have been aggravated by domestic situations stemming from characteristics unique to the countries in the Region themselves, which, nevertheless, have still much in common as subjects of external factors over which they have no control and are therefore spectators of the process rather than actors in it. There is also a fairly widespread - if not actually unanimous - view that the structural crisis and current recession are largely mutually reinforcing, the latter being exacerbated in many countries by high rates of inflation.

74. The traditional devices used in the past by the governments of the more developed countries to regenerate their economies have now proved to have been inadequate for the recovery begun, in some of them, in 1983 to be regarded as solid or and to generate enough momentum to be of benefit to the less developed countries as well. For example, it has not been possible to restore the rate of capital accumulation to the level reached before the onset of the latest decline; such instruments as credit and the traditional fiscal, monetary and trade policies applied in the more developed countries when aggregate demand and production decline are now less effective.

75. The crisis in Latin America and the Caribbean can have adverse consequences for the more developed countries themselves, as has been demonstrated for the United States by the drastic US$21 billion reduction of that country's exports to the Region during 1981-1983 (12 billion dollars of the reduction attributable to Mexico alone). These figures were disclosed by President Ronald Reagan in his report to the Congress in January 1984.

76. Again, according to President Reagan, "seven of the most heavily indebted Latin American countries took in 13.9% of the exports of the United States in 1981... (and) these losses (of those exports), caused by the economic adjustments that these heavily indebted countries had to make, will not be greatly reversed in 1984".18/

77. The foreign trade deficit of the United States during 1983 reached US$60.6 billion, 66% greater than the gap between exports and imports in 1982, which was US$36.4 billion; and 117% more than the trade deficit of US$27.9 billion in 1981.19/ According to the same source, the preliminary estimates for 1984 are of a trade deficit of about US$100 billion.

78. This situation has prompted groups of domestic producers to bring heavy pressure to bear on the Executive and Legislative branches for quotas and restrictions on the importation of some competing foreign products.

79. These figures also bear out the need for interaction between the more and the less developed countries and for efforts to attain recovery objectives in a spirit of solidarity and the international common good, along with fairness and equity in the distribution of welfare and wealth.

80. These efforts should also aim at assisting the less privileged countries and social strata, because "evidence exists to affirm that the general quality of life has declined substantially in most of the countries as a result of the many effects of the crisis in terms of reduced real outlays for education, health and housing brought about by stabilization programs, and because of the weakening of the social security and welfare systems. This has meant less access for the majority of the population to such basic goods and services as food, housing, health and education".20/

EFFECTS OF THE SOCIOECONOMIC SITUATION ON HEALTH INDICATORS

81. As mentioned in the introduction to this document, the main purpose of Resolution XX of the XXI Pan American Sanitary Conference was to determine the possible financial and budgetary implications, at both the national and international level, of the present socioeconomic crisis for carrying out the Plan of Action for implementation of the Regional Strategies for Health for All by the Year 2000. The specific request to the Director of the Pan American Sanitary Bureau was that he continue to examine the international economic environment, and national and international resource allocations to health and related sectors, regarding any significant changes that could affect the attainment of Health for All by the Year 2000.

82. In compliance with that mandate, Chapter I has provided a body of overall macroeconomic and social data, and in some cases references to the situation in the seven countries covered in more detail. Chapter II will examine more specific details of that situation, describe changes that took place in the economy during the period 1978-1983 and trace their implications for the financing of social programs with emphasis on health.

83. Assessing the effects of the crisis on the "health situation," that is, on coverage, on emergency services, and on the details of the allocation of financing of national health services, require data which either did not exist or was unavailable.

84. Distinction would also have to be made between inputs, such as the provision of services, their distribution, percentages of coverage, and results or effects. Such indexes as live birth weight, mortality among infants and children under five, morbidity from malaria, etc., are negative indicators which, however, can indicate measurements of gains. However, these indicators of "health results" are affected not only by inputs for health such as personnel and equipment for immunization, but also by improvements in development and social welfare. For example, an increase of the food supply in a country plagued by production, distribution and financing shortfalls, can give rise to a significant reduction of infant mortality.

85. Measurement by indicators of results is also hindered by other factors. There is a direct general correlation between the GDP and life expectancy at birth. However, this correlation is not absolute, as has been demonstrated in several countries, among them Sri Lanka, where high health levels have been attained with low per capita income levels thanks to the efficient application of very simple public health techniques.

86. While it is important to measure the results of the socioeconomic situation over the long run, it is not always feasible to predict the effect that the level of financing can have on health gains. Moreover, it is possible to predict that a reduction in financing for programs in the social sectors will have negative effects on investments in the health sector and on the trend toward improvement of the health situation. But it could not be predicted that, because of reduction in financing, infant mortality could be reduced or that the life expectancy of the population would be shortened.

MULTILATERAL PUBLIC BANK FINANCING FOR HEALTH

87. Until 1978 the Inter National Bank for Reconstruction and Development (World Bank) did not directly finance health programs but only certain components of health related activities such as water and sewerage. Since 1979, the Bank has begun to provide relatively small amounts of its total loan portfolio for health projects. In 1981 and 1982 such funds reached only 0.1 percent of total loans. In 1983, this increased by 0.5 percent.

88. During last year, the percent of loans of the total portfolio allocated to the social sector reeached 9.0 percent. Of this amount, 6.0 percent was used for water and sewerage, 3 percent for education and the remainder for health, including population programs, nutrition as well as health itself.

89. Loans for water and sewerage increased to 4 percent in 1982 and 6 percent in 1983. Funds for education, on the other hand, fell from 4 percent in 1981 and 1982 to less than 3 percent in 1983.

90. Countries which receive credits for investment programs must finance 90 percent of programs with national resources derived from ordinary budget accounts based on tax revenues or charges to borrowers. Similar restrictions are applied to IMF standby agreements, since both institutions operate according to similar policies and practices, although they have different goals. The World Bank is concerned with programs of structural adjustment over the mid and long term, closely associated with economic development. Indeed, this is the reason that 42 percent of its loan portfolio was allocated to productive sectors in 1983. The IMF grants credit according to a special drawing fund for short term adjustments or emergencies which require funds to improve balance of payments and the capacity to service foreign debt.

91. The World Bank granted a credit to the Government of Peru in the amount of US$35 million for health programs. Depending on an evaluation of the Peruvian experience, the Bank may continue to authorize similar loans to other nations in the future. But it is necessary to bear in mind the objectives of the Bank as expressed in its 1983 World Development Report which refer to:

- The type of administration which should be operational during periods of uncertainty, and which should be effective and efficient;

- the improvement of plans, budgets and evaluation of expenditures;

- improvement of information systems for management purposes;

- improvement in management of decentralized institutions;

- improvement in projects and programs; and

- national community participation.

92. With respect to the mandate of the Inter American Development Bank (IDB), its Special Operations Fund makes loans according to conditions which vary by type of country according to degree of development. In the first category are:

a) Bolivia, Ecuador, El Salvador, Haiti, Honduras, Guatemala, Guyana, Nicaragua, Paraguay and the Dominican Republic. They enjoy preferential, interest rates, usually from between 2 to 5 percent lower than market rates, with 30 to 40 year terms, and grace periods for amortization and interest payments. For the period of 1983-1986, US$100 million is available for these ten countries. This is still not enough to cover all needs, thereby forcing the countries to give priority, once again, to the producing sectors of the economy.

b) Barbados, Costa Rica, Jamaica, Panama, Suriname and Uruguay constitute the second group of countries. They have access to credits with an ordinary rate of interest, higher than that for the first group, which is about 11 percent yearly, less five points. Terms for liquidation of the entire debt range from 15 to 25 years. The grace period for amortization and interest payments is less than that granted to the countries in the first group. For 1983-1986, the amount allocated to this second group is US$800 million.

93. The remaining countries in the Region have to use the other resources of the IDB. These loans are not as soft as these nations are considered to have achived a higher level of economic development and have their own financial resources.

94. During 1981-1983, IDB authorized loans in the amount of US$724 millions for health programs and activities. Included in this figure are funds for drinking water, sewerage and environmental improvements. The distribution oif these resources has been:

1981 US$208 million or 8.3 percent of total loans
1982 US$245 million or 8.9 percent of total loans
1983 US$271 million or 8.9 percent of total loans

95. There appears to be a view in the multilateral and bilateral financial and technical assistance organizations that the social sectors, including health, are plagued by poor management, or at least are open to substantial improvement in the administration of their resources to improve impact. There is also the belief that health sector should generate savings and thereby capitalize more effectively on existing resources before seeking greater outside financial assistance.

96. It has been affirmed that attainment of HFA/2000 consitutes not only a substantive medical and paramedical effort, but it should also be understood as a natural economic achievement:

"The concept of primary health care as a strategy to attain HFA/2000 must meet the requirments of impact, equity, social efficiency, social participation, intersectoral linkaging and cooperation among countries. Its essence is based on the recognition that in order to achieve "Health for All," meeting all those requirements constitutes an economic problem. Such is the relative scarcity of multiple use resources in a given society containing different groups of people with unequal opportunities to express and satisfy their specific needs and aspirations in a space and moment in time. 'Primary health' constitutes a strategy because it proposes to resolve the above problem in a determined fashion by appropriating, recombining, reorganizing and reorienting all the resources (available and potential) from the entire health sector to satisfy the needs and aspirations (in the field of health) for all the society exactly according to the requirements for the goal and regional objectives already spelled out.

"From a strictly 'technical-administrative' perspective, the potential of this strategy lies in the hypothesis, empirically confirmed, that it is possible to solve, efficiently, given sets of health problems with combinations certain technological resources (functions of production), of different complexities, and therefore with varying social costs. It is suggested that there exists a correlation between the complexity of health problems and the complexity (and social cost) of production functions capable of solving them.

On the other hand, empirical evidence also supports the contention that less complex health problems occur relatively more frequently than

those which are more complex. From this it may be deduced that there is a possibility to solve health problems for a given population by organizing levels of care which minimize the social cost. In this way, primary care as a strategy implies organization of services according to levels of care, but can be limited in some fashiion to a single level considered to be minimal.21/

End Notes, Chapter I

1/ The data for 1983 are estimates subject to revision and the changes in 1981-1983 correspond to those accumulated during the same period. Document E/CEPAL/G.1279, p. 33.

2/ Alejandro Foxley and Dagmar Raczynski, Corporación de Investigaciones Económicas para América Latina (CIEPLAN), "Grupos Vulnerables en Situaciones Recesivas: El caso de los niños y jóvenes en Chile, Santiago de Chile", 1983, pp. 31 and 32.

3/ Roberto Macedo, "The Economic Crisis and the Welfare of Brazilian Children: A Case Study of the State of Sao Paulo", UNICEF, June 1983, pp. 43, 44 and 47.

4/ James P. Grant, Executive Director, Fondo de las Naciones Unidas para la Infancia (UNICEF), "Estado Mundial de la Infancia 1984", p. 6.

5/ James P. Grant, loc cit. p. 6.

6/ James P. Grant, ibidem, p. 12.

7/ "Noveno Período de Sesiones del Comité de Expertos de Alto Nivel (CEGAN)", Documento de Trabajo, Montevideo, 18 al 20 de enero de 1984, sn/p.

8/ Doctor Enrique V. Iglesias, Secretario Ejecutivo de la Comisión Económica para la América Latina, "Síntesis Preliminar de la Economía Latinoamericana durante 1983", Documento E/CEPAL/G.1279, p. 30.

9/ Doctor Enrique V. Iglesias, loc cit., p. 29.

10/ Lic. Antonio Ortíz Mena, President, Inter American Development Bank, "The Economic Crisis: Looking Beyond Emergency Measure to Long-Term Needs", FOCUS, January 1984, p. 5.

11/ Lic. Antonio Ortíz Mena, loc cit, p. 6.

12/ Lic. Antonio Ortíz Mena, ibidem, p. 7.

13/ Lindley H. Clarck Jr., "A Remembrance of Interest Rates--and an Editor-Past, The Wall Street Journal", 5 July 1983, p. 23.

14/ Organización Mundial de la Salud/UNICEF, "Informe Conjunto del Director General de la OMS y del Director Ejecutivo de la UNICEF, Atención Primaria de la Salud, Conferencia Internacional sobre Atención Primaria de la Salud", Alma Ata (URSS) 6-12 September 1978, pp. 15 and 16.

15/ Doctor Enrique V. Iglesias, passim, Cuadro 4, América Latina: Evolución del Desempleo Urbano, p. 34.

16/ Inter American Development Bank, Economic and Social Development Department, "External Debt Land Economic Development of Latin America, Background and Perspectives", A Study by Luis Carballo-Raines and Debora E. Rogers, January 1984, p. 91.

17/ Doctor Enrique V. Iglesias, supra, Cuadro 5, América Latina: Evolución de los precios al consumidor, sn/p.

18/ Inter American Development Bank, information received by teletype, 2 February 1984, p 1.

19/ The Washington Post, Trade Deficit for 1983 Hits $ 60.6 Billion, 8 February 1984.

20/ Comisión para América Latina, "Noveno Período de Sesiones de SEGAN", loc cit., sn/p.

21/ Manual sobre el Enfoque de Riesgo en la Atención de Salud, Medellín, Colombia, 1-10 March 1984, Vol. I, Chapters I-IV, pp. 7, 8 and 9.

CHAPTER II. SOCIOECONOMIC TRENDS IN SELECTED LATIN AMERICAN AND CARIBBEAN NATIONS

97. The preceding Chapter has described in some detail the present economic crisis throughout Latin America and the Caribbean. It has shown in broad outline the nature and extent of conditions, especially as they pertain to socioeconomic development, health in particular. In this Chapter the analysis narrows in focus on a review of seven countries. They are: Argentina, Brazil, Costa Rica, Jamaica, Mexico, Peru and Saint Lucia. While these nations do not constitute a representative sample of the Region, they do contain virtually 60 per cent of the population in Latin America and the Caribbean. Thus while it is not possible with scientific accuracy to generalize to the Region the experiences of the group, neither is it possible to dismiss entirely strong suggestions that what is happening in the seven countries may be occurring as well in the remaining nations of the Region. The seven countries included in the sample group were selected for a variety of reasons. Argentina, Brazil and Mexico are the largest territories and represent a total of 52 per cent of the regional population. Also, as large nations, they encounter health and finance problems of a distinct nature and scope than those of their smaller and less developed neighbors. Peru was chosen as an Andean nation, and one which is currently facing a series of severe development problems which were believed necessary to be accounted for in the group. Costa Rica, a small and relatively developed nation, was selected from the Central American area where yet another set of distinct conditions exists. Jamaica is the most advanced country in the English-speaking Caribbean, and Saint Lucia is among the smallest.

98. Before continuing, one important caveat needs to be explicated. In many instances data were not available or were so tentative to be of marginal value only. (A complete list of variables for which data were requested may be found in the Appendix.) Hence it was impossible to present uniformly comparable findings for all countries. What follows, then, is an elaboration of the major points of concern in examining public and private financing of health care and health care systems in Latin America and the Caribbean between the years 1978 and 1982. Countries in the group will be analyzed individually and conclusions regarding the group as whole are presented at the end of the report.

99. While budgeted funds are certainly a measure of health policy intent, as are national plans, they are not useful in evaluating real commitment and outcome. That is an analytical function of expenditures. Consequently, the analysis will be directed almost exclusively at public and, where possible, private outlays for health care and health related activities. It should be noted, in addition, that some definitional problems were present, as might have been expected. Thus health sector, for example, was defined differently in the majority of the nations in

the group. While attempts were made to establish uniform definitions to facilitate comparative analysis, this turned out not to be feasible. Consequently, comparisons between and among nations in the group are difficult but not entirely impossible.

The Economies and Public Spending

100. The macroeconomic indicators in Table 2.1 show a somewhat mixed pattern among the seven countries in the group. Argentina, Jamaica, Peru, Argentina, Mexico and Costa Rica all register declines in GDP as of the last year measured. The two remaining nations experienced small increases. However, during the five year period of measurement, 1978 to 1982, with the exception of Jamaica, the trend had been generally upward until 1982, especially in the case of Costa Rica. That is, if 1978 is compared against 1982 the net difference is positive. No doubt the world and regional economic crises are reflected in these statistics, especially as of 1982, as severe recession and a crushing foreign debt have been taking their toll. Once again it is useful to look at Costa Rica. That nation, which had been experiencing gradual growth since 1978 (although the rate of increase had dropped off), suffered a dramatic plunge in its GDP from 0.8 percent in 1981 to minus 9.9 per cent in 1982. Peru suffered a similarly spectacular decline.

101. A more sensitive indicator of economic vicissitudes, certainly in more human terms, is evidenced in Table 2.2, indicating per capita changes in real GDP. Here the pattern is less encouraging. As of the last year for which data exist, per capita GDP is down in all countries from the previous year, with the exception of Saint Lucia. So while in some countries the overall economic picture is not one of continuous decline, at least in macro terms, per capita examination of the GDP suggests that population growth along with faltering economies have offset whatever minor economic gains may have been achieved. Given the magnitude of the decrease in the regional economy, as presented in the statistics in Chapter I, the picture which emerges here is not so surprising. Indeed, considering the size of the foreign debt and the extent of unemployment a bleaker scenario may well have been expected.

102. But what has been the affect on public spending in the seven nations? How have the various governments been able to cope with public demands, especially for health care, in times of economic hardship? Once again the picture is mixed.

103. Argentina, Brazil, Costa Rica and Jamaica all show declines in per capita public expenditures, ranging from a significant 24 per cent reduction in Argentina to just 2 per cent in Jamaica, as is illustrated by the data in Table 2.4.

104. Perhaps he most puzzling sets of figures are those for Mexico and Peru. While GDP in both those countries declined in the last year measured, total central government expenditures increased across the

Table 2.1

AMOUNT AND PERCENT CHANGE OF GROSS DOMESTIC PRODUCT
(1978 Constant Prices, Millions of Local Currency)

COUNTRY	YEAR									
	1978		1979		1980		1981		1982	
	OUTLAY	%	OUTLAY	%	OUTLAY	%	OUTLAY	%	OUTLAY	%
ARGENTINA	5179800	...	5359253	3.5	5405823	0.9	5114706	-5.4	...	...
BRAZIL	3729700	...	4054191	8.7	4251849	4.9	4147921	-2.4	4203630	1.3
COSTA RICA	30193	...	31674	4.9	32107	1.4	32353	0.8	29145	-9.9
JAMAICA	3763	...	3708	-1.5	3506	-5.4	3593	2.5	3481	-3.1
MEXICO	2337398	...	2541447	8.7	2729268	7.4	2791758	2.3	2786213	-0.2
PERU	1672307	...	1743146	4.2	1777860	2.0	1837482	3.4	1720791	-6.4
SAINT LUCIA	187	...	214	14.4	211	-1.7	215	2.3	...	...

NOTE: Constant prices in all Chapter II tables calculated from Official Data.

board and per capita. In Mexico government outlays went up by an extraordinary 25.7 per cent* between 1981 and 1982, no mean feat considering the country's debt position and the conditions of the agreement with the IMF requiring reduction in the deficit from 16% to 8% of GDP by the year 1984. In Peru the increase is not nearly as dramatic--7.7 per cent--but still significant in a country saddled by a large foreign debt and staggering natural disasters which have destroyed much of the agricultural and aquacultural crop. Yet despite these hardships, the Peruvian GDP rose every year between 1978 and 1981 (see Table 2.4), perhaps helping to explain in part the increase in public spending. The same was not true for Mexico. Indeed, the GDP fell while public expenditures rose (see Tables 2.2 and 2.3)

Table 2.2

PER CAPITA GROSS DOMESTIC PRODUCT
(1978 Constant Prices, Local Currency)

	YEAR				
COUNTRY	1978	1979	1980	1981	1982
ARGENTINA	192558	196238	195086	182083	...
BRAZIL	33024	35028	35847	34125[a/]	33775
COSTA RICA	14242	14596	14270	14246	12683
JAMAICA	1775	1724	1616	1619[b/]	1533[c/]
MEXICO	35724	37696	39355	38828	38146
PERU	99424	100818	99992	97785	89082
SAINT LUCIA	1561	1785	1755	1795	...

a/Preliminary Data
b/Revised Estimates
c/Estimates

*This unprecedented growth in the Mexican budget may well be due in part to substantial increases in the Finance and Public Credit account, helping to service an enormous public debt. In 1979 this budget account grew only 0.85 per cent. In 1980, when the the magnitude of the Mexican debt was becoming apparent, the increase rose to 11.0 per cent. When the Public Debt account is added, the respective percentages become 14. 4 and 20.6. Further testimony to the impact of public debt service on federal expenditures growth is evident in the figures for 1981, where the per cent growth of the Public Debt and Finance and Public Credit accounts reached 24.3. In 1982 it was 36.0 per cent.

Table 2.3

TOTAL CENTRAL GOVERNMENT OUTLAYS
(1978 Constant Prices, Millions of Local Currency)

COUNTRY	YEAR 1978	1979	1980	1981	1982
ARGENTINA	829976	817215	718636	648620	498196
BRAZIL[a/]	...	1355821	1631272	1537243	1506556
COSTA RICA	16734	18389	20140	19454	17372
JAMAICA	1229	1537	1282	1641	1645[b/]
MEXICO	937834	1071809	1352043	1445487	1816458
PERU	225070	189803	255379	275077	...
SAINT LUCIA	...	...	...	71	84

[a/] Federal Government expenditures only (and for all subsequent tables).
Excludes transfers from Union budget and sanitation. Includes outlays for INAMPS and Monetary Budget, including subsidies for credit and supply.

[b/] Estimates.

105. Jamaica, too, displayed a similar pattern as in Mexico, increasing public spending at the same time GDP was falling. In Brazil, the reverse may be witnessed. GDP rose slightly at the same time federal spending declined marginally. In Argentina and Costa Rica, both indicators fell; and in Saint Lucia, as in Peru, GDP and expenditures increased simultaneously. On balance, it is difficult to say what the mid term trends (or even short term) will be. More time will have to pass since the brunt of the global economic trauma was felt before clearer patterns of the impact on public and health sector spending emerge.

Table 2.4

PER CAPITA TOTAL CENTRAL GOVERNMENT OUTLAYS
(1978 Constant Prices, Local Currency)

COUNTRY	YEAR 1978	1979	1980	1981	1982
ARGENTINA	30854	29924	25934	23091	17524
BRAZIL	...	11714	13753	12647	12105
COSTA RICA	7894	8474	8951	8566	7560
JAMAICA	580	715	591	739	724
MEXICO	14333	15897	19496	20104	24869
PERU	13381	10978	14363	14639	...
SAINT LUCIA	...	...	...	591	702

106. Another way of looking at public sector commitment is to consider public expenditures as a per cent of GDP (see Table 2.5). Here the picture becomes a little more focused than what has been seen above. Argentina, since 1978, has been experiencing a steady decline in public sector spending as a percentage of GDP, while Mexico has been undergoing a protracted increase, jumping prominently between 1981 and 1982. This complements what has already been exhibited in Tables 2.2 and 2.3. Jamaica, too, has been augmenting the percentage of public spending generally between the same periods of time. Brazil peaked in 1980 and declined slightly in 1981 and then again in 1982. The same is true of Costa Rica. The data reinforce a country-by-country pattern which has been emerging all along. What may be most noteworthy about the data in Table 2.5 are the disparities between and among countries. That is, Mexico and Costa Rica demonstrate strong public sector support, while Argentina and Peru reveal more tenuous levels of commitment, at least in terms of government expenditures as a percentage of GDP. There are doubtless many and complex reasons for the differences. But an analysis of them is beyond the mandate of the report. The fact remains, however, that relative public outlays vary widely.

Table 2.5

TOTAL CENTRAL GOVERNMENT OUTLAYS AS PERCENTAGE OF GDP
(1978 Constant Prices, Millions of Local Currency)

COUNTRY	YEAR									
	1978		1979		1980		1981		1982	
	OUTLAY	GDP %	OUTLAY	GDP %	OUTLAY	GDP %	OUTLAY	GDP %	OUTLAY	GDP %
ARGENTINA	829976	16.0	817215	15.2	718636	13.3	648620	12.7	498196	...
BRAZIL	...	...	1355821	33.4	1631272	38.4	1537243	37.1	1506556	35.8
COSTA RICA	16734	55.4	18389	58.1	20140	62.7	19454	60.1	17372	59.6
JAMAICA	1229	32.7	1537	41.5	1282	36.6	1641	45.7	1645	47.2
MEXICO	937834	40.1	1071809	42.2	1352043	49.5	1445487	51.8	1816458	65.2
PERU	225070	13.5	189803	10.9	255379	14.4	275077	15.0	...	...
SAINT LUCIA	...	...	...	...	...	...	71	32.9	84	...

The Social Sector

107. Having reviewed the principal patterns of government spending, what can be said for public commitment to the social sector in the seven countries under examination? Of all the nations for which data were available, per capita social sector spending in four of them grew, at least between the last two years measured (see Table 2.6). During the period 1978 to 1982, only Mexico registered a steady and noticeable increase in absolute expenditures. However, at the same time, Mexico decreased social sector spending as a percentage of total central government expenditure. Comparing per capita social sector expenditures for the year 1978 and the last year for which data are available, only Jamaica and Mexico show growth. Looking at the last two years on the table, it is clear Argentina and Costa Rica experienced substantial reductions in per capita social spending. The remaining nations weave a varied pattern.

108. Additional evidence pointing to unfixed economic and fiscal patterns may be seen in Table 2.7, showing social sector spending both as a percentage of GDP and total central government outlays. Argentina and Costa Rica remain faithful to the trends which have already characterized their economic and financial performance described in preceding pages of the report. In each case social sector spending may be seen to decline most clearly between 1981 and 1982.

109. Brazil, on the other hand, which exhibited a downward direction in total federal expenditures and per capita GDP, at least since 1980, now realizes a modest gain in social spending when measured against those two indicators. Mexico, which has demonstrated such a strong commitment to public sector activity, as evidenced by previous indicators, now experiences a decline in social outlays as a percent of total public expenditure. At the same time social spending has increased relative to GDP. The apparent anomaly may be explained by a GDP growing at a slower rate than social sector spending.

Health Expenditures

110. Outlays for ministry of health expenditures as a percentage of GDP show a mixed picture, as may be seen in Table 2.9. As may have been predicted, Costa Rica and Argentina exhibit declines. Changes in the other countries, between 1978 and 1982, are slightly upward or do not occur at all. The one noticeable exception is Saint Lucia, which declined substantially. However, Saint Lucia appears to be coming close to achievement of HFA/2000, which may help explain part of the decrease. The same table also indicates public expenditures on social security as a percentage of GDP. Interestingly, Argentina actually shows a slight increase in this measure, as do Costa Rica and Brazil. In fact, only Jamaica and Mexico show declines, though small, between 1978 and 1982.

Table 2.6

PER CAPITAL SOCIAL SECTOR EXPENDITURES
(1978 Constant Prices, Local Currency)

	YEAR				
COUNTRY	1978	1979	1980	1981	1982
ARGENTINA[a/]	8180	8610	10811	9164	6267
BRAZIL[b/]	908	877	777	865	867
COSTA RICA[c/]	2121	2797	2707	2197	1484
JAMAICA[d/]	199	229	213	...	218[h/],[i/]
MEXICO[e/]	2729	2859	3060	3126	3345
PERU[f/]	3853	3202	3292	3328	...
SAINT LUCIA[g/]	...	...	...	...	282

a/ Social Sector includes budget accounts of Ministries of: Culture and Education, Health and Social Welfare (i.e, Social Security, Labor, Housing, Social Assistance, Sports and Recreation, Social Promotion and other, unspecified, agencies).

b/ Social Sector includes Ministries of Health and Sanitation, Education and Culture, Labor, Housing and Urban Affairs, Social Welfare.

c/ Social Sector includes the following sectors: Health, Education, Labor and Social Security, Housing and Human Settlements, Culture and Recreation.

d/ Social Sector includes the following ministries: Health, Housing, Labour, Local Government (and Community Development), Education, Social Security.

e/ Social Sector includes the following sectors: Public Education, Health and Welfare, Labor and Social Security as well as "Controllable Agencies and Public Enterprises."

f/ Social Sector includes sectors of Health, Education and Labor.

g/ Social Sector includes Ministries of Health and Education.

h/ Excludes Ministries of Housing and Labor.

i/ Revised Estimates.

Table 2.7

SOCIAL SECTOR EXPENDITURES AS PERCENT OF TOTAL CENTRAL GOVERNMENT OUTLAYS
(1978 Constant Prices, Millions of Local Currency)

COUNTRY	YEAR 1978 OUTLAY	1978 SSE %	1979 OUTLAY	1979 SSE %	1980 OUTLAY	1980 SSE %	1981 OUTLAY	1981 SSE %	1982 OUTLAY	1982 SSE %
ARGENTINA	220050	26.5	235135	28.8	299559	41.7	257428	39.7	178168	35.8
BRAZIL	102515	...	101511	7.5	92186	5.7	105125	6.8	107901	7.2
COSTA RICA	4497	26.9	6069	33.0	6092	30.2	4990	25.7	3411	19.6
JAMAICA	423	34.4	493	32.1	461	36.0	225	13.7	494	30.1
MEXICO	178577	19.0	192754	18.0	212220	15.7	224754	15.5	244341	13.5
PERU	99490	28.8	89970	29.2	102920	22.9	113535	22.7	...	...
SAINT LUCIA	...	...	...	...	...	...	...	...	34	40.2

Table 2.8

SOCIAL SECTOR EXPENDITURES AS % OF GDP

	YEAR				
	1978	1979	1980	1981	1982
COUNTRY	%	%	%	%	%
ARGENTINA	4.2	4.4	5.5	5.0	...
BRAZIL	2.7	2.5	2.2	2.5	2.6
COSTA RICA	14.9	19.2	19.0	15.4	11.7
JAMAICA	11.2	13.3	13.2	6.3	14.2
MEXICO	7.6	7.6	7.8	8.1	8.8
PERU	3.9	3.2	3.3	3.4	...
SAINT LUCIA	...	...	...	...	...

For Mexico, this is one of the few indicators which revealed a slight downturn in an otherwise relatively positive trend for health. A more accurate indicator of the relative status of health care expenditures within the public sector, however, is the total of health ministry and social security outlays as a percentage of GDP. With the exception of Saint Lucia, the countries in the group have significant publicly supported social security programs. Once again the general pattern which has been traced in previous tables emerges. Costa Rica shows a significant reduction in expenditures on health and social security combined. Argentina displays a stable pattern as does Brazil. One nation which requires special comment here is Peru. While on other indices it has exhibited a relatively low degree of social sector support, it is clear from the data in Tables 2.9 through 2.11 that there is a slightly stronger commitment to health and social security, both within the social sector itself and as a percentage of central government expenditures, than would otherwise have appeared to be the case.

111. Social security expenditures demonstrate an even more impressive record. In Mexico the reverse happens, as indicated elsewhere. That is, while in budgeted and per capita expenditures there is an increase in health and health related support, as a per cent of social sector and central government outlays a constant decline since 1978 is quite evident. The remaining nations all show increases, however modest they might be. It should be pointed out, however, that social security costs are not necessarily all health related. Social Security data from Mexico

and Costa Rica are limited only to health expenditure; however, unfortunately, it was impossible to partial out for the group as a whole what percentage of social security actually went to underwrite health costs. Thus any interpretation of the data needs to be conditional.

112. As a percentage of total central government expenditures, health and social security, not unexpectedly, by and large adhere to the same trend (see Table 2.10). Taken separately, health ministry outlays, however, are less consistent with former patterns. They decline in Peru, Jamaica and Saint Lucia. This is also the case for Argentina and Costa Rica, as might have been anticipated in light of all the foregoing data. In Brazil there is a trace of upward movement. Combined with social security a more familiar set of trends appears, but not entirely. Most significant are the declines in Mexico and Jamaica. Where total public expenditures and social sector outlays had been increasing, the health sector was not keeping pace. While this is a disturbing statistic for those in the health field, in the case of Jamaica it is attenuated by two factors. First, the degree of decline is small. Second, it is much too early to establish if this is a trend or simply a one or two year break in an otherwise more positive cycle.

113. Of more concern is Mexico, where the decrease has been generally sustained since 1978. Yet, this in turn is offset, as can be seen in Table 2.12, which display a general increase in per capita health and social security expenditures.

114. The directions in Argentina and Costa Rica also give rise to concern. Since 1978, Argentina has been spending progressively less on health in proportion to total social sector expenditures. And for the last three years shown on Table 2.11, 1980 to 1982, Brazil has also accumulated a signficant decrease in health care and social security expenditures as a per cent of social spending. The situation in Jamaica has been variable. The one surprise, outside of Mexico, is Costa Rica. That nation, which has shown a consistent decline in health care outlays on every other indicator, does relatively much better than other members of the group in defending and increasing proportionately health expenditures in the social sector.

115. Finally, it is instructive to examine the data in Table 2.12 on per capita health and social security spending. Costa Rica and Argentina, once more, register declines, the former beginning in 1979 and the latter in 1980. Peru varies, but generally the pattern is upward. Jamaica is also uneven, but the changes are very small, pointing to a moderate stability in per capita expenditures. Only Mexico and Saint Lucia indicate clear upward trends, and this is in keeping with the patterns which have now been seen to exist.

Table 2.9

COMBINED MINISTRY OF HEALTH AND SOCIAL SECURITY EXPENDITURES
AS PERCENT OF GROSS DOMESTIC PRODUCT

	YEAR														
	1978			1979			1980			1981			1982		
COUNTRY	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL
ARGENTINA	0.5	0.9	1.4	0.8	0.9	1.7	0.4	1.0	1.4	0.3	1.1	1.4	...	...	...
BRAZIL[a/]	0.2	1.2	1.4	0.2	1.2	1.3	0.1	1.1	1.3	0.1	1.3	1.4	0.2	1.2	1.4
COSTA RICA	1.0	5.5	0.5	1.2	6.0	7.2	1.3	6.2	7.4	1.3	5.6	6.9	0.9	4.0	5.6
JAMAICA	2.4	0.2	2.6	2.5	0.4	3.0	2.3	0.5	2.8	...	0.1	...	3.0	0.3	3.3[b/]
MEXICO	0.5	3.3	3.8	0.4	3.2	3.6	0.5	3.1	3.5	0.5	3.0	3.6	0.5	3.3	3.8
PERU	1.0	2.1	3.0	1.0	2.0	3.0	1.0	2.5	3.5	1.0	2.8	3.8	1.2	2.0	4.0
SAINT LUCIA	10.7	...	...	0.0	...	...	4.9	...	...	5.1	...	...	...	...	...

[a/] Does not include costs for sanitation.
[b/] Calculation based on estimates.

Table 2.10

MINISTRY OF HEALTH AND SOCIAL SECURITY EXPENDITURES AS PERCENT OF CENTRAL GOVERNMENT OUTLAYS

	YEAR														
	1978			1979			1980			1981			1982		
COUNTRY	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL
ARGENTINA	3.0	5.5	8.4	5.0	6.0	11.0	2.9	7.6	10.5	2.5	8.3	10.8	2.2	6.8	9.0
BRAZIL	...	...	...	0.5	3.5	4.0	0.4	2.9	3.3	0.4	3.4	3.8	0.4	3.2	3.6
COSTA RICA	1.9	9.9	11.8	2.0	10.3	12.3	2.0	9.8	11.8	2.1	9.4	11.5	1.6	7.8	9.4
JAMAICA	7.3	0.7	8.0	6.1	1.0	7.1	6.4	1.3	7.7	...	0.2	...	6.3	0.7	7.0
MEXICO	1.2	8.2	9.4	1.0	7.6	8.6	0.9	6.2	7.1	1.0	5.9	6.9	0.8	5.1	5.9
PERU	7.2	15.4	22.6	8.9	18.2	27.1	6.9	17.4	24.3	6.6	18.5	25.1	...	...	...
SAINT LUCIA	...	...	...	...	...	...	...	...	...	15.6	...	...	13.6	...	...

Table 2.11

MINISTRY OF HEALTH AND SOCIAL SECURITY AS % OF SOCIAL SECTOR EXPENDITURES

	YEAR														
	1978			1979			1980			1981			1982		
COUNTRY	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL
ARGENTINA	11.2	20.6	31.8	17.4	20.8	38.3	7.1	18.2	25.3	6.3	20.9	27.3	6.2	19.1	25.2
BRAZIL	6.3	45.3	51.6	6.1	47.1	53.2	6.4	51.5	57.9	5.2	49.8	55.0	6.1	44.9	50.9
COSTA RICA	7.0	36.8	43.8	6.2	31.2	37.4	6.6	32.5	39.1	8.3	36.6	44.8	8.0	39.6	47.6
JAMAICA	21.2	2.1	23.3	19.0	3.2	22.2	17.7	3.5	21.3	...	1.5	...	21.1	2.3	23.4
MEXICO	6.4	42.9	49.4	5.4	42.5	47.9	5.8	39.5	45.3	6.4	37.7	44.1	5.7	38.2	43.9
PERU	16.4	34.9	51.2	18.7	38.5	57.2	17.1	43.1	60.3	16.0	44.9	60.9	...	...	...
SAINT LUCIA	...	...	...	...	...	...	...	...	...	...	...	...	33.9	...	...

Table 2.12

PER CAPITA HEALTH AND SOCIAL SECURITY EXPENDITURES
(1978 Constant Prices, Local Currency)

	YEAR														
	1978			1979			1980			1981			1982		
COUNTRY	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL
ARGENTINA	919	1686	2605	1501	1793	3294	763	1969	2733	582	1916	2498	387	1194	1581
BRAZIL	58	411	468	53	413	467	50	400	450	45	430	475	52	389	442
COSTA RICA	149	780	929	174	872	1045	179	880	1059	181	804	985	118	588	707
JAMAICA	42	4	46	44	7	51	38	8	45	...	2	...	46	5	51
MEXICO	176	1172	1348	153	1216	1369	178	1207	1386	199	1179	1379	191	1277	1468
PERU	968	2062	3030	976	2001	2977	992	2496	3489	965	2714	3679	1076	2455	3531
SAINT LUCIA	168	...	...	...	...	...	86	...	...	92	...	...	96	...	...

116. If, as has been illustrated, health care expenditures in the public sector are being reduced in a majority of the seven countries under examination, how then has this impacted distribution of financial resources within the sector? Have there been any significant changes in patterns of expenditures, by type of outlay and, if so, to what degree? Once again, it needs to be explained at the outset that few data were available. Even with that limitation, it is important to present what information exists.

117. The majority of disaggregated data dealt with salaries in the various ministries of health. While admittedly this is only a partial indication of types of expenditures within the ministries, it does point to the fact that salaries are a major (and in some instances the major) component of outlays (see Table 2.13). In Jamaica they have remained around half of all costs. In Costa Rica, with the exception of 1981, they have accounted for over 50 per cent, peaking in 1982 at 63.5 per cent. A similar if not identical, pattern emerges for Mexico. Indeed, as of 1982 salaries for the Mexican health sector climb close to 70 per cent of total sector outlays. Only Argentina reveals a generally declining and relatively small percentage of ministerial expenses as salaries. This might have been explained by a significant predominance of capital over recurrent costs. Yet this has not been the case. Recurrent costs ranged from a high of 94.4 per cent of all ministerial outlays in 1978 to a low in 1982 of 73.3 per cent.

118. A few data were also available on public expenses for hospital care. While the information is scarce, it does support the patterns which have been developed throughout this Chapter. In Costa Rica, for example, there has been a drop in hospital outlays from a high of over one billion colones in 1980, during the five year period under study, to a low of 663 million in 1982, or a 34 per cent decline. Brazil shows more stability, with outlay differences ranging only from a low of 57 billion cruzeiros to a high of 62 million.

The Private Sector

119. If, as a rule, public expenditures on health (and social security) as a proportion of social sector spending for the group have been falling, what if anything can be said about the ability of the private sector to help shoulder some of the increased health care burden? As data were available for just three countries, and only for 1982 in one of them, the question is really unanswerable. It simply needs to be stated here that the study did attempt to collect data on the private sector as a potentially important component of the entire health care system.

Table 2.13

SALARIES AS PERCENTAGE OF TOTAL HEALTH MINISTRY EXPENSES

COUNTRY	YEAR 1978 %	1979 %	1980 %	1981 %	1982 %
ARGENTINA	42.6	20.2	37.0	36.2	31.3
BRASIL	...	...	...	...	...
COSTA RICA	55.0	58.7	59.2	51.1	63.0
JAMAICA	...	51.1[a]	48.8	...	48.1[a]
MEXICO[b]	48.3	53.5	54.0	62.5	67.0
PERU	...	47.5	44.2	48.6	63.5
SAINT LUCIA	...	...	...	...	...

[a] Calculations based on estimates.

[b] Data are for entire Public Health Sector.

CHAPTER III. UPDATING SELECTED DATA IN THE BACKGROUND DOCUMENT ON THE NATIONAL AND INTERNATIONAL FINANCIAL AND BUDGETARY IMPLICATIONS OF THF REGIONAL STRATEGIES AND THE PLAN OF ACTION FOR HFA/2000

120. In this chapter, selected statistical tables from the "Background Document on the National and International Financial and Budgetary Implications of the Regional Strategies and the Plan of Action for HFA 2000" will be updated and briefly examined. Because only two years have elapsed since analysis of the data in the Background Document, it will not be possible to establish subsequent trend lines documenting changes since 1979. Nevertheless, useful and important tentative conclusions can and will be made. From the preceding pages, it has been made clear that of health care financing in Latin America and the Caribbean is not growing and, indeed, in many cases is declining in real terms. Based on the data in the Background Document, published in 1982, optimistic projections for expanding public health care financing were made. Due to the economic crisis which soon followed completion of the report, there was strong concern that the impact on health care would be significant. In terms of the available data, then, has this been the case? What follows is an attempt to answer this question. But once again it is necessary to caution the reader that findings from the analysis are tentative. More time will have to pass before firm conclusions are able to be established.

121. In Table 3.1 nine out of 11 countries, for which data were available for 1981 show that health care expenditures, as a percentage of total central government outlays, were smaller in the last year indicated than in the first year. This is not markedly different from the data in the Backgound Document which showed that 18 out of 23 nations reflected a similar pattern. Given the nature of the economic crisis a more accelerated decline may have been anticipated in 1982. However, that is no doubt attenuated by the fact that the crisis did not began to be felt until during 1981 when most countries were spending funds already appropriated.

122. A more significant and serious indicator, at least for the goals of primary care and HFA 2000, is the jump in expenditures in the public sector on hospitals between 1972 and 1979, noted in the Background Document. However, with the exception of the U.S., four countries in the Hemisphere--the only ones for which data were available--registered declines in expenditures for hospitals and clinics as a percentage of total central government health care outlays as of 1981. Whether or not this is a change in the previous trend has yet to be established. In the meantime, it is important to keep in mind that a "trend toward increasing proportions of total central government health expenditure to hospitals and clinics has serious implications for the strategies of primary health care and HFA/2000."*

*Plan, P. 14.

Table 3.1

CENTRAL GOVERNMENT EXPENDITURE ON HEALTH AS A PERCENTAGE OF TOTAL CENTRAL GOVERNMENT EXPENDITURES

Country	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982
Argentina	3.8	2.5	2.6	4.1	2.7	2.2	1.7	1.73	1.37	...
Bahamas	13.9	14.1	13.5	14.6	15.3	15.6	13.9	...	...	...
Barbados	15.5	12.8	11.8	11.2	10.6	11.5	10.3	10.19	10.76	...
Bolivia	7.8	8.9	8.4	8.0	8.0	8.0	8.3	...	7.21	...
Brazil	6.8	6.9	6.5	7.5	8.1	7.8	8.5	6.54	7.37	...
Chile	8.0	7.3	6.9	6.5	6.4	6.4	6.54	7.37	6.40	...
Costa Rica	3.1	4.0	4.3	4.6	3.2	3.7	2.4	5.05	...	...
Dominica	...	...	...	10.6	12.7	9.6	8.8	...	...	...
Dominican Republic	11.7	10.9	6.8	8.7	...	...	...	9.27	9.67	...
El Salvador	10.4	1.03	8.2	9.2	9.8	8.9	8.7	8.97	9.39	6.95
Grenada	...	14.1	14.6	12.7	15.6	...	...	...	...	...
Guatemala	9.2	8.4	8.6	8.3	7.6	7.1	7.6	...	...	...
Guyana	6.1	5.7	4.8	4.2	5.8	5.7	...	...	...	...
Honduras	...	11.7	15.7	12.8	14.7	8.5	8.0	...	...	...
Jamaica	...	...	9.3	8.2	7.8	...	...	...	...	...
Mexico	4.9	3.9	4.2	4.2	4.4	4.0	3.9	2.37	1.86	...
Netherlands Antilles	8.4	9.2	8.5	8.2	9.7	8.0	7.9	...	...	...
Nicaragua	5.7	6.2	8.4	4.1	...	...	...	14.58	...	...
Panama	15.1	13.8	14.5	13.2	14.5	15.1	12.3	12.71	13.24	...
Peru	3.3	3.0	2.8	2.8	2.7	2.6	3.7	4.52	5.30	...
Suriname	5.5	5.7	5.1	5.8	5.9	5.6	4.5	...	...	...
Uruguay	4.8	5.7	3.9	3.9	3.8	5.0	4.7	3.76	3.14	...
Venezuela	10.8	7.5	7.6	7.2	7.3	8.0	9.1	...	...	...

Source: IMF Government Finance Statistics Yearbook, Vol 5, 1981

Table 3.2

PERCENTAGE FOR HOSPITALS AND CLINICS OF CENTRAL GOVERNMENTS' TOTAL HEALTH EXPENDITURES

Country		1972		1979	1981
Argentina		33.3		78.6	71.2
Barbados		75.6		72.1	...
Bolivia	(1973)	23.1		40.1	...
Brazil		82.0		85.0	83.1
Chile		87.5		92.5	...
Costa Rica		...		...	...
Guatemala		71.0		79.3	...
Dominica (Millions)	(1976)	72.1		65.0	...
Honduras		87.0		49.0	...
Mexico		59.8		90.7	...
Panama (Millions)	(1973)	92.2	(1978)	93.8	89.1
Peru		...		...	...
USA (Millions)		85.1		92.9	94.1
Canada (Millions)	(1971)	55.1		59.0	56.1
Guyana	(1973)	93.5	(1978)	95.4	...
Nethelands Antilles	(1973)	63.1		45.3	...
Suriname		72.2	(1976)	63.3	...
Tanzania		86.0		72.7	...
India		83.0		75.6	...

Source: IMF Government Finance Statistics Yearbook, Vol. V, 1981 and 1982.

123. In many countries in the Region social security accounts for a large portion of health care expenditures. As such, it is an obvious and sensitive indicator of the status of support for health care. According to data in the Background Document, social security and welfare and health, as a percentage of total central government expenditures, grew from 27.4 percent in 1973 to 28.3 percent in 1979. By 1981 however, this pattern for the Region had been reversed and declined to 26.0 percent, according to the IMF.*

*IMF Government Finance Statistics Yearbook, 1983.

124. Another set of statistics, however, does not exactly point to what could be called an emerging pattern of decreases in health care financing in the public sector, as may be seen in updated figures in Table 3.3. What appears here instead is a mixed picture, certainly in regard to the Latin American and Caribbean nations included in the table. Some countries show declines in health care outlays. Others show increases. And one--Venezuela--reveals a seesaw effect. Of course, there are too few data and too few Hemispheric countries to be able to come to any firm conclusion about the region as whole, save to observe that what had been a relatively stable and upward pattern over the past decade now may be changing. More important is the need to interpet these data in light of the rest of the information presented in this Chapter.

125. While it may be expected that some of this decline would be compensated for by increases in private expeditures for health, this has not been the case, certainly not with respect to the four nations already cited--Honduras, Jamaica, Peru and Venezuela. The data in Table 3.4 below show that private consumption expenditures as a percentage of GDP, between 1975 and the last year measured, declined in Jamaica, remained the same in Panama and increased only slightly in El Salvador, Honduras and Venezuela. Nevertheless, given the lack of data on Latin America and the Caribbean for the years 1980 through 1982, it is not possible to make any definite statements regarding relevant patterns that are not already noted in the Background Document. As is asserted "...there is still a lot of room for the expansion of the public sector to capture a growing share within the framework of a more effectively organized and efficiently managed public health care delivery system"* (see, for example, Table 3.5).

126. The Background Document examined patterns of public and private consumption expenditure on health as a percentage of GDP. Using identical sources, it was impossible to update the information except in four countries, two of which are in Latin America, as may been seen in Table 3.6.

127. While clearly not enough time has lapsed in order to make any conclusive statements as to current trends, nor are their enough data yet available, it is not surprising that the trend from the previous years continues into 1980--except in India--the year before the start of economic crisis. Still, as has been evidenced on preceding pages, the overall picture is one of what appears to be the beginning of a general decline in health care expenditures.

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*"Plan of Action for the Implementation of the Regional Strategies for HFA/2000. Financial and Budgetary Implications." PAHO, August 6, 1983.

Table 3.3

TRENDS IN PUBLIC (GENERAL GOVERNMENT) CONSUMPTION EXPENDITURE ON HEALTH AS A PERCENTAGE OF 1) TOTAL PUBLIC (GENERAL GOVERNMENT) EXPENDITURE, AND 2) GROSS DOMESTIC PRODUCT

Country		1960	1965	1970	1975	1976	1977	1978	1979	1980	1981
British Virgin Islands	1	...	...	19.2	21.2	19.3	19.2	...	...	...	...
	2	...	...	2.6	2.6	2.8	2.8	...	...	...	...
Honduras	1	14.9	13.7	16.9	16.6	...	...	...	...	14.1	...
	2	1.6	1.4	1.9	2.1	...	...	...	...	1.9	...
Jamaica	1	...	...	...	15.5	13.0	12.7	...	...	...	...
	2	...	...	...	2.9	2.9	2.8	...	...	...	...
Panama	1	21.1	25.4	24.0	25.7	27.3	26.1	28.6	27.8	8.3	...
	2	2.4	2.8	3.5	3.9	4.3	4.1	4.3	4.3	1.6	...
Peru	1	...	...	13.0	11.4	11.0	9.9	12.7	12.6	14.0	13.3
	2	...	...	1.5	1.5	1.4	1.5	1.5	1.3	2.0	6.3
Venezuela	1	...	...	19.1	13.5	12.9	12.6	13.1	12.2	11.4	13.7
	2	...	...	2.5	1.8	1.9	1.9	1.9	1.6	1.8	1.9
United States of America	1	4.2	4.3	4.9	6.3	6.3	6.3	6.3	...	6.0	6.0
	2	.73	.72	.94	1.2	1.2	1.2	1.1	...	1.1	...
Tanzania	1	...	5.6	5.5	6.9	7.1	7.1	7.3	5.4	5.5	...
	2	...	1.0	1.3	2.2	1.8	1.8	2.0	2.0	1.8	...
India	1	...	...	5.2	6.1	6.4	6.8	7.0	...	6.9	...
	2	...	...	.41	.51	.56	. 57	. 61	...	...	6.1

Sources: UN National Accounts Tapes and IMF.

Table 3.4

TRENDS IN PRIVATE CONSUMPTION EXPENDITURES ON HEALTH AS A PERCENTAGE OF 1) TOTAL PRIVATE CONSUMPTION EXPENDITURES, AND 2) GROSS DOMESTIC PRODUCT

Country	1960	1965	1970	1975	1976	1977	1978	1979	1980	1981
El Salvador	3.6	3.4	4.3	4.4	3.9	3.9	...	...	...	...
	2.9	2.6	3.3	3.2	2.7	2.5	...	...	...	...
Honduras	6.7	6.8	6.6	5.9	...	...	...	...	6.9	...
	5.1	5.0	4.8	4.3	...	...	...	...	4.7	...
Jamaica	2.6	2.9	3.2	2.3	2.0	1.8	...	...	2.0	...
	1.8	2.1	2.2	1.4	1.3	1.2	...	...	1.3	...
Panama	3.1	3.5	4.4	6.1	6.1	5.6	6.0	...	...	...
	2.6	2.7	2.8	3.7	3.5	3.7	3.7	...	...	...
Venezuela	...	...	4.3	4.3	4.1	3.9	3.7	3.7	4.7	4.2
	...	...	2.3	2.1	2.0	2.0	2.0	1.9	2.5	2.4
Canada	6.4	4.5	3.5	3.0	3.2	3.1	3.2	3.1	3.1	...
	4.2	2.7	2.0	1.7	1.8	1.8	1.8	1.7	1.7	...
United States of America	6.6	7.6	9.5	10.9	11.1	11.5	11.4	11.6	12.0	12.7
	4.2	4.7	5.9	6.9	7.1	7.3	7.3	7.4	7.7	8.0
Tanzania	...	1.9	2.1	2.3	...	...	...	...	...	...
	...	1.4	1.4	1.7	...	...	...	...	...	...
India	1.7	2.1	2.1	2.3	2.5	2.3	2.3	2.2	1.9	...
	1.4	1.6	1.5	1.6	1.7	1.6	1.6	1.5	1.3	...

Source: UN National Accounts Tapes and IMF.

Table 3.5

TRENDS IN PRIVATE CONSUMPTION EXPENDITURE ON HEALTH AS A PERCENTAGE OF TOTAL PUBLIC AND PRIVATE CONSUMPTION EXPENDITURES ON HEALTH

Country	1960	1965	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982
Honduras	76.1	78.5	71.4	74.5	71.6	73.5	68.7	67.4	...	...	...	...	70.9	...	...
Jamaica	...	...	...	...	...	...	43.4	33.0	32.2	30.0	...	...	...	...	...
Panama	52.2	49.0	45.2	48.2	49.6	48.9	48.3	48.8	45.3	47.5	46.0	...	...	...	...
Venezuela	...	...	47.7	47.9	48.1	55.5	53.4	52.2	51.3	51.8	53.0	...	63.0	...	...
USA	85.3	86.8	86.4	85.8	85.6	85.4	85.2	85.3	85.9	86.4	86.5	...	87.5	...	...
Tanzania	...	56.9	53.0	51.0	53.2	48.9	44.7	43.0	...	...	...	...	...	...	...
India	...	...	78.7	77.7	77.1	74.9	74.3	70.3	67.7	65.6	63.2	...	68.7	...	...
Spain	...	...	81.6	82.7	81.7	80.4	79.4	75.2	73.3	...	...	...	...	...	...
United Kingdom	16.4	15.0	15.8	13.6	13.0	12.7	10.7	9.2	8.8	9.0	8.7	...	...	...	...

Source: UN National Accounts Tapes and IMF.

Table 3.6

TRENDS IN PUBLIC (GENERAL GOVERNMENT) AND PRIVATE CONSUMPTION EXPENDITURE ON HEALTH AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT[1]

Country	1960	1965	1970	1971	1972	1973	1974	1975	1976	1977	1978	1980
Honduras	6.9	6.4	6.8	6.3	6.5	6.1	6.3	6.4	...	...	...	6.7
Jamaica	...	...	...	...	...	...	4.7	4.3	4.2	4.1	...	...
Panama	5.0	5.5	6.3	6.6	7.5	7.3	7.0	7.6	7.8	7.7	8.0	...
Venezuela	...	...	4.9	4.6	4.7	3.8	3.1	3.9	4.0	3.9	4.0	4.1
USA	4.9	5.5	6.9	7.2	7.3	7.4	7.7	8.1	8.2	8.4	8.5	8.8
Tanzania	...	2.4	2.7	3.2	3.0	3.1	3.3	3.9	...	...	...	...
India	...	...	1.9	2.2	2.1	1.9	2.0	2.1	2.3	2.2	2.2	1.9
Spain	...	...	3.9	4.4	4.6	4.8	5.0	5.5	...	...	...	...
United Kingdom	3.8	3.8	4.2	4.3	4.4	4.3	4.9	5.2	5.1	5.0	5.1	...

Source: UN National Accounts Tapes.

128. Another set of indicators used in the Background Document which has been updated here is the series of trends in private consumption expenditures on selected consumer items as a percent of all private consumption outlays and as expressed in current prices. The Background Document states that "there are no clear-cut trends in the share of private consumption expenditures devoted to health"* as revealed in the data en Table 3.7. The updated information and conclusion are little changed from the 1982 report. The picture of societies spending relatively little on health, certainly in comparison to combined expenditures for such "anti-health" items as alcohol and tobacco, continues unabated from 1960. It is interesting to note, however, that in the most developed nation, the U.S., relative private expenditure on health is much higher than in the rest of the countries. Yet in Honduras a similar pattern emerges, while in Canada the proportion of private expenses on health is very small. Once again, the pattern is confusing and not open to facile analysis.

129. So far the examination has focused on health care expenditures as a measure of the status of health care financing in Latin America. There is a different type of measure which needs to be mentioned, the debt structure. Little has changed, at least for the better, since the Background Document was published. As may been seen in the table below, the largest change has been in the drop in the percentage of concessional loans, as a component of the debt structure, along with a substantial increase in grant elements. What was stated in the Background Document in 1982 holds true more than ever today; that the changed terms of the debt since 1971, exacerbated in 1982," highlight the Region's vulnerability and [make it] potentially the biggest detriment to the placement of health sector loans."* Such a situation is obviously of major importance to the affected countries. As revenues, especially in the public sector, decline, as the result of crushing external debt and high inflation, there will be increasing pressure to reduce public sector expenditures. What the eventual impact will be on the health sector can only be surmised at this point, other than to speculate that the present situation does not augur well for public sector programs based on the need for high-cost investment.

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*Plan, P. 29

Table 3.7

TRENDS IN PRIVATE CONSUMPTION EXPENDITURES AT CURRENT PRICES ON 1) FOOD; 2) HEALTH; 3) ALCOHOLIC BEVERAGES; AND 4) TOBACCO, AS A PERCENTAGE OF TOTAL PRIVATE CONSUMPTION EXPENDITURES

Country			1960	1965	1970	1975	1976	1977	1978	1979	1980	1981
Honduras	1	Food	40.5	40.3	39.3	44.1	41.1	41.1	41.2	41.2	41.2	...
	2	Health	6.7	6.8	6.6	5.9	6.9	6.9	7.0	7.0	7.0	...
	3	Alcohol[1/]	5.3	5.7	6.4	6.9	...	...	...	...	...	...
	4	Tobacco	1.3	1.5	2.1	2.5	0.7	0.7	0.7	0.6	0.6	...
Jamaica	1	Food	36.4	32.7	30.5	35.4	33.8	35.1	38.0	36.5	35.5	...
	2	Health	2.4	2.8	3.2	2.3	2.0	1.8	2.0	1.2	2.1	...
	3	Alcohol[1/]	6.2	6.8	5.9	3.7	3.8	3.8	4.4	4.3	4.2	...
	4	Tobacco	3.3	3.9	4.2	4.5	4.9	4.8	4.9	5.3	5.4	...
Panama	1	Food	39.8	41.3	47.4	59.2	54.8	48.6	51.4	...	...	...
	2	Health	3.1	3.5	4.4	6.1	6.0	5.6	6.0	...	...	...
	3	Alcohol[1/]	6.5	4.8	5.2	4.4	4.7	3.9	4.3	...	...	...
	4	Tobacco	2.2	1.9	2.1	2.1	2.2	2.1	2.1	...	...	...
Venezuela	1	Food	37.6	36.7	...	...	...	...	...	...	...	...
	2	Health	7.8	8.0	4.3	4.3	4.1	3.9	3.7	3.7	4.7	4.8
	4	Tobacco	2.6	2.8	...	...	...	...	...	...	...	...
Canada	1	Food	18.9	17.5	15.9	15.9	15.1	14.9	15.3	15.4	15.2	...
	2	Health	6.4	4.5	3.5	3.0	3.2	3.2	3.2	3.1	3.2	...
	3	Alcohol[1/]	3.6	3.7	3.8	3.7	3.5	3.4	3.3	3.2	3.3	...
	4	Tobacco	2.9	2.9	2.8	2.1	2.1	2.1	2.1	2.1	2.1	...
USA	1	Food	17.0	15.2	14.3	13.7	13.2	12.8	12.6	12.7	12.7	12.6
	2	Health	6.6	7.6	9.5	10.9	11.1	11.5	11.4	11.6	12.0	12.7
	3	Alcohol[1/]	2.0	1.8	2.0	1.9	1.8	1.7	1.6	1.6	1.7	1.6
	4	Tobacco	2.1	1.9	1.7	1.5	1.5	1.4	1.3	1.3	1.2	1.2
Tanzania	1	Food	...	45.3	51.1	57.9	...	...	...	...	...	...
	2	Health	...	1.9	2.1	2.3	...	...	...	...	...	...
	3	Alcohol[1/]	...	3.8	3.5	4.4	...	...	...	...	...	...
	4	Tobacco	...	1.6	1.0	2.6	...	...	...	...	...	...

Source: UN National Accounts Tapes, 1974.

[1/] Includes alcoholic as well as non-alcoholic beverages.

130. This is yet another persuasive argument for the need to look for other than financial resources to improve and extend health care coverage. As a result, the countries should seek to rationalize as much as possible allocation of resources in the health sector. For example, mechanisms for integrating social security and public health are urgently needed in order to avoid duplication of effort and at the same time offer greater health care coverage. In addition to intersectoral linkages, it is necessary to look for ways in which the health sector can be more fully integrated into national development planning processes. Development models used to date have not done this.

131. Finally, it is worthwhile to recall the low level of health-related loans on the part of the multilateral banks as cited in Chapter I. This is certainly a far from encouraging sign for the health sector. Even the Pan American Health Organization, as the multilateral presence in the Region most directly concerned with health, has not significantly increased its budget over the past several years. The average annual increase has been, since 1980, only 5.2 percent,* or just barely enough to keep up with U.S. inflation.

Table 3.8

CHANGED STRUCTURE OF LATIN AMERICAN AND CARIBBEAN DEBT

Type of Loan	1971	1980	1982
Concessional Loans	26.0%	7.7%	2.2%
Fixed Rate Loans	66.6%	33.8%	30.3%
Variable Interest Rate Loans	7.4%	58.5%	62.5%
Grant Element (all creditors)	15.4%	-4.9%	17.3%

Source: IBRD World Debt Tables, December 1981 and 1982.

*These figures are derived from biennial PAHO budgets for the years 1980-1981, 1982-1983 and 1984-1985.

CHAPTER IV. CONCLUSIONS AND RECOMENDATIONS

A. Conclusions

132. There is consensus that the current socioeconomic crisis in Latin America and the Caribbean is the worst of the last 50 years, more severe than the one which gave rise to the Great World Depression of the Thirties. There is also a widespread view that some countries have suffered more than others because of their dependency on developed nations and their own domestic policy adjustments.

133. In addition, most experts blame the crisis on essentially structural causes aggravated by short-term factors associated with domestic adjustment policies and measures, as well as simultaneous recession and inflation in some of the developed countries. In other cases, the crisis stems from noneconomic domestic problems, particularly internal and international warfare.

134. The macroeconomic characteristics briefly reviewed in Chapter I indicate the range of contributing causal factors, showing how causes and effects have been joined, even if they have been treated separately for analytical purposes. Somewhat similar is the dichotomy sometimes suggested to exist among factors involved in the overall development process, some of which are social or economic, but all so closely interrelated that it has been necessary to pay special attention to the former for purposes of this document, in order to lay a firm foundation and provide a clear frame of reference for determining their possible social and even political repercussions.

135. It is anticipated that for the rest of the first half of this decade the socioeconomic crisis will continue, and there are factors that could make it even worse, some of them entirely beyond the power of the Latin American and Caribbean countries to control within their own borders.

136. On the basis of the work of the ECLA Economic Projections Center, this situation may be expected to worsen if the decline of per capita GDP of the last three years persists in 1984. It is worth remembering that the Regional average per capita GDP declined US$10, or 0.9%, in 1981; US$32, or 3.3%, in 1982; and US$54, or 5.6%, in 1983.

137. If conditions were to exist for a firm recovery of the Latin American and Caribbean national economies by an increase in GDP of at least 5-6% a year in the second half of the decade - which would depend on internal as well as external factors - ECLA considers that the Regional per capita GDP would rise in 1990, in the optimistic projection, to the same level as in 1980, which means that 10 years of development would have been lost.

138. The demographic predictions are based on a natural population increase of 2.5% a year for the rest of the decade, and of 2.0% a year during the Nineties. If GDP were to rise between 5% and 6% a year, the result would be a net increase in per capita GDP of between 2.5% to 4.0%, respectively.

139. However, in order to provide employment opportunities not only for those entering the labor market for the first time, but also for many of those already in the labor market who are unemployed or underemployed, faster growth of the economy is needed, which the ECLA Economic Projections Center estimates at not less than 7.0% a year.

140. Impediments to the achievement of full employment of the economically active population have a negative impact on both the economy as a whole and on the financing of social security programs, which depend for their income on contributions from workers, employers and the government.

141. Many of the young people who today have no access to employment in the formal sector enter the informal employment sector, and thereby do not contribute to support of social security institutions whose growth would thus be slowed, along with that of some of their benefits, particularly for the aged. Having no formal employment, those working in the informal sector are not covered by labor insurance, which provides preventive and curative health services to workers and their immediate families.

142. Another damaging effect of the socioeconomic crisis, caused by interntional reserve restrictions in many countries and by those imposed on the importation of goods and services, has been the curtailment of the acquisition of medicines and drugs abroad, reducing the stock of imported goods in many countries and impeding maintenance of vehicles and equipment requiring foreign replacement parts.

143. Priority has been given to service on the external debt, regardless of whether or not that obligation is covered by the provisions of the standby agreements which most of the countries in the Region have entered into with the International Monetary Fund. This service on the foreign debt has consumed a high proportion of export earnings in many countries. Moreover, in the last 18 months of 1982-1983 export earnings have become the main source of foreign exchange, now that the flow of capital into the countries of Latin America and the Caribbean has dropped so substantially.

144. Internal adjustments required under the standby agreements also include conventional monetary and fiscal measures to reduce aggregate demand and expenditures from the treasury and decentralized public agencies. Fiscal austerity programs usually reduce a large proportion of

public investment and, to avert social problems, give priority to salaries; as a result, a high percentage of budgets goes for fixed expenditures for the payment of wages and salaries and for adjustments made in response to the demands of trade unions to prevent major losses of the purchasing power of real wages, particularly in countries with high and structured inflation.

145. Provisions are also favored which would make exports of the Latin American and Caribbean countries more competitive on foreign markets. To this end, one internal adjustment measure promotes the devaluation of national currencies regarded as overvalued. Sooner or later, however, this has a ripple effect resulting in, among others things, changes in the prices of imported goods.

146. As the currencies of many countries have steadily lost value - either abruptly or through frequent mini devaluations - their economies have become "dollarized." Although local currency is still legal tender, it is only used in transactions of little importance and small amounts, while for others the prices are set and revised in terms of parity to the United States dollar. Examples include the purchase and sale of property and vehicles, setting of rental rates, and for production and service contracts.

147. Many internal adjustments, such as the increase of export volumes, have been neutralized by external adjustments which, as they are made outside their sphere of influence, are beyond the control or reach of the less developed countries. This continues to happen despite all the efforts they have made to gain a voice and vote in matters that seriously affect them and to change international agreements governing those matters.

148. In many other cases these internal adjustments have been guided by policies and measures established by such agencies as the IMF, the World Bank, AID, etc., which giver priority to middle and long-term changes designed to reactivate production in agriculture, industry, mining, energy, etc., so as to increase exports or reduce imports and thereby redress or improve the balance of payments of countries and enable them to meet their foreign debt commitments.

149. The funds that the World Bank lends for programs in the social sectors of countries do not even reach 10% of its total loans, and come to a mere half of one percent for health, population and nutrition. Loans made by the IDB for health, drinking water and sewerage hardly exceeded 8% of its total loans in 1981, and reached about 9% during 1982 and 1983.

150. Other bilateral agencies, such as AID, beleive there were large investments in the past. But with savings and better internal efficiency, the countries would meet the goal of HFA/2000. Despite external aid, the countries have still had many financial and administrative problems.

151. The view is fairly widespread in many international financing and technical-financial collaboration agencies that the health sector is not well managed and needs substantive improvements to become effective, efficient to attain the goals of primary care by making rational use of already available resources, such as highly qualified professionals who recevied their basic or specialized training abroad. Coordination among the operations of the various institutions comprising the health sector, including private sector, also needs to be achieved.

152. In some countries conventional medical practices still prevail or, in the best of cases, parallel efforts to make changes according to the spirit of the goals of HFA/2000. There are some who consider that if the health sector wants more external financing for its investments, it must first generate savings and make better use of the resources already allocated to it. External financial support has to be seen as a complement and not a substitute for internal efforts to achieve greater organization.

153. In other cases, a gap has existed between high-quality medicine available to a minority of the population and a simplified medicine on which most of the population must rely, which runs counter to the Strategies of Health for All by the Year 2000.

154. Some resources are being used inefficiently; others are entirely wasted. Savings in some nonpriority programs and activities would result in additional resources for primary health care.

155. In addition, less and less international and domestic financing is available for new investments in physical infrastructure and for procurement and maintenance of equipment and vehicles for health for two reasons: a) because it is felt that enough has been spent on such goods in the past, indeed more than could be fully and efficiently and in relation national development levels; b) because international agencies for multilateral and bilateral financing and collaboration now have less resources to work with. In addition, they give higher priority to financing of production sectors of the economy on the premise that these contribute to recovery faster in the short run.

156. The trend toward reduction of support for social expenditures as a percentage of total public budgets is not restricted to the less developed countries alone, but is also true of some of the more industrialized countries.

157. Information from the study of seven Latin American and Caribbean countries suggests as yet ill-defined trends. Nor is it possible to say with precision what effects the social and economic crisis from 1981 to 1983 has had on the national financing of social programs, those for health in particular.

158. Because there were relatively few social, political and economic changes in the Region over the two year period updating the previous study, new trends have yet to be firmly established.

159. What can be concluded is that there is nothing in the short-term to justify any expectation of improvement in the negative developments already identified. Hence, use of projections based on previous years, when in most countries sustained economic growth permitted relatively generous allocations to social sectors, could lead to erroneous interpretations or false expectations of what could happen in the future.

160. A realistic view of the crisis by those in the social sectors, will make them better able to prepare for and deal with it. In the decision-making process, real knowledge of problems improves possibilities for solving them in a timely fashion. This is a responsibility that falls essentially on the individual country, and new ways should be found for overcoming the crisis in a spirit of regional and international cooperation.

161. Efforts to acquire the economic and financial data in the seven countries shows that, owing to the very specialized nature of the subject, which has been the exclusive province of other agencies and not those dealing with health sector, this sector is placed in a weak position for compiling, processing and analyzing such data. However, it is on the basis of these data that plans and programs are formulated and budgetary allocations and external financing decisions made. They also form the foundation for guiding formulation and evaluation of policies based on monitoring and evaluation of actual activities.

162. Many health sectors have not participated effectively in the national planning process, and their relations with the central planning agencies, the ministries of the treasury or finance, and central banks are, with few exeptions, tenuous. This hampers institutional relations. As a result, other agencies know few details of the work done in the health sector. This impedes more effective intersectoral coordination.

163. Moreover, in many countries of the Region the different public institutions that should be coordinated with the health sector continue to function independently, making intersectoral realtions difficult.

164. From the information available on the seven countries it is evident that the respective status of health care expenditures varies widely, according to the several measures used.

165. Definite and consistent trends are apparent only in Argentina and Costa Rica, but they are, unfortunately, negative in both cases. For the other countries, however, it may be concluded that the relationship between health expenditures and GDP also varies as a result of decisions taken at the national level. Because of this, the socioeconomic crisis has had different repercussions from one country to another, and at different times during the years considered.

166. It is possible that countries which had previously made larger investments in health infrastructure had been able to deal more effectively with crisis and its repercussions.

167. It also seems, for other countries, that the period from 1978 to 1982 was one of transition, and that the real effects of the crisis will probably emerge more clearly in the years ahead, possibly in 1987 and 1988.

168. The updating of data for all the Region demonstrates that, in general, there has been no significative change for the countries as a whole regarding financing of health programs, even though in the majority of them a decline in those expenses has occurred in relation to total government outlays. Further details on those figures are presented in Chapter III which represents an updating of the information contained in the document presented to the Subcommittee on Long-Term Planning, to the Executive Committee and to the Pan American Sanitary Conference in 1982.

169. A reduction in financing of public health hospitals has occurred which could be positive for HFA/2000, if this means a change in orientation toward financing of primary health.

170. As to concessionary loans, there was a significative decrease, but donations to countries for general activities increased.

171. It has not been possible to calculate projections nor to establish future trends for all the Region, as insufficient data were available for the years 1983-1984. Within the list of information which was requested from the seven countries (see Annex II), projections for the years 1984-1987 had been included. Unfortunately, the data were unavailable.

172. Acquisition of the information for the "social sectors," referred to in Resolution XX, has also had its limitations; first, beacuse of the variety of standards used to determine what constitutes a definition of "social." Some countries have included education, health, labor, social security, drinking water and sewerage, housing and social welfare. In others, the definition is narrower, and housing and drinking water and sewerage are included in either infrastructure or economic sectors, espeically housing which is frequently subsumed under economic sector.

173. Financing for housing has suffered a significant set back as a result of the crisis, since the latter has sent interest rates soaring and made it difficult to obtain credits for programs whose finaicial recuperation is a long term proposition, somehwere between 10 and 20 years.

174. In the countries where the government or public institutions have undertaken important low income housing programs, the difference between the costs of real interest which they have to pay for foreign credits and

lower subsidized rates charged to borrowers, has been covered by resources and charged off as a social-financial cost. When standby agreements have been neogotiated and sogned with the IMF, it has been necessary to adjust interest rates to real levels, eliminating subsidies and adding carrying and administrative costs. This has made it very difficult for borrowers to service their debt. The lack of new soft loans makes it difficult for important social programs to be continued, but does allow for generation of new employment and use of high grade national raw materials

175. Another aspect which exacerbates financing of low income housing programs is the high rate of inflation in so many of the countries in the Region, which distorts the relationship between fixed wages and salaries, on the one hand, and interest rates and mortagage terms on the other In many cases such costs constitute the major family expense for low and middle income people, when it should never exceed more than 10 or 20 percent of family income.

B. Recommendations

176. Analysis of available data in this study shows that future financial resources for the health sector may not even reach 4 percent of GDP, which, under different conditions, was felt to be a reasonable figure in the 1982 document. This may be due to the present socioeconomic crisis and in the face of projections of what will happen throughout the rest of the decade, as was indicated in the optimistic hypothesis, i.e., that in 1990 the per capita GDP will be the same as in 1980.

177. This evidently may have a negative impact on the proposals of the governments to achieve HFA/2000. For if resources available to the health sector are reduced, there is the clear and present danger of a corresponding reduction in health services. Hence, recommendations which can be made according to present judgments are framed according to a set of general principles, which provide a greater understanding of the availability and optimal utilization of human, financial, and physical resources.

It is recommended:

a) To conduct an analysis in each of the countries of available resources in the health sector. These studies should be the direct responsibility of the governments and their health institutions.

b) To review different forms of financing of national health service systems in each country, including the public and private sectors, in order to improve efficiencies, effectiveness and equity.

c) To analyze the utilization of resources in terms of cost-effectiveness and productivity, by institution and national program. Productivity and cost analyses should include, among other things, human capability and technology support.

d) It is necessary to promote intrasecotral improvements in order to allow the different health institutions to coordinate more effectively their programs and activities, including those with private entities which belong to the national health system. Community pariticipation should also be encouraged in the effort to achieve HFA/2000.

e) Intersectoral coordination should be improved in order to obtain the most efficient use of national resources and satisfy national development goals, as well as to integrate more effectively activities of institutions working toward similar social goals. It is therefore recommended that the mechanisms be found to promote this kind of intersectoral coordination according to conditions in and characteristics of each country.

f) To improve the management of the different institutions which comprise the health sector, placing emphasis on information and financial management, with the purpose of improving national policies, plans and programs, especially on the basis of information gained through evaluations and monitoring.

g) It is critical to promote, in addition, greater integration of the health sector within the national development planning process, providing fresh views in order to alter present theories, methods and and practices of planning.

TENTATIVE INFORMATION THAT THE STUDY GROUPS SHOULD OBTAIN, IN THE SEVEN SELECTED COUNTRIES

1. The actual plan for health, officially approved for 1983;

2. Short, medium and long term objectives of such plans as specified in detail in official documents, for example, in the National Plan of Development or in the health-sectoral plan;

3. Public budget assigned to the health sector for 1983, broken down by destination and origin for the ministry of health, and other public institutions decentralized by regions/parishes and functions;

4. Public budget assigned to other social sectors, such as education, labor, housing, etc. for 1983, broken down by destination and origin for the respective ministry other public institutions decentralized by region/parish and functions for each of those sectors;

5. Resources of the private sector assigned to health in 1983, indicating destination and origin of the resources;

6. Chronological information, historic and prospective for the 1978-1987 period for: Gross domestic product in absolute figures and as percentage of growth in relation to the base year (1978 = 100 percent); total expenditures for 1978-1982 and projected for 1983-1987 for the ministry of health and broken down: in current and capital expenditures, in absolute numbers and as percentage of increase in relation to the base year (1978=100 percent); total expenditures for 1978-1982 and project for 1983-1987 for the public agency for social security broken down in: recurrent and capital expenditures, in absolute figures and as percentage of increase in relation to the base year (1978=100 percent); retail price indexes as percentage of increase in relation to the base year (1978=100 percent) for 1979, 1980, 1981 and 1982 and a projection for 1983-1987;

7. Observed trends and projections for the sectoral distribution of recurrent expenditures of the public sector during the 1978-1987 period, in absolute figures in dollars and as percentage of distribution of the total of the respective year. Breakdown in three big groups of sectors,* social, economic, and infrastructure, and within each one of these groups by the divisions that will take place in the respective country, for example health, education, labor, housing, etc., for the social; farming and animal husbandry, mining, industry, hunting and fising, forestry, etc., for the economic; and construction, transportation; energy, etc., for the infrasture sector;

8. Trends (1979-1982) and projections (1983-1987) for the recurring spending distribution of the Health System during the period 1978-1987, in absolute terms and s a percentage of the total distribution for the respective year. Information should be divided by public and private institutions,* indicating in the former case the institutions that form part of the central government, and separately, the ones that are territorially and functionally descentralized;

9. Observed trends and projections one for the distribution of the health system's expenditure during the 1978-1987 period in absolute terms and as percentage of the total distribution of the respective year. Breakdown the information by entities:* public and private, indicating in the first group the one that are from the central government and in the other group the ones the decentralized, entities, by function and territory;

10. Trends and projections for the distribution of the health system's expenditures during the 1978-1987 period, in absolute terms and as percentage of distribution of the total of the respective year. Breakdown that information in the same way as indicated in No. 9 above, starting with the*;

11. Financing sources of the entities of the national health system, in thousands of dollars during the 1978-1982 period and in the projection for 1983-1987, breaking down for each year the part coming from the government budget, form social security quotas, from services provided and other income. Breakdown the information in two grupos*: public sector and private sector, giving for the first one details for central public entities: ministries of health and decentralized functionally and territorial, with a breakdown of each;

12. Structure of the expenditures of the entities of the national system of health, as tendency of the evolution observed and one expected for 1978-1987, in the same way as it was requested for other points before, for the constituent of the hole health system, in thousands of dollars. Breakdown the expenditure for personnel, construction, maintenance of equipment and buildings, medicines and drugs for each year. Also breakdown the information as indicated in No. 11 starting from the asterisk on page 1;

13. Tendency of the evolution of the expenditures of the entities of the national health system during the 1978-1982 period and the porjection for 1983-1987 for drugs and medicines, breaking down the information depending on the national or international origin and to the cost in thousand of dollars; breakdown that information by sectors, public and private and within the first one by entities that form it;

14. Tendency of the evolution of the expenditures of the entities of the national health system during 1978-1982 and the projections for 1983-1987, for expenditures of investment as per space distribution: central, metropolitan, other urban and rural areas.

APPENDIX II

OFFICIALS PARTICIPATING IN THE STUDY

A. Nationals

Argentina

Olga Niremberg
Abraam Sonis

Brasil

Solón Magalhaes Vianna
Lucia Pontes de M. Baptista
Sergio Francisco Piola

Costa Rica

Humberto Aguilar Arroyo
Carlos Luis Marín Mora
Rodrigo Meneses Castro

Mexico

Daniel Gutiérrez Paillet
Margarita Ochoa de Mendoza

Peru

Antonio Aires Sicherio
María Esther Pérez López
Juan Manuel Sotelo
Félix Vallena Sicherio

B. Pan American Health Organization

Mario Boyer
Peter R. Carr
Francisco Castro
Lee M. Howard
Wilburg Jiménez-Castro*
Robert S. Landmann
Francisco Cruz B. López
Philip A. Musgrove
Luis Jorge Osuna
Néstor Rodríguez Campoamor
Mark L. Schneider
José Romero Teruel
Juan Carlos Veronelli

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*General Study Coordinator.

APPENDIX III

OFFICIALS OF INTERNATIONAL ORGANIZATIONS INTERVIEWED FOR THIS STUDY

Luis Olivos, Deputy Chief, Program Division and Chief of the Latin American and Caribbean Branch, United Nations Fund of Population Activities.

Roberto Olivero, Public Administration Program, Department of Technical Cooperation for Development, United Nations.

Joseph Oyugi, Officer in Charge, Public Administration Training System Branch, Public Administration Program, Department of Technical Cooperation for Development, United Nations.

Juanita Bobbitt, Public Administration Program, Department of Technical Cooperation for Development, United Nations.

Dragoljub Kauran, Public Administration Program, Department of Technical Cooperation for Development, United Nations.

Dardo Sagredo, International Adviser, Development Advisory Services, Department of Technical Cooperation for Development, United Nations.

James R. Himes, Chief, Americas Section, Program Field Services Division, UNICEF.

Walter Franco, Technical Officer in charge of health Programs in the United Nations Development Program (UNDP).

Toshio Sigematsu, Chief, Demographic Statistics Section, Statistical Office, Office for Development Research and Policy Analysis, Department of International Economic Affairs, United Nations.

Michael Platzer, Department of Technical Cooperation for Development, Unied Nations.

Alan Heston, National Accounts, Section, Statistical Office, Office for Development Research and Policy Analysis, Department of International Economic Affairs, United Nations.

Julián Bertaux, External Relations Officer of WHO, New York.

Vera Kalm, Director of the External Relations Division of WHO, New York.

Carlos García-Tudero, Interregional Adviser, Department of Technical Cooperation for Development, United Nations.

Faquir Muhammad, Director Public Administration for Development, Department of Technical Cooperation for Development, United Nations.

Christian Ossa, Chief International Economic Branch, General Analysis and Policies Division, Office for Development Research and Policy Analysis, Department of International Economic and Social Affairs, United Nations.

Julián Gómez, Secretary of the Committee for Development Planning and Assistant Director, Office for Development Research and Policy Analysis, Department of International Economic and Social Affairs, United Nations.

Alex Cornelissen, External Relations Officer from ECLA to the United Nations.

J. Baudot, Direction of Social Affairs. Department of Technical Cooperation for Development, United Nations.

Gonzalo Martner, Director of the Center for Social Research of Vienna. United Nations.

John R. Moore, Assistant Provost for International Programs, Division of Agricultural and Life Sciences, Maryland Universtiy.

Richard F. Davis, Professor and Associate to the Provost for International Programs, Division of Agricultural and Life Sciences, Maryland Universitiy.

Edward Rizzo, Consultant, Division of Agricultural and Life Sciences, Maryland University.

Jorge Ruiz Lara, Assistant Administrator, Department for Economic and Social Development, Inter-American Development Bank.

Roberto Mayorga Cortés, Member of the Directing Council of the World Bank.

Carlos Quijano, Assistant to the Vice President Executive for Latin America of the IBRD (World Bank).

Eduardo Weissner Durán, Director, Occidental Region for the International Monetary Fund.

Ricardo Cibotti, Director of the Economic Development division of ECLA (Economic Commission for Latin America).

Andrés Bianchi, Economic Development Division of ECLA.

Germán Rama, Social Development Division of ECLA.

Enzo Faletto, Social Development Division of ECLA.

John Durston, Social Development Division of ECLA.

Eligio Alves, Director of the Center for Economic Projections of ECLA.

Oscar Julián Bardeci, Director of the Latin American Demographic Center (CELADE).

Carmen Arretx, Chief of the Demographic Department of CELADE.

Guillermo Maccio, Officer of CELADE.

Alfredo Costa Filho, Director of the Latin American Center for Economic and Social Planning (ILPES).

Jorge Israel, Officer of ILPES.

Abraham Horwitz, Consultant to the Pan American Health Organization.

Dwight Johnson, Director of Development Resources, Agency for International Development, State Department, Washington, D.C.

Frederick W. Schieck, Agency for International Development, State Department, Washington, D.C.

Paula Feeney, Public Health Advisor, Agency for International Development, State Department, Washington, D.C.

GUIDELINES FOR THE PROMOTION OF TCDC/ECDC IN THE HEALTH SECTOR WITH THE COLLABORATION OF PAHO

PAN AMERICAN HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION

ORIGINAL: SPANISH

IV MEETING OF THE SUBCOMMITTEE
ON LONG-TERM PLANNING
OF THE EXECUTIVE COMMITTEE

Washington, D.C.
11-13 April 1984

Subcommittee on Long-Term Planning
Executive Committee
Pan American Health Organization

Subcomité de Planificación a Largo Plazo
Comité Ejecutivo
Organización Panamericana de la Salud

GUIDELINES FOR THE PROMOTION OF TCDC/ECDC IN THE HEALTH SECTOR WITH THE COLLABORATION OF PAHO

CONTENTS

I. INTRODUCTION

PAHO's Administration has established as a priority that "the Organization will give increasing and effective support to actively promote cooperation among countries. National "centers" with particular potential for cooperation will be given the incentive and support to enable them to meet international responsibilities in priority action areas for PAHO and the countries."*

In addition, in the Plan of Action for Health for All by the Year 2000, the Governments identified "specific areas which may be addressed through (collective intercountry action)..., such as problems common to several countries (communicable and non-communicable diseases, and environmental problems), development of human resources, production and purchasing of critical supplies and equipment, and development of research and technology. The most effective mechanisms to develop and implement these joint activities will be through the bilateral and sub-regional pacts and agreements, and through Technical and Economic Cooperation among Developing Countries (TCDC and ECDC)."

This document, entitled "Guidelines for the Promotion of PAHO-Assisted TCDC/ECDC in the Health Sector," has been prepared to serve as a guide in implementing these actions. It proposes general and specific actions, but by no means an exhaustive list, designed to facilitate, encourage, and systematize the utilization of TCDC and ECDC mechanisms in the solution of certain priority problems in the implementation of HFA/2000 strategies in the countries of the Region of the Americas.

The document proposes some specific areas of action in the context of the priorities set by the Member Governments and in accordance with the guidelines established by PAHO's administration.

To provide a better understanding of TCDC/ECDC, there are attached hereto, in certain cases verbatim, the TCDC concepts adopted by the Governments at the highest level in the Buenos Aires Plan of Action, a document which has been endorsed by the United Nations General Assembly and the Governing Bodies of WHO and PAHO.

Based on the concepts laid down by the Governments in the Buenos Aires Plan of Action or emanating from it, PAHO will direct its efforts towards the promotion of TCDC and ECDC in the health sector in accordance with the priorities established by its Governing Bodies, especially those contained in the HFA/2000 Plan of Action.

* Declaration of Principles Dr. Carlyle Guerra de Macedo, 1982

Since it is not possible to cover all fields simultaneously, it is necessary to establish priorities, taking into consideration the two mechanisms of TCDC: joint actions between two or more countries, with the utilization, where applicable, of existing subregional organizations (CARICOM, Andean Group, SELA, etc.), and bilateral agreements in which countries cooperate between themselves in accordance with their respective capacities and needs. Both mechanisms require that the Organization continue to foster greater use of national resources in extending its cooperation to each country. This catalytic role involves stimulating institutional development, identifying national centers of excellence in research and training, utilizing national experts and consulting firms, implementing governmental projects, and procuring domestically-produced equipment, materials, and supplies.

II GENERAL MEASURES

1. Policy Decision

Negotiated at the highest level and explicitly expressed in appropriate policy statements. PAHO actions of support and promotin of TCDC/ECDC should be based on negotiations and agreements between the Organization and the highest political levels of each government. The policy decision of the government should be expressed in writen commitments, without in any way limiting natural soverenity, but with sufficient force to overcome obstacles which frequently impede TCDC/ECDC.

2. Information

The national health plan and health programming in each country should identify external technical cooperation "needs", including those that can be satisfied through TCDC. PAHO, aided by AMPES strategic analysis, and statistical data will survey the areas in each country that may benefit from intercountry cooperation in the spirit of TCDC/ECDC.

Each country, for its part, will have to establish a system to provide basic information on its "capacities" in the health area, covering experts, consulting firms, research and training institutions, and manufacturers of equipment, drugs, and other inputs. PAHO will promote and support those capability assessments.

The responsibility for compiling the above information lies with the Governments: the ministries of health and health-related sectors. To facilitate this process, each ministry should establish a high level TCDC focal points, for instance in the international health office, or the planning office of the Ministry or at the national planning agency.

PAHO, in association with UNDP, will cooperate in setting up with each ministry of health a simple, low-cost information system on TCDC/ECDC. This activity should be started in a small number of countries and could focus on priority areas determined by the Office of the Director within the context of the HFA/2000 Plan of Action.

3. National Panel of Health Experts for TCDC/ECDC:

Each Ministry of Health should consider establishing a panel or committee of experts on TCDC/ECDC drawn from both the public and private sectors and reporting to a senior official. The committee would analyze the information, examine the opportunities for TCDC/ECDC, and stimulate intercountry exchanges among various governmental agencies and the community at large, including universities, centers, consulting firms, industry, and labor. It also would propose legal and administrative measures to facilitate TCDC and ECDC and consider solutions to problems arising within the process.

4. Regional Working Group to Examine Intercountry Cooperation:

The importance of support by developed countries in the field of TCDC/ECDC has been recognized by Governments in both global and regional discussions. For this purpose, a working group should be established. Participants would include countries with a recognized technical potential in the sector, based on innovative, appropriate, and low-cost technology applicable in other countries. These experts would perform the following tasks:

a. Analyze the specific technical cooperation capacity of those countries.

b. Analyze the constraints and obstacles (institutional, technical, and legal) to intercountry cooperation.

c. Propose strategies and mechanisms to facilitate cooperation.

d. Design specific and concrete action proposals.

PAHO will provide the logistical, bibliographic, administrative and technical support that may be necessary. At an specified time, the results would be reviewed and consideration given to a detailed plan of action in the priority areas proposed below or those arising from the multilateral study.

5. Application of the Network Concept:

PAHO, in conjunction with the countries, will identify health research and training institutions or centers that might be recognized as collaborating centers of excellence. It will sign agreements, or letters of understanding with those institutions or centers so as to recognize formally this mechanism of exchange and provide for joint action in specific areas. With the endorsement and support of the Governments, a national inter-institutional network will be progressively established in selected areas. These institutions will be recognized by PAHO/WHO as collaborating centers.

6. Actions with Intergovernmental Agencies for the Promotion of TCDC and ECDC:

PAHO will discuss with regional or subregional intergovernmental organizations and bilateral agencies, such as the following, the use of TCDC and ECDC mechanisms in priority areas of HFA/2000:

a) Regional Organizations

ECLA/ILPES
UNDP: Latin American Office
UNICEF: Regional Office
UNEP
UNFPA
Inter-American Development Bank
Organization of American States
Inter-American Institute for Cooperation in Agriculture (IICA)
Inter-American Commission of Women (CIM)

b) Subregional Organizations

CARICOM
Cartagena Agreement Board
Hipólipo Unanue Agreement
SELA
Central American Bank for ("Economic") Integration
Caribbean Development Bank
Andean Development Corporation
Subregional Conferences of Ministers of Health
Inter-American Social Security Organizations
Nongovernmental agencies
Others

c) Bilateral Organizations

Agency for International Development of U.S.A. (AID)
Agency for International Development of Canada (CIDA)
Other bilateral agencies

ECLA/ILPES is of particular interest because it is reexamining all aspects of TCDC/ECDC, especially new financing mechanisms for intercountry undertakings.

The Latin American Office of UNDP and UNDP Representatives in each country have potentially important roles in spurring TCDC/ECDC. At the regional level, PAHO TCDC proposals can be presented for UNDP regional funding. At the local level, the Office of the UNDP Representative can be of decisive help since some countries have allocated a percentage of their Indicative Planning Figures to TCDC. Also, the Resident Representatives are able to assist in intersectoral actions, such as in the areas of food, nutrition, and essential drugs.

UNEP, UNICEF, UNFPA, and other United Nations agencies have declared their adherence to the principles of TCDC and have sponsored TCDC activities. In the light of the agreements between PAHO and these agencies it may be possible to identify interagency action in TCDC/ECDC.

The Inter-American Development Bank, through its Technical Cooperation Department, has supported TCDC projects by providing grants to individual countries.

The existing geopolitical subregional organizations, CARICOM, the Cartagena Agreement Board, the Hipólito Unanue Agreement, constitute a valuable source of collaboration for TCDC/ECDC. There is also a potential for collaboration with other multilateral entities, including the Conference of Ministers of Health of Central America and Panama, for which PAHO acts as Secretariat. SELA is an organization with which PAHO has had little contact but which has great importance for ECDC, since it is authorized to promote activities enjoying strong political support by the governments.

7. Seminars to Provide Orientation to National and PAHO Staff on TCDC/ECDC Concepts and Mechanisms

These country or intercountry seminars will be conducted by PAHO in collaboration with UNDP, and will utilize the Manual of Instructors for TCDC. Past observations indicate a serious lack of knowledge among governmental health professionals concerning the concepts and potential of TCDC/ECDC. In order to keep costs down and achieve greater benefits, these seminars may be conducted as a part of other meetings on mobilization of external resources, project management, or AMPES orientation.

8. Financing

a) Budget regional financial resources to catalyze and facilitate TCDC/ECDC activities. This decision already has been taken and approved by the Executive Committee for the 1984-85 Budget.

b) Propose to the countries that they allocate a percentage of their PAHO/WHO budget to TCDC activities, especially of a bilateral type.

c) Recommend to the Governments that they allocate funds in their national budgets of the Ministries of Health and other Public Health Institutions for TCDC activities.

d) Promote the mobilization of resources of other international agencies for TCDC and ECDC programs.

e) Accept the invitation of ECLA/ILPES to study most appropriate financing strategies and mechanisms for intercountry cooperation within the framework of TCDC.

f) Maintain a register of experiences with new financing alternatives with the objective of promoting their replication.

9. PAHO Financial and Administrative Mechanisms for Promoting and Supporting TCDC/ECDC:

In mobilizing PAHO financial resources for the purposes indicated in point 8, existing mechanisms will be utilized and adapted and others will be proposed:

a) Covenants or agreements for the provision of technical services. Description of research and other technical services (Official formats of WHO/PAHO).
b) Agreements between countries with the involvement or participation of PAHO.
c) Convenants or agreements between national institutions of several countries with PAHO participation.
d) Models for the assignment of national experts offered by national institutions in one country for cooperation in other countries.
e) Subsidies/grants
f) Revision of PAHO norms related to the procurement of goods for developing countries without any reduction in quality or any increase in costs.
g) Designation of participating centers of excellence to integrate the networks of cooperation.
h) Guides for Representatives in their soliciting support from national institutions which are potential providers or receivers of horizontal technical cooperation.
i) Redefinition of the category of "temporary advisor" to provide greater flexibility for their use in TCDC/ECDC.

III. PRIORITY ACTION AREAS

In light of the priorities set forth in the HFA/2000 Plan of Action, and PAHO's mission, and the socio-economic reality of the Latin American and Caribbean countries, certain action areas will be given preference in the promotion of TCDC/ECDC.

a) Operations Research and Health Services: In view of the heterogeneous levels of development in the Latin American and Caribbean countries, the instrumentation of the strategies for attaining the goal of HFA/2000 demand new research. Research must be directed to iniciating and establishing changes throughout the health sector in order to achieve equity, efficiency, and effectiveness in the health services.

When research is viewed as a change agent, it becomes apparent that countries need to expand their ability to identify problems and to formulate innovative alternatives for the provision of health services. Simultaneously, the exchange of experiences and resources on a regional scale must be strengthened. Research needs include analysis of the

population's health requirements and demands of appropriate technologies suited to the nature of existing problems, and structural and organizational adjustments of resources for the delivery of services. The establishment of interrelations among these three fields is vital to rationalize the management of health services.

The utilization of TCDC in this area requires, as a prerequisite the establishment of a network of centers or institutions with recognized "capacities" in service research. Appropriate agreements will be needed to establishing formal linkages among those institutions. The principal functions of this network would be:

- Identification of priorities
- Design of protocols on selected subjects
- Development of approaches and methods
- Implementation of research projects
- Exchange of experiences and resources for the implementation of studies
- Dissemination of the results and support for their application in the management of services
- Evaluation of the process as a whole
- Training of personnel
- Mobilization of financial resources from national or international sources.

As a result of the Study on Research Trends in Health Services in 17 countries in Latin America and the Caribbean, the Organization will be able to identify centers and institutions as potential network participants. Although these institutions may be at different stages of development, they still would be capable of beginning the process of constructing a network which subsequently could be extended to cover all of the countries of the continent.

b) Research in Other Priority Health Areas: This will be carried out under an approach similar to that described above and will include, for instance, malaria, endemic diseases, acute respiratory infections, chronic diseases, and environmental health, etc. Groups of countries remain to be identified.

c) Research in Technology and Technological Development: The countries of the region face extremely varied technological problems, dominated by the lack of an independent capacity to develop their own technologies. This inadequacy, once linked to advanced levels of health, results in a growing dependency on technologically advanced countries.

Although some countries have achieved adequate technological development in the field of health, such as in the production of biological agents, drugs, biomedical equipment, etc. The absence of raw materials represents a severe restriction which maintains their external dependence.

To overcome this situation, PAHO has been developing a program whose objectives seek to strengthen specific relationships among the countries to augument their technical capacity. It is hoped that this process will lead to the development or transfer of indigenous technology among themselves.

Within the Technology Program, special importance is attached to biotechnology targetted on solving problems which affect the socioeconomic development of the countries of the Region. The application of new techniques such as the production of recombinant DNA (gene insertion), production of mono clone antibodies, protein engineering, etc., will permit the development of new vaccines and diagnostic and therapeutic reactive agents to aid in disease control and health promotion. For these reasons, primary importance is assigned to strengthening centers in the region dedicated to the study of molecular biology. The goal is to create a regional network to permit biotechnology development and the training of personnel. To achieve this goal, the following objectives must be obtained:

--To strengthen national centers dedicated to research and development in biotechnology to resolve critical problems in the region.

--To promote cooperation among the different research and training units.

--To promote the development of basic science, such as microbiology, molecular biology and genetics, which support biotechnology.

--Stimulate the public and private sectors to invest in biotechnology.

--To compile, analyze and distribute information about biotechnology and its applications to various groups within the region.

d) Development of Institutions and Programs for the Training of Personnel: Significant number of innovative projects have sought to reorient health workers in the Americas. These experiences can be compared and contrasted as a key element in a dynamic process of intercountry exchange. That exchange can gradually incorporate more and more institutions. It offers a significant potential for information dissemination among all the countries. Various components, inter alia program development, educational research, technological evaluation and direct training, may be included. The following are concrete proposals in this field:

-Reorientation of personnel training for health systems, to cover initially public health training programs in Mexico, Colombia, Brazil, and Argentina. The curriculum would be based on an extensive review of the contents and methodology for the teaching of planning and strategic management. The object would be to adjust the curriculum to the plan of action for attaining Health for All. This initial network would be enlarged gradually to cover all the Latin American countries in accordance with financial posibilities.

More specifically, this action is directed at:

-Advancing regional and national capabilities for the preparation and training of human resources specialized in developing health systems, and establishing a regional network of national centers with reciprocal cooperation.

-Adjusting the preparation of human resources to the requirements of the process for achieving the goal of health for all.

-Retraining health systems development personnel in the policies and national and regional strategies of primary health care.

-Identifying those gaps in knowledge of socioeconomic phenomena and the structure, operations, and institutions of the health sector which impede system development.

-Promotion of teaching and in-service training in the health sciences through a network of selected institutions in most of the countries in the region. Exchanges among would develop and use common protocols for the evaluation of procedures and performance. In this proposal, the evaluation would be based on an analysis of how the technology was actually used in the training of different levels of personnel. measured by levels of achievement. A non-governmental organization (The Pan American Federation of Faculties and Schools of Medicine) will participate in this program along with PAHO, and it is hoped that financial support will be forthcoming from a foundation.

e) Latin American Health Bibliography Information Network: The network will build upon the past work to consolidate BIREME as the largest repository of biomedical information and as the unit responsible for collection, indexing, and dissemination under a Latin American referral system. It will seek to strengthen the national nuclei of the network in all countries and promote a two-way flow of health information to take place among the 397 associated libraries, among ministries of health and among related services, universities, and social security institutions. In addition to the conventional information already available, emphasis will be placed on developing banks of non-conventional information, usually unpublished or not collected on a regular basis throughout the region.

f) Similar networks are planned for development in the field of educational technology applied to health and health legislation.

g. Nutrition and Food: Unevenness in the availability and consumption of food in the countries of the Region leads to nutrition deficiencies and chronic malnutrition, particularly in the poorer segments of the population and, within these, among mothers and young children. Chronic malnutrition is present among these and other high risk groups, especially in urban populations.

Basic food availability and consumption depends essentially on the production of farm products through two well-defined channels:

1. Small subsistence producers, with deficient technologies and inputs, and

2. Medium-capacity and industrial producers, with greater access to technological developments, capital,and other inputs and land of good quality generally oriented toward production of exports , including food. Food input policies and programs to cover periodic deficits also frequently reduce and discourage local food production .

Perhaps the most important problem even beyond those pertaining to crop and livestock production, are the inefficient marketing and distribution of foods, which raise the price of products to low-income groups, the consumers' low level of food education, and their low purchasing power.

In view of these determining factors, the following strategies for improving the situation are proposed:

- Increase the supply and improve the quality of basic foods;
- Improve the efficiency of food marketing and distribution systems;
- Increase the consumption of basic foods;
- Maximize the biological utilization of the food consumed;
- Orient consumers' food conduct and habits toward the satisfaction of their nutrition requirements.

In this context, TCDC/ECDC represents a valuable, far-reaching instrument for establishing a regional network of national food and nutrition centers to make it possible to develop and maintain a critical mass of scientific and technological resources in support of the region's food programs.

The conclusion of intercountry agreements providing for bilateral cooperation and a concentration of subregional and regional resources for the purpose of identifying the critical areas for food and nutrition intervention will make it possible to strengthen priority activities in the following fields:

- Development and training of human resources in food and nutrition;
- Performance of research--basic, applied, and operational--directed to the solution of prevailing problems;
- Dissemination and exchange of experience and information on scientific and technological advances in food and nutrition;
- Studies to evaluate strategies and programs aimed at improving the food intake of poor segments of population;

- Technical and financial complementarity in support of national food and nutrition programs directed to increasing the production, supply, and consumption of basic foods, including food hygiene and nutrition quality control;
- Development of information and surveillance systems for the monitoring and evaluation of national food and nutrition programs.

h. Essential drugs: Promote the signing of agreements between countries with similar levels of development of their pharmaceutical industries and marketing systems, so as to ensure the availability and accessibility of essential drugs at a reasonable cost to the population. TCDC/ECDC will enable the participating countries to achieve economic levels in the production and procurement of raw materials and finished products and reduce the sector's dependency on external technology.

Such agreements will encompass the following activities:

- Definition of a listing of essential drugs and standardized forms of presentation;
- Exchange of information on availability, costs, prices and market;
- Development of quality control systems and establishment of reference centers;
- Mechanisms for achieving compatibility and complementarity in lines of production and research;
- Establishment of joint purchasing and distribution mechanisms.

Following is a preliminary classification of countries by levels of production and marketing:

First type of countries:	Argentina, Brazil, and Mexico
Second type of countries:	Andean area countries
Third type of countries:	English-speaking Caribbean countries or Central American countries and Panama

Within this last group of countries, it is proposed to obtain and provide drugs needed to permit the achievement of health for all. At present, the countries of the isthmus invest $250 million annually for drugs. It is hoped to diminish this large amount which serves to increase the foreign debt by expanding national production, using common markets, and carrying out quality control programs. To achieve this objective, the following actions are suggested:

- Reduce the consumption and pattern of utilization of medicines.

- Modify the manufacturing infrastructure.

- Increase the production of essential drugs.

- Guarantee the quality and efficacy and safety of drugs.

- Promote investment and development of an outline of medicinal plants.

It is also very important to promote agreements and collaborative mechanisms among countries at different levels of development, offering opportunities which are nonexistent or very limited at present. Some examples:

- Production technology transfer from Argentina or Mexico to Central America;
- Financing for the procurement of products manufactured in Colombia or Venezuela for the English-speaking countries;
- Technical advisory services from Brazil for the implementation of essential drug programs in the Andean area.

i. Equipment and supplies: The central purpose of the Plan of Regional Action for attaining the HFA/2000 goal is to improve the accessibility of health services, with emphasis on providing service to disadvantaged groups in rural and marginal urban areas. This implies, first of all, a significant increase in the availability of services. Taking the growth of the population into account, if availability indices were to remain at current levels it would be necessary to nearly double the existing installed capacity, especially in basic or peripheral units and in general hospitals of an intermediate type. This assumes an enormous investment which the countries can ill afford to make, burdened as they are by economic-financial crises resulting from world inflation and domestic economic conditions.

In this context, equipping the health establishments is an item of fundamental importance within the process of resource-rationalization which the countries will have to undertake in order to develop the physical infrastructure of their services.

With regard to technical cooperation between countries, the basic need in this field is for both exchange of experiences in equipment programming methods and for joint compilation and analysis of the most frequently utilized types of equipment, instruments, tools, and medical and surgical supplies which can serve to stimulate the development of national industries based on wider potential markets. This will contribute to the alleviation of situations of technological dependency. A clearly defined field of activity for the Organization, therefore, should:

- Stimulate, promote, and support the joint development of methodologies for programming the equipping of health facilities.

- Promote and support the establishment of training programs in this field to be shared by several countries.

- Establish basic categories, by type of health facilities, which can help to simplify a given process and which can serve as a basis for drawing up specific listings reflecting the characteristics of services in urban and rural situations.

- Foster the exchange of experts in support of national activities, based on a similarity of development levels.

- Promote the exchange of information on costs, prices, market characteristics, and availability, as well as the establishment of joint quality-control mechanisms and, possibly, joint purchasing procedures and forms for purchasing and distribution as well as for maintenance.

- Facilitate and support the compilation and analysis of information to be made available to national and intercountry organizations whose activities are related to industrial development and production.

j. TCDC: Bilateral or Intercountry, with PAHO in a Catalytic and Supporting Role.

a) Exchange of experts/consultants
b) Fellowships
c) Exchanges in kind
d) Exchange of health science information

With regard to exchange of experts and to fellowships the Organization's assistance would be limited to the priority areas of the HFA/2000 Plan of Action and would be implemented through tripartite agreements under which the role of PAHO would be that of a catalyst and facilitator.

k. TCDC under the Organization's Regular Program.

The TCDC concept and mechanisms should be included as a necessary and increasing complement in PAHO/WHO programs. They should be identified from the first phase and through all phases of planning and programming with at least the following obligations required:

- promoting the establishment of networks;
- facilitating intercountry exchanges of information on the progress, problems, and results of the overall program or its components;
- facilitating the exchange of experts and the awarding of fellowships by one country to another;
- quantifying the national costs and those to be borne by PAHO;
- evaluate results.

IV. EVALUATION

The Organization's performance in the promotion of TCDC/ECDC oriented toward operational activities should be evaluated annually qualitatively and quantitatively. Their results should be measured against the proposed objectives in each area or program. Problems encountered and their solutions will be identified and recommendations for the future will be proposed. The TCDC/ECDC activities carried out under the program chosen will be publicized in selected PAHO publications and brought to the attention of the Governing Bodies.

V. SUMMARY:

The general quidelines which have been described in the previous chapters have the following purpose: to propose criteria or standards for the promotion and support of TCDC/ECDC by PAHO and its Member Governments. Recognizing that TCDC/ECDC is not an end in itself, but one of the instruments available to address the problems of the development process, general criteria are proposed in chapter II for its use in any of the areas which were chosen and highlighted in chapter III. Some of these criteria are fundamental to the concept of TCDC/ECDC. They include criteria such as the governments's political will, clearly expressed in agreements among themselves and with the Organization; establishment of country information systems to identify needs and potentials for TCDC/ECDC; mobilization of financial resources to support TCDC/ECDC, and cooperation with existing regional integration processes.

In chapter III specific action areas are identified. Some of these require joint actions whose purpose is to solve problems common to several countries. These problems would be more difficult to solve if each country were to approach them in an isolated manner.

The first group of specific action areas address such issues as research, and development and training of human resources. Likewise, it deals with actions to increase, to make more accessible and to exchange scientific and technical health information.

Given the special characteristics of the problems addressed in the second group of action areas, these require --beyond TCDC -- certain components of economic cooperation among countries (ECDC). These are, for instance, the cases of food and nutrition, medicine, and medical supplies and equipment.

Furthermore, it is recognized that the potential for bilateral TCDC is quite considerable. In fact, this is a process which --in different fields --is now underway with different degrees of emphasis. There is a need to systematize the Organization's cooperation, bearing always in mind the policies of each individual government, in addition to the fact that PAHO's role must be a catalytic and supportive one.

Finally, it is proposed that PAHO's programs should include, as far as possible, TCDC components. It is also recommended that the Organization's technical cooperation and TCDC must complement each other. TCDC was never intended to be a substitute for previous forms of technical cooperation. They must all try to stimulate national and collective capabilities in the different technical fields.

To sum up, these criteria are intended to accelerate and to strengthen cooperation among countries -- something which, in these times of international economic crisis is becoming more important every day -- and to accelerate the process toward the goal of HFA/2000.

ANNEX

I. CONCEPTUAL ELEMENTS

1. What is TCDC

It is a means (mechanism) of building communication and of promoting wider and more effective cooperation among developing countries. It is a vital force for initiating, designing, organizing and promoting cooperation among developing countries so that they can create, acquire, adapt, transfer and pool knowledge and experience for their mutual benefit and for achieving national and collective self-reliance, which are essential for their social and economic development*.

TCDC is a multidimensional process. It can be bilateral or multilateral in scope, and subregional, regional or interregional in character. It should be organized by and between Governments which can promote, for this purpose, the participation of public organizations and, within the framework of the policies laid down by Governments, that of private organizations and individuals*.

In the above context, TCDC signifies an agreement for mutual cooperation for the purpose of carrying out a common undertaking in a development area.

Bilateral cooperation among developing countries represents an important form of TCDC and an instrument for forging links between national and collective self-reliance. Therefore, the main aim of recommendations concerning bilateral cooperation is to stimulate, intensify and improve it in substance, form and mechanisms.*

(It should therefore be understood that) TCDC is neither an end in itself nor a substitute for technical cooperation with developed countries* (or with multilateral international organizations).

2. Forms of TCDC

Technical cooperation among developing countries may assume any of the following three forms:

- reciprocity;
- exchange;
- contribution.

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* An asterisk identifies a direct quotation from the "Buenos Aires Plan of Action for Promoting and Implementing Technical Cooperation in Developing Countries (TCDC)."

Reciprocity. Reciprocity involves bilateral or multilateral cooperation in which two or more Governments agree to assist one another in their respective areas of excellence. These endowments are not necessarily shared on a one-to-one basis, but within the context of a general agreement a mutual cooperation. The reciprocal assistance may be provided either concurrently or for specified periods.

Exchange. Exchange takes place when two or more Governments agree to cooperate in a common undertaking through the exchange of information and technology geared to a common goal embodied in a program or project.

Contribution. Contribution is the transfer of resources or technical from one country to another or others in the spirit of developing collective self-reliance through the application of the latters' own experience and knowledge. In this type of relationship there is no expectation of immediate reciprocity or exchange.

3. Mandate for Technical Coooperation among Developigng Countries by the Organizations of the United Nations Development System in their Respective Fields*

The governing bodies of the organization of the United Nations development system (are committed to making) every effort to mobilize their organizations (design and implement strategies) in order to contribute to implementing (the Buenos Aires Plan of Action) on a continuing and intensive basis, both in their respective fields of competence and in multidisciplinary joint action. Such efforts should focus on promotional, coordinating, operational, and financial issues and should inter alia be aimed at:

(a) Identify, through joint analysis with Governments, TCDC, solutions, or TCDC contributions to solutions, for specific development problems, inter alia by incorporating TCDC aspects into international meetings and/or organizing when necessary international meetings on specific fields of interest to developing countries with relevance to TCDC;

(b) Applying TCDC approaches and techniques in their programmes;

(c) Supporting on request the preparation and execution of TCDC projects;

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* An asterisk identifies a direct quotation from the "Buenos Aires Plan of Action for Promoting and Implementing Technical Cooperation in Developing Countries TCDC)."

(d) Developing (and promoting) new ideas and approaches for realizing the full potential of TCDC and, for this purpose, (undertaking) the necessary studies and analysis;

(e) Developing, strengthening or reorienting specific sectoral or subregional and regional information systems, and establishing functional linkages between such systems and (the UNDP Information Referral System) with a view to their effective utilization;

(f) Organizing and assisting public information support for TCDC in their respective areas of competence;

(g) Monitoring and reviewing the implementation of their TCDC activities;

(h) Utilizing to the maximum extent possible the inputs available locally and those from other developing countries.

4. Maximization of the use of Developing Countries' Capacities*

In designing, formulating, and executing technical cooperation projects, Governments and, at the request of developing countries, inter-governmental and other organizations concerned with supporting inter-governmental and other organizations concerned with supporting international development efforts (should: (a)) make the greatest possible use of local capabilities, including local expertise and consultancey firms. (b) Where institutions and expertise of the requisite level, quality and relevance are not available locally, developing countries should have the option of obtaining such technical resources from other developing countries, taking due account of factors of quality, cost, delivery schedules and other related conditions. Similarly, the placement of fellowships and the procurement of equipment should also be directed towards other developing countries, wherever their facilities and experience are suitable.

5. Internal Arrangements for TCDC in the Organizations of the United Nations Development System*

In order to pursue vigorously TCDC policies and measures at all levels in different sectors of development, all organizations and bodies of the United Nations development system should, if they have not already done so, reorient their internal policies and procedures in order to respond adequately to the principles and objective of TCDC. These organizations should also make the necessary internal adjustments and arrangements in their secretariats in order to integrate TCDC in their programmes of work. These arrangements should be result-oriented and should promote TCDC in the operational activities of these organizations.

II. INFORMATION SYSTEM FOR TCDC

Gaps in the information needed for operational purposes are one of the factors hindering TCDC. In response to this state of affairs, a recommendatin was included in the Buenos Aires Plan of Action calling for the establishment of an Information Referral System in the Special TCDC Unit at UNDP Headquarters to compile data on capacities, and the 77 Group has decided to mount a multisectoral information system on "needs." Both are global efforts whose results are uncertain. There is an urgent need to design and set in motion a system to provide information on capacities and needs, the means and opportunities with respect to TCDC, if better cooperation is to be achieved among Governments and institutions of developing countries.

1. Clarification of Concepts:

In order that the nature of the information required for TCDC/ECDC may be understood? It is advisable to clariy the meaning of its components? which in practive are reduced to two:

a. Definition of the Term "Capacities" in Connection with TCDC

When used in connection with TCDC, "capacities" means the practical knowledge, skills, and experience that the developing countries have accumulated in the course of their efforts towards achieving progress. These "capacities" or resources are expressed in terms of experts, consulting firms, research and training institutions, development-financing institutions, equipment and inputs industry, etc.

b. Definition of the Term "Needs"

In connection with TCDC the term "needs" is applied to the case of a developing country that seeks solutions to problems it has encountered and, with this purpose in view, endeavors to find appropriate capacities (practice knowledge, experience, and skills) in another developing country.

c. National and International Sources of Information

The sources of information on TCDC may be classified in three categories:

1) national sources;

2) international sources of technical cooperation:

   a) United Nations system;
   b) Pan American system.

For many years, a major portion of the technical cooperation among developing countries has taken place pursuant to bilateral agreements between nongovernmental organizations and professional and technical organizations. These channels of cooperation constitute a rich repository of data for TCDC activities.

Countries may obtain useful and systematized information on TCDC capacities through national mechanisms from the following sources:

- embassies;
- government ministries and cabinet departments;
- international organizations;
- professional and technical organizations, associations, and institutes;
- directories;
- official missions;
- economic communities and integration movements.

The basic information on capacities may be recorded under the following general categories:

- education and training;
- technological resources and development;
- appropriate technology
- research facilities;
- consultancy services;
- information on manufacturers;
- sources of information on legal, administrative, etc., aspects of TCDC and ECDC.

III. FINANCING FOR TCDC ACTIVITIES

The primary responsibility for financing TCDC activities falls on the developing countries themselves. However, the economic difficulties faced by those countries, accentuated today by the international economic crisis, pose a serious obstacle to the mobilization of resources for TCDC. The channeling of required funds from external sources is therefore important. PAHO's potential role in this field is outlined elsewhere in this document.

IV. ROLE OF DEVELOPED COUNTRIES

Developed countries and their institutions should give their full support to TCDC initiative by inter alia:*

(a) Increasing their voluntary contributions to the operational programs of the United Nations development system in order to permit a greater quantum of multilateral technical cooperation funds to be devoted to supporting TCDC;

(b) Providing financial support on a voluntary basis to technical cooperation between two or more developing countries and to institutions in developing countries that have a TCDC outreach potential;

(c) Accelerating the process of untying their aid resources, so as to make possible more rapid progress in the promotion and strengthening of TCDC;

(d) Giving, in their economic and technical cooperation activities, due priority to intercountry projects and programmes at the bilateral, subregional, regional and interregional levels which promote TCDC;

(e) Making qualitative improvements, if they have not yet done so, in their policies and procedures related to technical cooperation, in order to be able to support TCDC activities and projects at the request of participating developing countries so as to contribute to (a) greater reliance by those countries on resources available locally or in other developing countries.

executive committee of the directing council

PAN AMERICAN HEALTH ORGANIZATION

working party of the regional committee

WORLD HEALTH ORGANIZATION

92nd Meeting
Washington, D.C.
June 1984

Provisional Agenda Item 15

CE92/16, ADD. I (Eng.)
25 June 1984
ORIGINAL: SPANISH

LONG-TERM PLANNING AND PROGRAMMING SUBCOMMITTEE

Introduction

During the meeting of the Long-term Planning Subcommittee in April 1984, there arose the need to review the Subcommittee's functions within the framework of the management approaches of the new Administration of the Pan American Health Organization.

Within the basic principles of the "Management Strategy for the Optimal Use of the PAHO/WHO Resources in Direct Support of Member Countries," the need for more active participation by Member Countries in their relationship with the Organization is emphasized. They are the primary actors in the definition of national needs and priorities and, together with the Organization, in the design of the country program so that it responds to those needs in the context of both national and regional priorities. Together with the Organization, they have co-equal responsibility in the administration of the Organization's cooperation and in assuring the efficient use of country program resources within their national frontiers. That increased participation at the country level by the Governments also should serve as a stimulus for their increased involvement in the critical readjustment of the Organization's regional programs of technical cooperation. Ultimately, it is the Government's responsibility to translate the collective decisions of the Governing Bodies into commitments and concrete actions in each country.

Those decisions impose mutual obligations on the Secretariat and on the countries to put into practice individually the agreements which have been adopted collectively. The Secretariat--as the executive branch of the Governing Bodies--and the countries share the responsibility to assure that the measures which are taken at the country level are compatible with regional policies and priorities.

The Member Countries participate in the conduct of the Organization through diverse official and unofficial interactions. The new emphasis of the management strategy is to spark more active participation by the Member Countries. In meetings of the Executive Committee, the Directing Council and the Pan American Sanitary Conference, the Member Countries participate actively in the formulation of policies and in the examination of the Organization's program. This permits each country's interests and needs to be reflected more rapidly in policy and program changes, and in the way the Organization uses its resources within the countries.

Planning, programming and budgeting for technical cooperation constitute a continuous process with integrated short-, medium- and long-term cycles. The medium-term planning process takes place at the country level within the context of the long-term plans approved by the Governing Bodies, the joint examination of country and regional needs and the specific resolutions of the Governing Bodies. The changing short- and medium-term demands of countries should be the major determinants in a continuing process of readjustment of regional programs, which also implies greater flexibility in budget execution based on the results of joint analysis by PAHO and the Member Governments.

In relation to these considerations, the need for a closer involvement of the countries in certain aspects of planning, programming and budgeting of technical cooperation was recognized. With the objective of obtaining this more effective involvement, the Subcommitee on Long-Term Planning expressed a desire to review its functions and submit its views to the Executive Committee.

Background

The Subcommittee was created by resolution of the Executive Committee in June 1979 (CE83.R13). At that time, it was evaluating the Ten-Year Health Plan for the Americas and considering the regional contribution needed to achieve the goal of health for all in the year 2000. In that context, it recognized the responsibility of the Governing Bodies and of the Member Governments for long-term planning and programming. The Subcommittee initially was comprised of Canada, Chile and Guatemala. In 1980 it examined, modified and expanded the document "Regional Strategies for Health for All in the Year 2000," which subsequently was adopted by the Directing Council (CD27.R20) in that same year.

The Subcommittee, comprised of Chile, United States of America, Guatemala and Mexico, met again in April 1981 to review in detail the Plan of Action prepared by the Director to implement the Regional Strategies. The Plan of Action, with modifications, adjustments and suggestions made by the Subcommittee, was approved by the Executive Committee (CE81.R19) and by the Directing Council (CD28.R11).

In accord with the instructions of the 86th Meeting of the Executive Committee, the Subcommittee, comprised of Chile, Mexico, Panama and Uruguay, met in June 1982 to examine the "Basic Document on the Financial and Budgetary Implications of the Regional Strategies and the Plan of Action." At that time, the Subcommittee studied the document and formulated recommendations on the criteria and standards for the planning of the budget for 1984-1985 and the proposed provisional budgeting of WHO for the Region of the Americas for 1984-1985.

The Subcommittee was not convoked in 1983; however, the number of members was expanded to five: Canada, Cuba, United States of America, Panama and Uruguay. With these members, the Subcommittee met in April of this year and considered an 8-point agenda which resulted in the report presented to the Executive Committee.

Members

The resolution which established the Subcommittee (CE82.R13) in June 1979, did not establish a fixed number of members. Since the Executive Committee is comprised of nine members, it appears that the Subcommittee's current size of five members is adequate to represent the full Committee and to provide a sufficient contrast of opinions and perceptions in the examination of the topics submitted for its consideration.

Since it is a Subcommittee of the Executive Committee, its members have been selected from among the members of the Executive Committee, and their tenure has corresponded to their membership on the Executive Committee. This practice appears to be the most appropriate since the Subcommittee is a tributary of the Executive Committee. When there is a need to fill a vacancy because of the completion of an Executive Committee member's term and, therefore, its participation in the Subcommittee, a new member would be chosen from among the countries serving on the Executive Committee.

Meetings

With the objective of maximizing the participation of governments in Long-term Planning and Programming, it appears desirable for the Subcommittee to meet twice a year. One of the meetings will be scheduled prior to the Executive Committee meeting normally held in June-July and a second, following the second Executive Committee Meeting which occurs immediately after the Directing Council in September-October. The first Subcommittee Meeting of the year should also occur following the WHO Executive Board meeting and prior to the World Health Assembly.

It is suggested that PAHO Headquarters continue as the site for the meeting because of its convenience in terms of ready access to all the information and staff responsible for coordinating the different programs. Only in exceptional cases and for some specific topic, the Subcommittee might decide to meet elsewhere.

The duration of the Subcommittee meetings, as has been the experience in the last four years, should not be less than two or three days with a decision left to the discretion of the Subcommittee's president whether to expand or reduce this time period in light of the work of the Subcommittee.

Functions

The Subcommittee itself, in its last meeting, reached a conclusion that it should maintain its strictly advisory character to the Executive Committee, defining its functions principally in assisting the Executive Committee in its analysis of important and strategic medium and long-term issues. Second, the Subcommittee also could advise the Director on matters related to the conduct of the Organization. In general terms, the following are the principal purposes of the Subcommittee:

i) Analysis of the planning and programming methods and process for medium- and long-term activities;

ii) Analysis of information systems, for management of PAHO/WHO's technical cooperation with the countries, including monitoring and evaluation;

iii) Analysis of the socioeconomic framework and conditions and of their repercussions on the health sector;

iv) Analysis of PAHO budget processes and of the background and basis for their formulation;

v) Study of aspects related to the policies and overall directions of the administrative systems of the Organization, particularly involving the planning and development of human resources;

vi) Analysis, formulation and evaluation of special programs;

vii) Other functions as assigned by the Executive Committee.

In light of the positive contribution that the Subcommittee has been making during the last five years, and recognizing that a still greater involvement would result in added benefits to the activities of the Organization, the Executive Committee is requested to give its consideration to the recommendations contained in this report.