Global Health in Transition: A Synthesis: Perspectives from International Organizations

John H. Bryant and Polly F. Harrison for the Board on International Health, Institute of Medicine

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INSTITUTE OF MEDICINE

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This document is a synthesis of the content of selected reports published in the international health literature during the last 5 years. It consists of summaries of those reports, accompanied by a synthesis of the major themes they express, and contains only the conclusions and recommendations that are presented in those reports. It was developed by its authors, Institute of Medicine Staff Officer Polly F. Harrison, and John H. Bryant, Board on International Health member, as a foundation document for the work of that Board. Though approved for distribution by the previous and incumbent Boards on International Health, it should not be construed as reflecting the views of the National Academy of Sciences or the Institute of Medicine.

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DEDICATED TO

Bernard N. Fields, M.D.

So fine in every way,
so committed to the dream of global health,
so missed.

Synthesis:

syn = with, together

the = to put, place

sis = process, condition

The combining of the constituent elements of separate material or abstract entities into a single or unified entity (opposed to *analysis*, the separating of any material or abstract entity into its constituent elements).

Global Health in Transition: A Synthesis

Introduction

For many reasons, this decade is a time of rethinking many things. There is the impending turn of the millenium, an event packed with meaning. There is recent political history, which has changed the global structure of power in ways few could foresee, and there is an economic fluidity worldwide that makes every day unpredictable and the future uncertain. There are movements of people and surges of violence that seem unparalleled, and well may be. We are awash in change, and people everywhere are trying to understand that and read its implications. It is a time that provokes soul-searching: backward, into the lessons and achievements of the past, and forward, into ways for the future to be better.

The fields of health and social development are no exception. More specifically, events and conditions in the health sector point to the need to rethink some large issues. Nations everywhere are grappling with the economic and ethical dilemmas of achieving and maintaining healthy populations, since these are both cause and consequence of true development. Increasingly, the thinking is global, because there are comparisons to be learned from, connections that have implications, obligations to fulfill, and costs that are somehow shared.

As part of this dynamic, there has been an explosion of analytic documents, published since the start of this decade, that deal mainly, though not exclusively, with health in developing countries. Although these documents have various authors and institutional provenance, and although not all are formally published volumes in the public

domain, they comprise a fair spectrum of opinion about issues of global health, though surely not a complete one. Each document advances understanding of specific challenges to health in the development process, and each raises further questions, explicitly in its content or implicitly by work that it has left undone. Each assesses the current status of the areas of health or social development with which it is most concerned; expands on the ideas and methods its authors wish to advance; proposes strategies; and then reflects on their likely impacts, shortfalls, and policy implications. Each document acknowledges that much more needs to be done to bring key ideas to fruition in terms of developmental effects than is specified in its own strategies. Finally, and importantly, each document intimates that what we have been calling "international health" may need, somehow, to be rethought in a more comprehensive way as "global health."

Two aspects of these documents commanded the attention of the Institute of Medicine's Board on International Health. One was the broad range of constituencies and points of view drawn upon in producing them. The other, all the more striking because of this breadth of representation, was the degree to which the documents appeared to converge on what seemed to us a significant number of goals, values, and principles, as well as on some key development themes. Whether this reflects real and mounting consensus on what is important in health development or whether it is just a coincidental uncovering of related ideas and experiences is an interesting question. More interesting to the Board was the fact of convergence, which, in itself, would serve to make the collection greater than the sum of its parts.

We do not mean to give an impression of total harmony. That would be naive and wrong. The titles alone reflect variations in emphasis and scale, and there are differences in geographic and sectoral foci and in the priorities assigned to kinds of assistance. Still, after years of grappling intellectually and practically with the problems of health and illness in the developing world, the fact that there is some core of agreement among major actors is not trivial. At a minimum, it is a reasonable point for new departures.

This is a body of thought from a voyage of discovery by hundreds of individuals around the globe. Our purpose was to distill the essential elements from those efforts, discuss the major ideas they share and the thoughts they prompt, ask what those might mean for a next agenda in global health, and comment on the shifting context in which our current concepts of the ideal will prove—or not prove—their adequacy for the future.

THE DOCUMENTS REVIEWED: AN ANALYSIS

The first part of this *Synthesis* is an analysis that summarizes 10 documents in a common format. Each summary starts with a brief background note and then analyzes the document in terms of its objectives, conclusions, and main recommendations for policy and action, hewing as closely as possible to its original language. All presentations end with a brief commentary highlighting issues that we consider pivotal and locating them in the larger contexts of health and social development. The following 10 documents were reviewed:

- *Disease Control Priorities in Developing Countries* (World Bank, 1993);
- *World Development Report 1993: Investing in Health* (World Bank, 1993);
- *The Health of Adults in Developing Countries* (World Bank, 1992);
- *Human Development Reports, 1993* and *1994* (United Nations Development Programme, 1993, 1994);
- *Ninth General Programme of Work, 1996–2001,* and *Intensified Cooperation with Countries in Greatest Need* (World Health Organization, 1994);
- *The State of the World's Children, 1994* and *1995* (United Nations Children's Fund, 1994, 1995);
- *Health Research: Essential Link to Equity in Development* (Commission on Health Research for Development, 1990);
- *Global Comparative Assessments in the Health Sector* (World Health Organization/World Bank, 1994);
- *Partnerships for Global Development: The Clearing Horizon* (Carnegie Commission on Science, Technology, and Government, 1992); and
- *Strategies for Sustainable Development* (U.S. Agency for International Development, 1994).

THE DOCUMENTS CONSIDERED: REFLECTIONS AND IMPLICATIONS

Invitations to Further Inquiry

The second approach to the *Synthesis* documents is a set of reflections on their implications. We first extract 10 themes, ideas, or concerns that are explicit in at least some of the documents or implicit in

what they suggest as work remaining to be done. There are surely more than 10 ideas in this considerable group of documents. We chose those that we believe lie at the heart of what needs to be asked about what is useful, appropriate, and possible in the field of health development in today's changed and changing circumstances, ideas that will be critical to any reconceptualization of that field. Because at least some of these concepts require more—sometimes much more—theoretical or practical attention, we deal with them as *invitations to further inquiry*. They are outlined below.

1. *Changing dimensions: new needs in development.* As countries proceed along their individual development trajectories, patterns of development and needs for assistance are becoming far more diverse. This means that unidirectional, unidimensional patterns of development and development assistance are yesterday's patterns.

2. *Models and methods: going beyond the generic.* Given each country's particular needs, there is also a need to find ways to build local capacity and to adapt evolving models and methods so that they are attentive to the uniqueness of local settings.

3. *WDR methodologies: contributing to global mechanisms.* The *World Development Report (WDR)* framework offers a basis for shaping collaboration and action agendas that is both more expansive and more precise, including measurement of the world's burden of disease over time; a global health information network; and ways to vitalize coordination among the research, disease control, and donor communities. All remain to be realized.

4. *The health transition: waiting for attention.* The policy and research vacuum around the health of adults in developing countries is a consummate example of the tardy response to the realities of the demographic and epidemiologic transitions and of the substantial costs that they will inevitably exact virtually everywhere.

5. *Coping with violence: rising problem, complex response.* Violence exemplifies the problems that emerge and spread in marginalized populations, problems whose determinants are complex; deeply embedded in the nature of family and community life; and exacerbated by poverty, ethnic differences, population displacement, societal discrimination, and political instabilities. There are no simple solutions for any of these.

6. *Strengthening health systems: a necessary pathway.* The strengthening of health systems through various approaches, including research, improved management, and enhanced human resources for health, appears in most of the documents. Yet, how to do this effectively is largely unstated and undersupported in many health

development strategies, though it is central to realizing many health development recommendations.

7. *Universities and nongovernmental organizations: essential partners.* The public, private, and independent sectors are essential partners in development cooperation. Governments are obvious partners, and the private sector receives growing encouragement, but two crucial actors receive but modest attention: universities and nongovernmental organizations.

8. *Ethics and human rights: expanding concerns.* In many parts of the world, the impact of bioethics on patient care is noteworthy, as is its focus on the moral criteria for decisions about that care. The question now is how to bring comparable concerns to the care of populations, communities, and, indeed, the world itself.

9. *External assistance: magnitude and directions.* Assessments of the global burden of disease and funding flows by categories of health problems suggest some dissonances in priorities that call for fresh scrutiny of allocative processes, worldwide and within individual countries.

10. *Health research: large returns, small investment.* Payoffs to investment in health research have proven to be high in several ways, notably in fostering indigenous capacity for resolving indigenous problems. Yet, in proportional terms, investment in creating such capacity has not been commensurate with its potential rewards.

A NEXT AGENDA: CONVERGENCE, DIVERGENCE, AND CHANGE

We next examine the nature of the consensus that we identified among the *Synthesis* documents and explore three zones of convergence, the first having to do with principles, values, and goals; the second with tools and mechanisms; and the third with priorities.

We then talk of change and the uncertainty that it is provoking. As heartening as it is to see commonalities in a field that, understandably, has been driven by particular institutional agendas, a stern eye is required nonetheless. The documents themselves call attention to the fact that the context for what we have considered "development" is shifting, in many respects tectonically. This means that some areas of convergence may be more fragile than they seem. Others may need bolstering if they are to survive and, like the most technically advanced earthquake-proof buildings, will require deeply thoughtful engineering, great structural flexibility, and ample creativity. A whole new architecture, and perhaps even a new language to describe it, may be needed.

The *Synthesis* documents contribute a distinct set of concepts, methods, and strategies for promoting and protecting health in developing countries, contributions of much potential interest to all countries engaged in development assistance. The documents suggest a framework within which countries—notably including the United States and this Institute's Board on Internaitonal Health—might rethink the character and directions of their participation in global health.

A FINAL NOTE

The "Final Note" of our *Synthesis* turns to three large questions: Will this distillation of the best ideas, common themes, and principles that animated a decade's worth of good, hard thinking about what we have been calling "international health" be an adequate foundation for a new architecture; will the foundation have to be entirely rebuilt to serve good purpose in a world awash with change; and who will do it?

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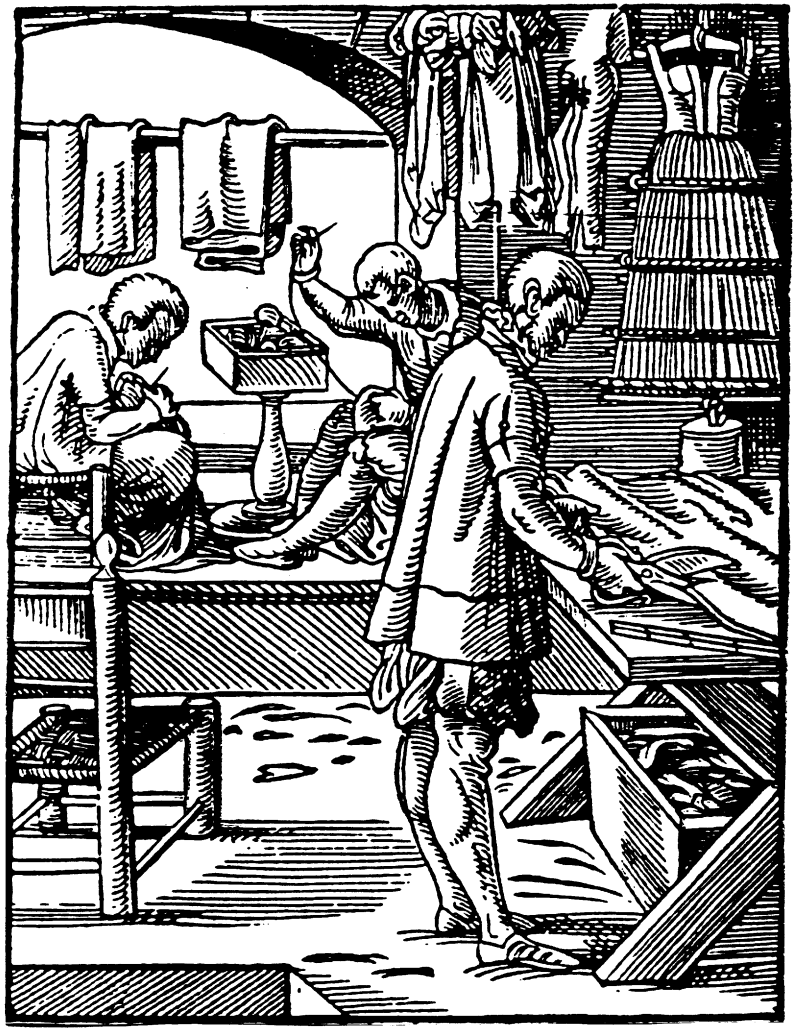

The Documents Reviewed: An Analysis

Disease Control Priorities in Developing Countries

Jamison, DT, WH Mosley, AR Measham, and JL Bobadilla, eds. 1993. Disease Control Priorities in Developing Countries. New York: Oxford University Press. *The core of this collection is a set of analyses undertaken for the World Bank's Health Sector Priorities Review. Its impetus was recognition of the lack of analytic approaches developing countries might take in dealing with the implications of the health transition and the emergence of behavioral risk factors and noncommunicable diseases as significant problems. Each chapter assesses the current and probable future public health significance of over 100 individual diseases or related clusters of diseases in the developing world. It then assesses the cost and effectiveness of alternative interventions for preventing each condition and managing it clinically in different contexts by using the Disability-Adjusted Life Year as a measure. Each chapter also includes an extensive bibliography. The authorship of the collection reflects a balance among economists, epidemiologists, clinicians, and biomedical scientists—over 80 in all—drawn from the international academic and technical communities.*

OBJECTIVES

- To assess the current and probable future public health significance of the burden of disease in developing countries as those countries experience demographic and epidemiologic transitions.
- To take stock, in a systematic disease-by-disease manner, of the cost-effectiveness of alternative responses to those conditions in various socioeconomic, demographic, and epidemiologic contexts.

CONCLUSIONS

- The net effects of demographic and epidemiologic transition and

socioeconomic change will be unprecedented increases in the volume, diversity, range, and complexity of problems developing country health systems will face in the next decades. The "unfinished agenda" of communicable disease, malnutrition, and unwanted fertility among the most vulnerable groups will persist, along with an "emerging agenda" of new health risks, noncommunicable diseases, injury, and disability in an ever-greater proportion of the population.

- The total burden of disease, measured by days lost to acute disease episodes, chronic disabilities, and premature death (Disability-Adjusted Life Years), will grow. Demand for health services, especially by more urbanized, educated, affluent, and vocal populations, will also grow, at the same time that access to health resources for the most vulnerable populations will need to be strengthened and preserved.
- This means that the range of health services will have to expand correspondingly, since new provider skills, technologies, and organizational arrangements will be required for even minimum standards of care. The needs of these new sectors, as well as the higher health maintenance costs for older cohorts, will require rising percentages of gross national product, at the same time that austerity will continue to dominate the economies of most countries. Health systems will be challenged to mount a broader range of preventive measures and to develop very low cost protocols for managing increasing numbers of cases.
- Though marginal cost-effectiveness varies widely, many interventions are attractive by any reasonable economic standard. A major challenge will be to use them, optimally grouped into efficient basic packages of prevention and essential clinical services. Although core sets of preventive and clinical interventions would seem appropriate to the needs of most countries, they will have to be defined and targeted to account for local epidemiologic variability and financial capacities.
- Primary prevention or public health interventions are not inherently more cost-effective than the clinical strategies that are suggested, none of which requires more specialized facilities than those available at a reasonably well-equipped, well-organized district hospital. Although some components of an individual package are simple technologies, their recombination, reassignment to different delivery levels, and proper functioning will require new standards of care and provider skills. This will be especially crucial for those diseases that carry particularly large burdens of death and disability.
- The full range of policy tools available to governments—for example, regulatory interventions or taxes to promote public health and

raise revenue—is underused. The economics of investment in research, its transportability, and the existence of substantial research capacity in donor countries make research a most viable domain for foreign aid, yet the current volume of resources going into research is quite limited and virtually ignores issues that will dominate the policy agenda in years to come. Vaccine development, which offers the means of preventing a broader range of conditions with greater cost-effectiveness and less logistical complexity than many other preventive interventions, receives relatively little support.

RECOMMENDATIONS FOR POLICY AND ACTION

• **As their central task, national governments should explore, develop, and apply the following:**

1. A full range of policy instruments—legislation, regulation, taxes, subsidies, investment research;

2. Goal-oriented, comprehensive, integrated strategies mixing preventive and clinical interventions, continuing education for providers, and technology assessment and control; and

3. Analytic skills in demographic and economic analysis, epidemiologic surveillance, health technology assessment, and input-output-outcome interactions.

• **The central tasks for countries providing development assistance are to help do the following:**

1. Improve health services delivery by

— continuing emphasis on immunization and family planning and increasing selectivity in delivery of oral rehydration therapy and tuberculosis vaccine (BCG) in low-risk environments;

— enhancing emphasis on measles immunization, case management of acute respiratory infection, control of vitamin A deficiency, tuberculosis chemotherapy, anti-helminthic prophylaxis, control of sexually transmitted diseases, and control of cancer pain;

— strengthening capacity for drug logistics to support system priorities, provider training to manage priority procedures, and delivery of inexpensive rehabilitative services; and

— reducing support for hospital facilities and shifting emphasis away from general institutional development and toward strengthening specific capacities.

2. Improve the policy environment by

— applying a full range of mechanisms to limit tobacco use;

— tracking and reducing use of procedures that are of low cost-effectiveness;

— reducing occupational and transport injuries, including control of alcohol use;

— strengthening the capacity to develop policy instruments for sustainable allocations to the health sector; and

— formulating and implementing policies involving taxation, regulation, and communication.

3. Increase allocation of resources to research for

— exemplary programs of essential national health research;

— epidemiologic and operational research on cardiovascular and other noncommunicable diseases, sexually transmitted diseases, mental and chronic obstructive pulmonary disorders, and injury;

— assessment of intervention cost-effectiveness in different environments;

— vaccine development;

— strengthening national and international capacities to address these research emphases; and

— monitoring epidemiologic trends and the efficacy of intervention in well-documented populations.

COMMENTARY

This comprehensive collection of concepts, methods, and strategies for addressing the major health problems of the developing world advances the global capacity for management or control of those problems in two crucial ways. Its methods for measuring disease burdens and intervention cost-effectiveness provide a basis for priority setting, and thereby support policy formulation and resource allocation, as well as epidemiologic and health care guidance for managing these diseases. A major question remains: how to facilitate the absorption and application of these important findings and strategies into developing country settings.

Stated somewhat differently, although each disease problem is well analyzed, with appropriate advice for disease control and case management, there is still the substantial challenge of how to develop health systems that can encompass interventions for large clusters of such problems. In the 1960s and 1970s, the search was on for models

of primary health care that were effective and affordable in settings of poverty and remoteness in developing countries. Some were found and served as the basis for strengthening health systems in a variety of settings. Now, new models are needed that, first, go beyond primary health care, to more comprehensive approaches in which primary and secondary care are effectively and efficiently joined to address emerging epidemiologic diversity, and, second, can act as policy generators for system development and change.

In material that follows, we will call attention to the usefulness of models and their limitations as universal solutions on the basis of the fact that each country is unique. Modeling remains important, but in a context in which each country is helped to build capacity to assess its own needs, reform its own policies, and adapt models to its own situation.

Thus, the new capacities required to advance health would build on the methods and strategies presented in this volume and would include construction of health care prototypes at the district level to handle changing epidemiology, relevant health research, human resources development, and related policy making and implementation. The metric described here and in the *World Development Report* for determining burdens of disease and the cost-effectiveness of interventions provides a basis for priority setting and related policy formulation, assuming that capacities exist at the country level for their adaptation and application.

World Development Report 1993: Investing in Health

World Bank. 1993. World Development Report 1993: Investing in Health. New York: Oxford University Press. *This is the 16th in an annual series on individual sectors and cross-sectoral themes. It was prepared in partnership with the World Health Organization (WHO) and benefited especially from WHO's technical expertise in the assessment of the global burden of disease and in the preparation of a number of comparative economic, epidemiologic, demographic, and institutional analyses that informed the Report. Production of the World Development Report (WDR) was led by a World Bank team, guided by a 22-member external advisory committee, and assisted in its development and review by 19 external consultations and a series of seminars within and outside the Bank. More than a dozen bilateral and multilateral foreign assistance agencies, foundations, and academic institutions provided financial and analytical support, and the process involved more than 600 individuals from many disciplines, countries, and institutional venues. The document includes extensive tabular material and a large bibliography of original papers and statistical analyses, as well as many academic and institutional sources, published and unpublished.*

OBJECTIVES

- To examine the interplay among human health, health policy, and economic development, and to explore in depth a single sector in which the impacts of public finance and public policy are of particular importance.
- To set the priority policy issues and actions that are likely to be most relevant for low-income, middle-income, and formerly socialist countries.
- To present a measure of global disease burden that could serve

in identifying cost-effective interventions and guiding resource allocations.

CONCLUSIONS

• A central assumption of the *WDR* is that the health sector differs from other sectors, such that there is justification for a direct role for government beyond its already large, indirect influence through policies related to water supply, sanitation, education, household income, and health system regulation.

• There are three rationales for a direct role, all related to government's capacity to provide better outcomes in some respects than private markets can: (1) its ability to use investment in the health of the poor to reduce or alleviate poverty; (2) its ability to ensure that health interventions that are public goods, such as public health information and the control of contagious diseases, benefit everybody regardless of ability to pay; and (3) its capacity to act under circumstances of uncertainty, insurance market failure, and inequities in risks and costs.

• Even in the poorest countries, the past 40 years have brought great improvements in the two key indicators of health status—life expectancy and child mortality—partly because of growing incomes and increased levels of education around the globe and partly because of government efforts to expand health services, further enriched by technologic progress.

• Still, large problems remain: unacceptably high mortality, much of it preventable; a pace of progress that is uneven among and within countries and regions; and a growing burden of avoidable disability. There are serious new health challenges: mounting burdens of human immunodeficiency virus and AIDS and other emerging and reemerging infectious diseases; an increasing number of drug-resistant strains that cause disease; significant increases in noncommunicable diseases; violence; and continued use of health-damaging substances such as tobacco.

• All of these will make new demands on health care systems as mortality rates decrease and populations age. Most systems now have problems that, if left unresolved, will seriously hamper efforts to address misallocations of financial resources; inequities in services; inefficiencies; and, in middle-income countries, exploding costs.

• Thus, almost all countries confront some kind of health system reform. Such reform faces especially serious obstacles in low-income countries where, in competition for scarce national budgets, the dis-

trict-level infrastructure often loses out to the special interests of physicians, politicians, trade unions, and urban populations.

• A core need in reform is new modalities—for financing health, determining priorities, reallocating resources, and providing the most compatible, cost-effective public health measures and clinical services. A plausible tool in this connection for national decision making and external assistance is the Disability-Adjusted Life Year (DALY). The DALY was developed as a way to measure the global burden of disease and combines loss from premature death with loss of healthy life due to disability. It can help guide resource allocations toward conditions producing the greatest burdens of disease and for which there are cost-effective responses.

• As for global resource allocations, after growing rapidly in the 1970s, aid for health declined as a share of all development assistance in the 1980s, despite widespread calls by donors for more investment. Donors are directing more of their funds through multilateral rather than bilateral channels, increasing from 25 percent in 1980 to more than 50 percent in 1995.

• Only 5 percent of all expenditures on health research worldwide goes to health problems unique to developing countries; less than 10 percent of all donor assistance for health goes to biomedical and social science research.

RECOMMENDATIONS FOR POLICY AND ACTION

• **For developing economies, the *WDR* recommends a three-pronged approach:**

1. Fostering an environment that enables households to improve health:

— pursue growth policies that benefit the poor;
— expand investment in education, particularly for females; and
— promote the rights and status of women.

2. Improving government spending on health:

— reduce government expenditures on tertiary care;
— finance and implement a package of public health interventions;
— finance and ensure delivery of a package of essential clinical services; and

— improve management of public health services.

3. Promoting diversity and competition:

— encourage social or private insurance for clinical services outside the essential package;

— encourage public and private suppliers to compete to provide inputs and services; and

— provide information on provider performance and accreditation and on cost-effectiveness.

• For developing countries, the *WDR* suggests a range of health policy reforms:

1. Low-income countries:

— provide primary school for all children, especially girls;

— invest in cost-effective public health measures;

— shift health spending for clinical services from tertiary to district health facilities;

— reduce waste and inefficiency in government health programs; and

— encourage community control and financing of essential health care.

2. Middle-income countries:

— phase out public subsidies for better-off groups;

— extend insurance coverage more widely and give consumers a choice of insurer; and

— encourage payment methods that control costs.

3. Formerly socialist countries:

— improve the efficiencies of government health facilities;

— find new ways to finance health care; and

— encourage private health care and strengthen public regulatory capacity.

• For international assistance in health, the *WDR* recommends:

— Immediately restore the share of aid for health to its pre-1985 level of 7 percent of total official development assistance, increasing in the next 5 years to 9 percent.

— Improve the effectiveness of aid for health by better targeting

and management of assistance and by building local capacity to plan and manage health systems and support reform.

— Increase assistance for health research, focusing on the major health problems of developing countries.

— Stabilize funding, improve priority setting, and boost efficiency by developing a global mechanism for better coordination of international health research.

COMMENTARY

The *World Development Report* addresses the challenges to advancing health in developing countries directly, contributes ideas and methods that are relevant to the most pressing problems, and encompasses these in a strategic approach that is broad and clear.

The preparation of the *WDR* was based on the unprecedented involvement of key communities outside the World Bank and reflects a major change in the Bank's view of government responsibility in the health sector. Its advocacy of a relatively strong financial role for the state not only speaks to the state's functions in poverty reduction and education and the assurance of universal access to some basic set of services but also argues for a government role in the private market for health care and insurance. The argument that the public sector can—and should—use the financial, informational, and regulatory instruments at its disposal to improve efficiency and assure equity in cases of insurance market failure is new for the Bank.

A major contribution was the estimation of the global burden of disease by using the DALY, a unit that combines loss from premature death with loss of healthy life due to disability, which can be used to calculate the cost-effectiveness of interventions. The DALY was a major methodologic advance. As such, it will be argued, adjusted, and improved; in the interim, it is a widely applicable strategic tool that will nonetheless require thoughtful training and adjustments in its use at the country level.

The *WDR* lays out a reasoned package of ideas for health development that deserve consideration by donors and national policy makers, pointing out that they will have to wrestle with the reality that, in the health sector, there is no simple paradigm for policy choice. Both free markets and public sectors may fail in attempts to provide public health activities and clinical care, so that effectiveness in this arena will require strong private and public institutions, which are seriously lacking in many developing countries. Recognizing this, the *WDR* observes that the productivity of support to developing countries would

increase substantially were donors to direct more of their assistance to public health measures and essential clinical services, especially in low-income countries, and focus correspondingly on capacity building, research, and reform of health policy.

A related, critical question is the following: Can the ideas and methodologies recommended in *WDR* be absorbed by developing countries? Some will be able to adapt and adopt these approaches fairly straightforwardly into system design, financing, and management; others, principally lower-income countries, will not. Thus, strengthening capacity to absorb the concepts and approaches described in the *WDR* could be a logical part of a next agenda in health development.

The Health of Adults in Developing Countries

Feachem, RGA, T Kjellstrom, CJL Murray, M Over, and MA Phillips, eds. 1992. The Health of Adults in the Developing World. New York: Oxford University Press. *No new data were collected for this document. Existing mortality data were reworked extensively, several unpublished data sources were brought together to illuminate current understanding of morbidity in adults, and disparate strands of evidence were compiled to help quantify the consequences of adult ill health for families, communities, and societies. The authors acknowledge that future research may modify some of their conclusions. The book was intended for a broad readership, including researchers and health policy makers in developing country governments and development agencies. Material on underlying relationships and patterns, of most interest to the research community, is presented together with practical guidance about future directions for action for consideration by developing country governments, but the book does not provide fully justified prescriptions for action. Its definition of adult ill health embraces all major health problems of adults—communicable and noncommunicable diseases, injuries, childhood exposures to risk factors for adult disease—and is not restricted by gender, residence, or socioeconomic status. The international, multidisciplinary team that prepared this book was aided by a panel of anonymous reviewers and a number of specialists supporting its work with various contributions.*

OBJECTIVES

- To document the nature, determinants, extent, and patterns of adult mortality and morbidity in developing countries and their social and economic consequences.
- To suggest priority research areas and potential avenues for analysis, policy development, and action for consideration by national and international researchers and health policy makers.

CONCLUSIONS

- In the past 30 years, there has been appropriate, effective emphasis in research and action on tropical diseases, the health of children, the communicable diseases of childhood, and maternal health. Surviving childhood is not the only hurdle, however: 27 percent of all deaths in developing countries occur among adults ages 15 to 59; 72 percent of those deaths are avoidable.
- The nature, distribution, and trends of adult mortality in developing countries challenge preconceptions: noncommunicable diseases and injuries are the leading causes of death among adults in most developing countries. Deaths from noncommunicable diseases among adults are increasing both in absolute numbers and in relative importance. These high mortality rates are accompanied by substantial (and costly) levels of morbidity.
- The noncommunicable diseases, commonly thought of as diseases of the rich, actually cause higher death rates among individuals in poorer populations. Poor adults suffer more often from severe ill health, are more likely to depend on regular physical work, and have fewer resources with which to cope. Consequently, they are more heavily penalized by ill health, which also has major impacts on children, family, and society, so that the health risks that they take may have direct or indirect deleterious effects on the health of individuals in other age groups. Since adults make up the majority of the labor force, their ill health or death also tends to have negative effects on productivity and may be related to the slow pace of development in some countries.
- Sick adults consume substantial proportions (often more than half) of health sector resources in developing countries. Yet, because adult ill health involves more noncommunicable disease, more long-term morbidity and disability, and more lifestyle risk factors, policy makers cannot reduce the numbers of adults with ill health simply by expanding policies that have been successful in improving child health.
- There are large gaps in knowledge about the levels, causes, distribution, and determinants of sickness and death among adults—cancer, cardiovascular disease, chronic obstructive lung disease, diabetes, injuries, sexually transmitted diseases (including human immunodeficiency virus infection and AIDS), and tuberculosis. Because morbidity is poorly understood and hard to measure, policy in both the curative and preventive subsectors is rudimentary, and there is imbalance between current resource allocations and reality. Absent better data, understanding, and policies, expenditures on sick adults will grow rapidly and sometimes inappropriately, as in the developed

world, even though there are alternative investments that would produce greater benefits to public health at lower cost.

• The demographic and epidemiologic transitions and the resulting "health transition" do not occur at the same pace or take the same form everywhere. Thus, countries are not locked into an inevitable experience of the health transition and can take steps to anticipate and avoid some of its undesirable manifestations. Many determinants of adult ill health in developing countries are behavioral, and the presence of some important risk factors is increasing. It is crucial to understand the factors that contribute to the transition—changing patterns of mortality, demography, and lifestyles—so that effective health promotion can be pursued.

RECOMMENDATIONS FOR POLICY AND ACTION

• Development of appropriate, effective health policies and programs should be based on relevant data obtained by routine collection and analysis of health statistics and research focused on practical questions.

• The information needed for good decision making and research can be obtained, at reasonable cost, principally in developing countries themselves, and will require the establishment of appropriate institutional and financing mechanisms to expand the relevant research capacities.

• Much knowledge about the basic pathogenesis and pathophysiology of adult disease can be extrapolated from research in developed countries. Thus, these aspects need to be studied in developing country contexts only when there is some significant difference or objective, for example, distinctive environmental or genetic factors or special advocacy needs, and they subsequently need to be adapted to those needs.

• Priority research areas are

— the levels, causes, and determinants of adult ill health;

— inexpensive, innovative, easy-to-use methods of collecting and analyzing data on adult mortality;

— methods for clarifying the kinds of morbidity data that are useful and how to interpret them;

— collection and use of good data on health services utilization, the kinds of morbidity that prompt people to seek care, and the demands placed on private and public health care systems;

— consequences of different kinds of adult ill health and of ill

health experienced at different ages, in different economic circumstances, or by men and women; and

— achievements and costs of alternative approaches to improving adult health.

• Countries need to formulate at least interim policy agendas. In the short and medium terms, resources that are known to be inefficient may be withdrawn from government health services for adults to free resources for interventions known to be cost-effective, many of which are neglected interventions, such as

— stopping smoking,
— making road travel safer,
— vaccinating against hepatitis B virus,
— making motherhood safe,
— promoting safe sex and treating sexually transmitted diseases,
— improving case management of tuberculosis,
— screening for cervical cancer and relieving cancer pain, and
— treating diabetes.

• Other interventions for policy consideration for the longer terms would include

— dietary interventions,
— pollution control, and
— control and management of occupational illness and injury.

COMMENTARY

This book advances understanding of a critical area of health development in which the necessary steps for dealing with underlying problems are just beginning and are occurring only in a halting way. The authors describe adult health as "a research and policy vacuum."

Given the epidemiologic transition from infectious and deficiency diseases to noncommunicable diseases, the rising incidence of injuries, and the demographic momentum associated with the growing population of adults, there is no turning away from the urgency of dealing with this set of problems. Nonetheless, there will remain variable reluctance to accept the health of adults as of priority importance in the face of the still unfinished agendas of maternal and child health and tropical infectious diseases. Although this is surely a policy di-

lemma, ways must be found now to begin grappling with the issues, at least in a preparatory way.

The first step is to characterize the incidence, prevalence, determinants, and interventions in the area of adult diseases in local terms. There is a potential trap here, however. These diseases are so well known in developed countries that it will be tempting to simply transfer the understandings of and interventions for these diseases to developing country settings. That could be an epidemiologic mistake, since the character and determinants of those diseases could vary dramatically. It could also be impractical from an intervention perspective, since the diagnostic and therapeutic approaches used in developed country settings may surpass the resources of developing countries. Clearly, existing knowledge about diseases of adults in developed countries must be interpreted, applied, and extended carefully in developing country settings, an obvious area for close collaboration between the research and health system development communities of all countries.

The directions of action that are called for are similar to those noted in connection with *Disease Control Priorities in Developing Countries*: assisting those countries in building their capacities in research, policy making, health system development, and development of human resources for all levels of the health care system.

Human Development Reports, 1993 and 1994

United Nations Development Programme. 1993 and 1994. Human Development Reports. New York: Oxford University Press. *The purpose of these reports, published yearly since 1990, has been to contribute to the larger development debate and to track and update the Human Development Index (HDI). HDI is a measure, analytically applicable to regional, national, or subnational groups, that combines three equally weighted indicators: life expectancy at birth, educational achievement (adult literacy rate and mean years of schooling of individuals over age 25), and a modified measure of per capita income. Each report has a special focus. In 1993 the focus was on people's participation in markets, governance, and community organization and on five core concepts for a new, people-centered world order. The 1994 report enlarged on those concepts as the framework for the 1995 World Summit for Social Development. All reports reflect the contributions of practical experience, research results, and statistical information from a large number of organizations and individuals worldwide. Report preparation is the charge of an independent United Nations Development Programme team with the support of a consultant panel and an extensive external drafting and review process. The following summary comprehends both reports.*

OBJECTIVE

- To explore the key dimensions of participation of people—through markets, government, and community organizations—as a central theme in human development.

CONCLUSIONS

- The democratic transition in many developing countries, the

collapse of socialist regimes, and the worldwide emergence of people's organizations are part of historic change, not isolated events.

- Unless the full context of the dynamics of development is kept in view, development perspectives become narrow and are likely to miss critical issues that bear importantly on health.
- Analysis of countries ranked according to the HDI found that:

— There is no automatic link between income and human development; poor distribution of income, however, does have a major impact on human development.

— Improvement in a country's HDI is as meaningful as its absolute level: Starting at similar levels, some countries have advanced their HDIs far more than others.

— When the HDI is adjusted for gender disparity, no country improves its ranking; that is, no country treats its women as well as it treats its men.

— Startling divergences from averages are revealed when the HDI is disaggregated for purposes of intraregional and intranational comparison so that, simultaneously, there may be great progress and great persistent deprivation.

- Given major cuts in global military expenditures, the numbers of nuclear warheads, and the sizes of armies and defense industry workforces, there needs to be a significant redefinition of the concept of national security—as in food, employment, and environmental security.
- Despite the assumption that pursuing economic growth would necessarily increase employment, there is a new and disturbing economic phenomenon—growth that does not generate new jobs, that is, "jobless growth."
- Concentration and centralization of power and resources are still more the rule than the exception because of the centralization of nation building derived from the colonial experience, weak democracy, low levels of social spending, urban bias, and the composition and directions of foreign aid.
- Nongovernmental organizations are effective in advocating for the disadvantaged, empowering marginalized groups, reaching the poorest, and providing emergency assistance. Still, they reach only one-fifth of the 1.3 billion people living in absolute poverty in developing countries and receive only 2.5 percent of the total resources that flow to those countries.

RECOMMENDATIONS FOR POLICY AND ACTION

The central concept for development should be societies built around people's genuine needs, a perspective that calls for five new pillars of a people-centered world order:

1. New concepts of human security, for nations and for people—food, employment, environmental security—as functions of

— defense cuts to finance human development and the transition from defense to civilian production;
— accelerated disarmament in the developing world; and
— new regional and international alliances for peace.

2. New models of sustainable human development that enable full use of human potential through

— investment in basic education, relevant skills, and worker retraining;
— support for small-scale enterprises and informal employment through fiscal incentives and credit system reform;
— creation of an efficient service economy by investing in new skills;
— encouragement of labor-intensive technologies, especially through tax incentives;
— extension of employment safety nets in times of major economic distress through labor intensive public works programs; and
— sharing of limited employment opportunities through adjustments to the work week.

3. New partnerships between the state and the market that

— combine market efficiency and social compassion;
— empower people to exert more effective influence;
— allow many more people to capitalize on the advantages that markets offer by providing the preconditions for participation—education, health, productive assets, physical infrastructure, information, liberal trade, and supportive legal and regulatory systems;
— provide the accompanying conditions for participation—stable macroeconomic environment and comprehensive and predictable incentive systems; and
— maintain a social safety net—employment, pensions for the

elderly, feeding programs for malnourished children and mothers, and free basic health and education for all low-income groups.

4. New patterns of national and global governance that accommodate the rise of people's aspirations and the decline of the nation-state through

— the decentralization of power, with genuine democracy at the local level; and
— broader and more participatory institutions of global governance.

5. New forms of international cooperation built on a new motivation for aid and a global war on poverty based on the needs of people rather than the preferences of nation-states through

— tripling current allocations to 20 percent for health, basic education, environmental security, and reducing population growth;
— basing aid allocations on poverty levels;
— linking aid with mutual concerns of recipients and donors, the interdependence of developed and developing countries, and the sharing of global market opportunities;
— establishing a new people-centered policy dialogue; and
— using technical assistance for national capacity building.

COMMENTARY

The *Human Development Report* (*HDR*) contrasts with the other nine documents reviewed in our *Synthesis*. It deals largely with a vision of development; the others deal with methods and strategies. The *HDR* builds a context of concern for people as the central feature of development; the others address health problems and analytical and policy approaches to grappling with them. Both are necessary. Indeed, an interesting aspect of the *Synthesis* documents is that duality: attention to the methodologic details of development on the one hand, and attention to the context in which those methods are made operational on the other.

For years there have been calls for greater participation of people in the development process, but those calls have often been muted by an insistence on economics as the primary determinant of development progress. It is increasingly clear, however, that other parameters of development share central positions with economics. For example, the thesis underlying the *World Development Report* is that

investing in health itself is essential to development. There are other indications that economics cannot be treated as the sole measure of development: The *HDR* points out that employment opportunities have not expanded with economic growth, as had been expected, so that other routes to employment security for people must be sought. In questioning traditional concepts of development, the *HDR* also puts forward notions of security that go far beyond customary definitions of national security to a definition of the security of people. It goes on to state that sustainable human development cannot depend on economics alone, but must be built on people's capacities, which can be enhanced only through participation in the development processes.

Health is integral to the social imperatives put forward in the *HDR*. The health sector has approaches to assessing risks and needs, setting priorities, planning interventions, and monitoring outcomes that can bring both concern and methodologic rigor to social development. The principles of social development that are expressed in the *HDR* can also bring to the health sector an insistence on shared decision making and respect for individuals and communities. Viewed this way, there is a complementarity between the health and social sectors of development.

Ninth General Programme of Work, 1996–2001
and
Intensified Cooperation with Countries in Greatest Need

Ninth General Programme of Work, 1996–2001

World Health Organization. 1994. Ninth General Programme of Work: Covering the Period 1996–2001 (Health for All Series, No. 11). Geneva: World Health Organization. *This is the third of three General Programmes of Work since the resolution on Health for All was adopted by the World Health Assembly in 1977. It has two functions. First, in the context of the Health for All strategy, it defines the policy framework for world action during the period 1996–2001. Second, it sets the framework for program development and management for WHO itself during that period. Both frameworks take into consideration progress made during the Seventh and Eighth General Programmes of Work in development, trends in health status, and changing health system needs.*

OBJECTIVES

- To reaffirm WHO's commitment to the principles of health for all.
- To set global targets for major health-related problems.
- To identify the major policy issues for the world and for the WHO.

CONCLUSIONS

- Inequities in health status and access to health care persist between and within countries, and their reduction is essential.
- One of the most important global trends has been democratiza-

tion of political systems and a greater participation of people in determining their own future.

• Growing concern is expressed about the adverse health effects of environmental degradation, pollution, diminishing natural resources, and global climatic change.

• Gains in health status and coverage are notable worldwide. Still, although the disparities between developed and developing countries are narrower, those between developing and least-developed countries have widened.

• The increasing costs of health care, coinciding with global economic problems, have prompted many countries to explore new financing mechanisms.

RECOMMENDATIONS FOR POLICY AND ACTION

1. Collaborative efforts must be intensified if disease elimination and control targets for the year 1995 (neonatal tetanus) and targets for the year 2000 (poliomyelitis, dracunculiasis, leprosy, and measles) are to be met.

2. Three types of more specific regional and national disease control targets for the most common health problems will need to be set within the framework of the Ninth General Programme of Work:

— health status targets for reducing mortality, morbidity, disability, and health risks;

— health services targets for good-quality care and services; and

— policy targets for all countries for adopting policies and strategies and implementing action plans in areas that also act as health determinants: living and environmental conditions, behavior favoring health, and health systems.

3. Sustained world action is called for if the following four aspects of policy are to be realized:

— integrating health and human development;
— ensuring equitable access to good-quality health care;
— promoting and protecting health; and
— preventing and controlling specific health problems.

Intensified Cooperation with Countries in Greatest Need

Division of Intensified Cooperation with Countries (ICO). 1995. Report on Activities 1990–1994. Geneva: World Health Organization. *In 1989, the WHO, its governing bodies, and its secretariat decided to take urgent action with respect to the growing worldwide inequities in health status and access to health care. This commitment was then translated into an initiative called Intensified Cooperation with Countries in Greatest Need. The WHO Director General created a special division dedicated to this initiative, with the necessary institutional authority and management capacity. That division is now involved in 28 of the least-developed countries.*

OBJECTIVES

- To formulate and implement policies and plans for health development reform, to correct inequities, and to lead to sustainable health development for the most needy groups.
- To improve financing and management of health systems at all levels, with emphasis on the most disadvantaged groups, peripheral areas, and universal access to basic health services.
- To more effectively mobilize, coordinate, and manage external resources.

CONCLUSIONS

- As the program of Intensified Cooperation with Countries in Greatest Need has evolved, it has taken a "horizontal" and nonmedical approach, in contrast to a "vertical," disease-specific approach.
- It is also a demand-oriented initiative based on the particular needs of each country, in contrast to WHO's global programs and its major involvement at the central and regional levels.
- Thus far, the initiative has placed primary emphasis on strengthening the health sectors in the poorest countries. It has become increasingly evident, however, that halting and reversing the decline in health status requires as a complement a strong and highly focused attack on poverty and its health consequences.

RECOMMENDATIONS FOR POLICY AND ACTION

1. The next phase of the initiative will require a more comprehensive approach based on

— ensuring that the poorest, most vulnerable groups have access to primary health care through expansion of basic health services and more emphasis on community involvement, so that they can take action on their own behalf;

— protecting the poorest from risks to health that are beyond their control by using multisectoral strategies; and

— promoting a strong commitment on the part of leaders in the poorest countries to the health of their populations, including assumption of responsibility for monitoring reductions in health inequities.

2. Experiences with this initiative in specific countries will provide the basis for promoting a policy for health development in the neediest countries, toward three broad objectives:

— to provide technical information and insight to policy makers and development experts;

— to communicate to the general public the nature and seriousness of the health consequences of poverty, as well as the sorts of policies and actions required to address them; and

— to emphasize the solidarity required for ensuring greater attention to health in overall human development, as well as the political commitment required to reverse the downward trend in donor funding allocations.

COMMENTARY

These two WHO documents bring to this *Synthesis* two critically important emphases:

- A global approach to assessment of health-related matters, target setting for improving health and health services, and establishment of norms or standards for provision of health care services, such that they are equitable and efficient and involve people in their provision and evaluation.
- A country-specific approach to building the capacities required to set and implement policies appropriate to health development, particularly for countries in greatest need.

A relatively new initiative, Intensified Cooperation with Countries in Greatest Need rests on the principles that there are no universal prescriptions and that development is the product of local capacities. The one principle that is universal, however, is that poverty is the most fundamental obstacle to health and overall development and is a permanent menace to world peace. This brings WHO closer to the United Nations Children's Fund triad of poverty, population growth, and environmental degradation as humankind's greatest challenges.

The Ninth General Programme of Work sets directions for global health policies in normative and country-specific terms. The 1995 World Health Assembly approved a conceptual framework and timetable for developing a New Global Health Policy based on equity and solidarity as the pivotal process for renewing WHO's Health for All strategy. In 1995 the World Health Assembly proposed the development of a New Global Health Policy, with the intent of achieving high-level political endorsement of a global health charter at the World Health Assembly in 1998. Based on equity and solidarity, the new policy would be pivotal in renewing WHO's Health for All strategy. WHO is inviting widespread contributions, from its member states, international organizations, and all interested parties, to the formulation of this Global Health Policy. Given WHO's mandate for coordinating global approaches to health development, this process could be critical in bringing greater coherence and consolidation to the health-related commitments of the international community.

The State of the World's Children, 1994 and 1995

Grant, JP. 1994 and 1995. The State of the World's Children. New York: Oxford University Press. *This series of annual reports presents a compilation of well-referenced, all-country statistical tables on basic indicators, nutrition, health, education, population, economic progress, and the situation of women. It includes regional summaries of those statistics, basic indicators for less populous countries, and a variety of analytical graphics. It also assesses progress toward established program goals, including components of the Child Survival Initiative and the goals set at the 1990 World Summit for Children. All of this information is scrutinized in the context of the larger social and economic forces that have positive or negative impacts on the data presented and on the overall well-being of children worldwide.*

OBJECTIVES

- To summarize progress against the major specific threats to the health of children in the world's poorest communities and outline the potential for further significant advances in the years immediately ahead.
- To focus attention on the persisting challenge of poverty, population growth, and environmental degradation, of such grave potential that they cloud humanity's prospects for the 21st century.

CONCLUSIONS

- Significant advances have been made against major threats to the health and well-being of the world's children: decreases in the number of deaths among children under age 5, cases of measles and polio, and total fertility rates; and increases in the number of 1-year-olds protected against vaccine-preventable diseases, percentages of

married women using contraception, and the level of primary school enrollment.

- Progress in these areas depends not just on economic development but also on sustained commitment to improvements in the well-being of the poor; yet, only small proportions of government expenditures and foreign aid are devoted to basic human needs in health, nutrition, education, and family planning.
- Given greater priority, child malnutrition, disease, disability, and illiteracy could be drastically reduced by the year 2000. That potential is threatened, however, by extremes of deprivation, exploitation, and abuse of children everywhere and by the poverty/population/environment spiral, in which the worst aspects of poverty propel rapid population growth and environmental degradation, which circle round to exacerbate poverty.
- Conversely, mutually reinforcing investments in health, nutrition, basic education, and family planning can create an upward and synergistic spiral of improvements in well-being that would help reduce population growth and alleviate environmental stress. Absent this, social division, economic disruption, political unrest, and reversals in progress toward democracy and international stability can only continue to occur.
- Sub-Saharan Africa is a special case, sliding back into poverty at an average annual rate of 2 percent of per capita gross national product in the 1980s. The population of almost half of the region is now in absolute poverty; malnutrition has quintupled in some areas; health services have declined, despite heroic efforts in immunization; primary school enrollment has fallen; and one-third of all college graduates have left the continent—all in the context of the AIDS epidemic, conflict, environmental degradation, and population growth.
- Improved health is a powerful weapon for attacking poverty, as judged in terms of the economic losses due to specific diseases, returns to investments in water supply, increases in productivity and decreases in lost labor time, greater returns to other forms of investment, decreased medical costs, long-term effects on population growth, or the profound connection between the mental and physical development of children and the social and economic development of their societies.
- Education, particularly for females, means fewer and better-spaced births of offspring who are more likely to survive, be better nourished, and become educated, as well as greater overall capacity for ensuring better family health and managing the environment. Family planning is a major contributor to lower mortality rates among children under age 5, which, in turn, contributes to greater demand for

family planning and significant improvements in health, survival, nutrition, education, and quality of life for both mothers and children.

RECOMMENDATIONS FOR POLICY AND ACTION

The central organizing principle of the post-Cold War era must be managing a transition to a sustainable future, an essential part of which is coming to grips with the great crises of poverty, population growth, and environmental deterioration. Because of their complexity and the synergy among these crises, the developed nations must move cooperatively, with a new ethic of progress, on several broad fronts.

1. Creation of an enabling economic environment through

— agreements on fair and stable commodity prices;
— more open access to markets for manufactured exports;
— forgiveness of significant proportions of debt in selected regions and cases;
— more investment in the health, nutrition, education, and employment of the poorest people;
— rapid progress toward at least primary education for all children, especially for girls;
— improvement of the lives of women in poor communities—their health, education, and status; and
— making available family planning information and services to all who need them.

2. Intensive research efforts, in cooperation with scientists and technicians from developing countries, to develop economies and technologies that can raise living standards and fulfill legitimate aspirations without endangering the biosphere.

3. New definitions of progress in developed countries that maintain or improve the quality of life yet significantly reduce impacts on the environment.

4. Articulation of a special strategy for Africa:

— Debts must be written down.
— The region's trading position must be allowed to become stronger through lower trade barriers to its processed and manufactured goods, creation of an economic diversification fund, and increased aid and investment.

— Military spending by African governments and by those who export arms to the region must decline more steeply.

— African governments must make good on their commitments of greater proportions of revenues to human resources and to basic goals in health, nutrition, education, and family planning.

— The international community should assist Africa in its struggle toward democracy through direct assistance to those policies and institutions that deepen democracy's foundations.

COMMENTARY

The State of the World's Children points to the considerable progress made in fighting the diseases that kill and disable children and lists those that are in retreat: measles, tetanus, polio, diarrhea, and iodine and vitamin A deficiencies. However, it notes other problems: the extreme deprivation and exploitation of children and the abuse of children in war, in the workplace, on the street, and at home, which afflict millions of children everywhere. Even here, however, the report notes a few tentative signs of an emerging new ethic that might one day offer children protection from the perils of the adult world.

Still, achievements in the health of children and the promise of further achievement can only be seen as fragile, set as they are in what the United Nations Children's Fund (UNICEF) terms the poverty/population/environment spiral—the complicated dynamic among poverty, population growth, and environmental degradation. UNICEF sees the global management of that spiral and emergence to a sustainable future as the most complex, difficult transition in all human history.

The responsibility for that management falls to both the developed and developing countries. The most difficult challenge for the developed world will be a redefinition of its own concepts of growth and progress. If the transition is to be made, the developed world will also be challenged by a continuing need to play a major part in helping to resolve the problems of poverty, population growth, and environmental degradation in the developing world. A central point of UNICEF's argument is that it is hard to imagine this occurring in any way but cooperatively and with a fresh definition of progress.

In the context of this *Synthesis*, we are aware of UNICEF's perspective, that is, to locate ourselves along the paths of developmental progress—on the one hand, to be certain of victories that are being achieved, and on the other hand, to ready ourselves for new challenges, particularly when they involve transitions to different kinds of problems requiring entirely different responses.

Health Research: Essential Link to Equity in Development

Commission on Health Research for Development. 1990. Health Research: Essential Link to Equity in Development. New York: Oxford University Press. *The Commission on Health Research for Development, an independent international initiative, was formed in 1987 with the aim of improving the health of people in developing countries through a focus on research, in a belief in its enormous—and, in great part, neglected—power to accomplish that goal. Over 24 months, the Commission reviewed information, implemented a survey, commissioned papers and case studies, and convened regional workshops. The Commission had a multinational, multidisciplinary membership, and its work was supported by a diverse group of 16 donors from Europe, North America, Asia, and Latin America. The report has three sections. The first reviews inequities in health and argues for health as both a beneficiary of and a spur to development. The second presents survey and country study findings related to the financing, focus, location, and promotion of health research. The third presents conclusions and recommendations for action.*

OBJECTIVE

- To analyze health research as a tool for health and development, both for applying solutions already available and for generating new knowledge to tackle problems for which solutions are not yet known.

CONCLUSIONS

- There is a gross mismatch between the burden of disease, whose occurrence is overwhelmingly greater in the developing world, and investment in health research, which is overwhelmingly focused on

the health problems of people in developed countries. Of the estimated $30 billion world expenditure on health research, only 5 percent ($1.6 billion) is devoted to the health problems of people in developing countries, which account for 93 percent of the years of potential life lost in the world.

- Of that $1.6 billion, 42 percent ($685 million) originated in the developing countries themselves; 58 percent ($950 million) originated in the developed countries. However, of the $950 million devoted to research on health problems in developing countries, only $150 million was actually transferred to those countries. Almost half of the research funding on the health problems of people in the developing countries goes to support researchers in developed countries working in their own countries.
- Overseas development assistance (ODA) varies greatly among developed countries, from 0.2 percent of gross national product in the United States and 0.3 percent in Japan, to about 1 percent in Scandinavia. The percentage of ODA invested in health research also varies widely, but overall, it seems to have been static or declining over the past decade, because of economic recession and a decline in ODA in real terms.
- Though some major health problems are receiving attention, others—notably, the policy and social sciences, epidemiology, and management research—are relatively neglected. Biomedical and clinical research initiatives are somewhat stronger, but capacity-strengthening efforts in these fields are modest in scale and are narrowly targeted. Major gaps exist in information, monitoring, and assessment of the evolving health picture.
- Still, the number of international research promotion programs is growing and could form the core of a worldwide health research system. Joint efforts by United Nations agencies are noteworthy, and privately sponsored efforts have been productive, though these are characterized by fragmentation and multiple, narrowly focused research initiatives.
- Although investment in health research in developing countries is impressive, 75 percent of this investment comes from eight large or rapidly developing countries; most developing countries invest little in health research. In those countries that invest little, scientists and institutions are pursuing a range of research activities, but they face serious professional, institutional, and environmental constraints. Coherent research responses to high-priority problems at the national level are limited, and national commitment and international reinforcement for health research, specific actions to tackle constraints, and capacity building and maintenance are, at best, uneven.

RECOMMENDATIONS FOR POLICY AND ACTION

1. The most urgent need is the rapid expansion of country-specific health research through the development of institutional and individual capacities, especially in the neglected fields of policy and the social sciences, epidemiology, and management research. Each country, taking account of its own circumstances, should carefully plan and carry out sustained, long-term programs for essential national health research. The four major components of such a process would be

— research priority setting;
— professional recognition and construction of career paths;
— development of reliable and continuing links between researchers and research users; and
— investment of at least 2 percent of national health expenditures in essential national health research.

2. Recommended priorities for internationally organized research programs are

— expanded support for the World Health Organization's tropical disease, human reproduction, and diarrheal disease control programs;
— rapidly expanded research on acute respiratory infections, emphasizing simple, effective treatment;
— improved methods for case detection, ambulatory treatment, and prevention of tuberculosis;
— national programs to eradicate micronutrient deficiencies, especially deficiencies of vitamin A, iron, and iodine;
— modifiable factors associated with a high risk of diabetes, coronary heart disease, and hypertension;
— behavioral interventions to reduce injuries, sexually transmitted diseases, and substance abuse;
— international collaborative research on mental health problems, emphasizing methods of diagnosing and dealing with the most prevalent and treatable conditions; and
— establishment of sustained international research networks in the most important areas of environmental and occupational health.

3. Humanity's greatest health problems can be addressed most effectively through cooperative efforts by scientists

around the world. Developing and developed countries and international agencies should promote and support establishment of international partnerships and steady growth in collaborative research networks as the main means for mobilizing scientific talent to attack common problems and share research strategies and results.

4. Investment in health research and strengthening the capacities of tropical disease institutes, medical and public health schools, and development studies groups should be elevated to at least 2 percent of national health expenditures in developing countries and at least 5 percent of the health portfolios of development agencies, with greater investments as well by developed country research agencies, foundations, nongovernmental organizations, and the pharmaceutical industry to support research focused on the health problems of people in developing countries, with longer time horizons than is typical for most development assistance projects.

5. Establishment of an independent, objective international mechanism for monitoring progress in health research and, when needed, promoting financial and technical support for research on health problems of the developing world, would provide sustained impetus to the global research enterprise.

COMMENTARY

The analysis of the Commission on Health Research for Development is focused and insistent. There is no doubting the importance of health-related research centered on the problems of developing countries. Far from being a luxury, such research is a particular necessity in those countries, where better health status for more people must be achieved with sometimes painfully limited resources. The Commission identifies equity of opportunity as an overriding, if elusive, goal of development, for which research is imperative.

A large part of the necessary health research will have to be done in the developing countries themselves—to delineate the problems specific to each country and to serve as a basis for policy making and strategy development. Nonetheless, research capacities in those countries are generally quite limited, as are the capabilities for absorbing research findings from elsewhere.

Attention to building such capacities in developing countries has been weak to nonexistent. Neither training nor support for health

research has had the coherence and continuity required and both have tended to be fragmented, short term, and focused on the interests of individual organizations. Moreover, while research on some health problems is well supported, research on other problems of importance remains largely unattended.

The Commission recommends the establishment of an international mechanism to monitor the progress of research on developing country problems and to identify unmet needs. The mechanism would be responsible for monitoring, assessment, convening, and advocacy, but it should not itself be an executing agency. In a way, the Commission has served this function in its own work—an analysis of the situation with respect to research in developing countries and recommendations for strengthening the areas of research to which it would give priority. This recommendation of the Commission to establish an independent mechanism for monitoring and research exemplifies the ways in which the independent sector can ensure progress in other areas of development as an essential component of global governance.

In fact, the Commission envisages something more—a pluralistic, worldwide health research system that will nurture productive scientific groups linked in diverse national and transnational networks to address both national and global health problems.

This interest of the Commission parallels the call in other documents reviewed in this *Synthesis* for international mechanisms to bring greater coherence to the functions of donors and supporters of development-related activities. This raises the following question: How susceptible to international coordination and control are global strategies and programs for supporting health system development, including research?

Global Comparative Assessments in the Health Sector

Murray, CJL, and AD Lopez. 1994. Global Comparative Assessments in the Health Sector: Disease Burden, Health Expenditures, and Intervention Packages. Geneva: World Health Organization. *Underlying the conclusions of the 1993 World Development Report is a series of comparative economic, epidemiologic, demographic, and institutional analyses undertaken collaboratively by the World Bank and the World Health Organization. Many of these analyses present original data and interpretations, and most are lengthy and somewhat technical. To make these analyses more widely and readily available to the policy and scholarly communities, the authors summarized their results in a series of eight papers, reprinted in this volume. The first four papers present details on methods and assumptions used to quantify the global burden of disease and the findings from that quantification. The remaining four papers present the methodology used for comparative assessment of the financial resources available to the global health sector, the results of that assessment, the range of intervention options that can be purchased with these resources, and a method for using information on the burdens of different diseases and cost-effectiveness analysis to identify packages of cost-effective health care. Because this compilation has two parts, our analysis is slightly longer than most of the others in this report.*

OBJECTIVES

- To provide the conceptual and empirical underpinnings for the 1993 *World Development Report* and to make the best possible use of available data by assessing information from a common perspective.
- To develop a methodology for measuring the global burden of disease that would account for morbidity as well as mortality.
- To quantify public, private, and total expenditures on health for

all countries and to analyze trends in volumes and allocations to specific activities.

• To consider alternative allocations of resources on the basis of the burden of disease, health resource availability, and intervention cost-effectiveness.

CONCLUSIONS

the global burden of disease

• Despite an uneven and sometimes flawed database, there are clear and profound differences in cause-of-death structures between developed and developing regions. Of the 50 million deaths worldwide each year, 39 million (78 percent) are in developing countries. Communicable, maternal, and perinatal causes account for 40 percent of those deaths, whereas these causes account for only 5 percent of deaths in developed regions.

• Injuries cause roughly equal proportions of deaths in both developed and developing countries and are invariably more common in males than in females. Their relative importance in cause-of-death structures varies, from greater importance in Eastern Europe, Latin America, and China to lesser importance in developed countries.

• Major challenges in the developing world are inherent in the disease burden on children ages 0 to 14 and are well known: perinatal conditions, diarrhea, acute respiratory infections, measles, malaria, tetanus, and pertussis. Other diseases, notably tuberculosis, syphilis, and meningitis, produce large disease burdens throughout the life span but are underappreciated as causes of mortality.

• Still, the noncommunicable diseases are already the leading causes of death in the developing world, where they account for one in two deaths, and where the *risk* of death from those diseases is much higher than in the developed world. There is more disability from noncommunicable causes in India alone than in the entire group of established market economies. Only in the Middle Eastern Crescent and sub-Saharan Africa are communicable, maternal, and perinatal diseases more important than noncommunicable diseases.

• There are some startling mismatches between the burden of disease by cause and international efforts in research and health policy analysis: many of the causes of disease burden in developing countries receive grossly disproportionate attention in international public health forums.

resource allocation and development assistance

- In 1990, the world spent $1.7 trillion on health, or 8 percent of global gross domestic product (GDP). The established market economies accounted for more than 87 percent of that amount, with the United States alone accounting for 41 percent; the developing countries accounted for 10 percent. Of global health spending, 60 percent is from the public sector, and 40 percent is from the private sector.
- There is a virtual dichotomy between per capita health spending in the established market economies and the rest of the world, ranging from $1,859 in the United States to $11 in India.
- All external assistance (overseas development assistance [ODA], multilateral loans, and nongovernmental flows) to health sectors in developing countries in 1990 amounted to $4,800 million, 82 percent of which came from public coffers in developed countries and 18 percent of which came from private households of those countries.
- Of those resources 40 percent flowed through bilateral agencies, 33 percent through United Nations agencies, 8 percent through the World Bank and regional development banks, 17 percent through nongovernmental organizations, 1.5 percent through foundations. The share of external assistance from the bilateral agencies began to decline in the mid-1980s, whereas the multilateral contribution (especially that from the World Bank) has more than quadrupled.
- In 1990, 9 percent of all external assistance was allocated to the health sector. That assistance was most important for Africa, which got the largest share of donor support and the highest per capita allocation. In 1990, 20 percent of all health expenditure in sub-Saharan Africa (excluding South Africa) came from external assistance. Yet, for all developing countries, external assistance represented only 2.8 percent of total health expenditures. In no region outside Africa did ODA surpass 1.6 percent of total regional health expenditures.
- Total external assistance for population activities was $936 million, about 20 percent of all health sector assistance. Sixty percent of that amount flowed from bilateral agencies, and although in absolute terms the United States has been the largest single bilateral donor, its share fell from 88 percent in 1972, to 55 percent in 1980, and to 32 percent in 1990.
- Trends in overall ODA over the last two decades are clear. Between 1972 and 1980, there were steady annual increases; in the next 5-year period, levels remained constant in real terms. Although the

years between 1986 and 1990 again brought steady annual increases, the rates of increase were half those of the 1970s.

- Of the 18 member countries of the Organization for Economic Cooperation and Development, the biggest contributors of ODA to the health sector relative to their own national GDPs in 1990 were Norway (0.159 percent), Sweden, Denmark, Finland, and The Netherlands. Germany, Japan, Austria, and New Zealand (0.006 percent) provided the least. The United States ranked 13th among the 18 countries, with its 0.02 percent of GDP close to the percentages contributed by Italy and the United Kingdom.
- Countries vary greatly in the way that they channel external assistance funds. The United States, Italy, France, and Belgium disburse the majority of funds through direct bilateral channels; most others channel about two-thirds through multilateral agencies and one-third through direct bilateral projects.

relationships between resource allocation and disease burdens

- Measures of health status do not inevitably correspond with aid volumes. Half of health assistance goes for infrastructure development via grants for health services and hospitals, and half goes for specific health programs—19 percent to specific health problems, 9 percent to nutrition programs, and 20 percent to population activities.
- There are some striking disproportions in funding for specific health problems in terms of the burdens that they produce. Using the Disability-Adjusted Life Year (DALY) as a metric, the best funded—leprosy, onchocerciasis, other tropical diseases, sexually transmitted diseases and human immunodeficiency virus infection, and blinding conditions—get around $4 per DALY; the immunizable diseases, malaria, and trachoma get a little over $1. Acute respiratory infections, which produce by far the largest DALY burden in the developing world, get $0.015 per DALY and noncommunicable diseases and injuries, which produce 50 percent of the disease burden in developing countries, get less than $0.05 per DALY.
- A minimum package of highly cost-effective public health and clinical interventions that address the main sources of disease could be provided in low-income countries for about $12 per person per year (more than is now spent in the poorest countries) and for about $22 in middle-income countries (where it is affordable at current expenditure

levels). Properly delivered, this package could eliminate 21 to 38 percent of the burden of premature mortality and disability in children under age 15 and 10 to 18 percent of the burden in adults.

RECOMMENDATIONS FOR POLICY AND ACTION

1. The mismatch between international efforts in research and policy analysis and the individual causes of the burden of disease suggest that it is time to review the international health research system, attending carefully to the relationships between disease burden and the current availability of cost-effective interventions.

2. For the global burden of disease and DALY to be better tools for policy and program determination, more research and methodologic development are needed in the following areas:

— increasing the number of conditions included in the global burden of disease;

— studying those conditions that cause many years of disability and designing methods for prospective monitoring of disability on a sample or a general basis;

— developing simple methods to account for comorbidity;

— improving the mapping from disease to impairment to disability and better quantifying the cost-effectiveness of health interventions for preventing or treating disability; and

— extending the burden-of-disease approach to assessments of contributions from environmental factors and individual behaviors in the causation of disease and injury.

3. Regional disability patterns should be seen as highlighting foci for health protection interventions by age, sex, and cause. Despite data limitations (which should be neither overnor underestimated), the numbers are large enough even at this early methodologic stage to identify some clear priorities.

4. If information on the burden of disease is found to be useful as a baseline for health policy makers, the logical next step is to assess the overall performance of the health sector in terms of trends in that burden.

5. Given its proportion, external assistance to the health sector must be seen realistically as functioning at the margin, not as the centerpiece of developing country economies. As such, its most powerful effects might be capital formation, policy formulation, and, in those connections, research and capacity building.

6. Because no single database permits a comprehensive view of external assistance to the health sector, some international mechanism needs to be established that will provide such a view through regular, consistent monitoring of health expenditures at the national and international levels.

COMMENTARY

This compilation of interrelated analyses contains the only available comparative assessments of cause of death, disease burden, health expenditures, and international aid for health. It is therefore a unique resource for policy analysts and scholars. The processes preparatory to these analyses also served to identify and mobilize a broad network of national and international expertise. Finally, the methodology as a whole serves to level the playing field so that decisions about priorities are based on objective realities rather than personal or political vested interest.

The preparation of these analyses also clarified what has long been the case: the existence of significant gaps, if not chasms, in international and national systems for gathering, analyzing, and distributing policy-relevant comparative data. Without information on how levels and trends in key indicators in their own countries compare with those in other countries, those intent on health sector reform will continue to lack any reasonable basis for policy determinations and planning strategies and programs, or any benchmarks for judging performance. Students of health systems will lack an empirical basis for making judgments on which policies work and which do not in developing and developed countries, including the United States. Reliable information on global and regional mortality and disability by cause are essential to managing health sector activities; determining financial and human resource allocations; balancing apportionments of all resources among different categories of disease; and deciding on the levels, types, and focus of research activities.

The DALY indicator can be very helpful in assessing the combined burdens of disability and premature mortality, and doing so by age

and sex across a wide variety of disease categories and geographic regions. The DALY's development has been—and undoubtedly will continue to be—somewhat embattled, as has every past effort to develop composite indicators that go beyond measuring mortality. The conceptualizers of the DALY have been at some pains to state that it is one more step in a process, not some ideal methodologic endpoint, and have invited critical comment as a way to enhance its utility. At the same time, the DALY advances the field by incorporating several new features. First, it explicitly incorporates some ethical dimensions and value choices by taking into account the meaning of loss of welfare and the implications of time lived with a disability, weighing the severity of the disability, treating health outcomes equitably, and measuring the value of human life at different ages by using an exponential function that reflects the dependence of the young and the elderly on adults. The inclusion of these value choices serves to make the indicator applicable across a wide range of environments, by age group and by gender. For comparable reasons, the indicator can also be used in conjunction with the literature on cost-effectiveness of health interventions. At the same time, it is primarily these value choices that are at the heart of the ongoing debate about the DALY approach.

The analysis of changes in distributions of global health expenditures and flows of external assistance to the health sectors in developing countries raises large and challenging questions, especially when the relative volumes of those expenditures are poised against the structure of the global burden of disease. For example, given its small size relative to overall health expenditures in developing countries, what is the appropriate role for external assistance and how can that role be maximized realistically, respectfully, and usefully? What will be the effects of the de facto shift in the ODA portfolio away from bilateral dominance to dominance by multilateral banks? What might be said about the small proportion of GPD in the established market economies that is dedicated to ODA, recognizing that some of those countries have their own economic problems and that previous attempts to seek global formulas and standard funding commitments have been almost totally unsuccessful? What might be done about the lack of compatibility between the burden of certain diseases or conditions and the corresponding proportions of ODA and research dedicated to them?

Partnerships for Global Development: The Clearing Horizon

Carnegie Commission on Science, Technology, and Government. 1992. Partnerships for Global Development: The Clearing Horizon. New York: Carnegie Corporation of New York. *This report is one in a series of documents whose purpose is to strengthen the institutions and decision-making processes by which the use of science and technology is connected to world affairs. A number of workshops, research efforts, analyses, and consultancies involving leaders of industry, governmental and intergovernmental foreign assistance programs, major private voluntary organizations, workers in the field, and scholars of development furnished the underpinnings for the report.*

OBJECTIVES

- To define as the central goal of development the realization of the full potential of all individuals in all societies in a way that enlarges the range of people's choices and makes development more democratic and participatory without compromising options for future generations.
- To analyze the dissonance between changes in the world over the past three decades and the institutional and legal framework of the United States' approach to development cooperation, little changed since the 1960s.

CONCLUSIONS

- Beneath waves of political change have been sustained material growth and improved welfare in developing countries. Growth was spurred by fundamental changes in economic structure, so that those countries are no longer simply sites where natural resources are mined:

Now more than half of developing country exports are manufactured goods, up from 26 percent in 1965.

• Underlying economic and social advances are progress in science and technology. To capitalize on these opportunities for developing countries, much more widespread application of science and technology is needed in the manufacturing and service sectors and in the creation of an educated, skilled workforce.

• **U.S. interests include a range of factors:**

— *Moral interests*. Generosity and humanitarian concerns are a hallmark of American values; global partnerships lead to learning and action, at home and abroad.

— *Economic interests.* Global prosperity is crucial to continued prosperity in the United States. In 1950, exports and imports accounted for less than 5 percent of the U.S. gross national product; in 1990 they made up 28 percent. Between 1986 and 1990, exports accounted for 41 percent of growth in the gross domestic product; in 1990 alone, they accounted for 88 percent.

— *Security interests.* These are linked to four core, interactive, and interdependent areas: advances in democracy; economic and social progress; reduction of conflicts within and between nations; and environmental security.

— *Scientific interests.* The progress of science requires cooperation. Though science and technology have had limited roles in past cooperation for development, they will be necessary factors in the future.

RECOMMENDATIONS FOR POLICY AND ACTION

1. Principles of balanced institutional development. The most fundamental principle of cooperation for development is to foster the balanced development of the public, private, and independent sectors; pluralism within these sectors; and creative interaction among them.

2. A balanced approach. For much of its history, development assistance has emphasized only one sector or approach, with predictable shortcomings in the results. Cooperation for development must encourage balanced evolution in societies of the knowledge, organizations, and decision-making processes used in each of the above sectors. In all of these, science and technology play essential roles.

3. Critical roles of science and technology. Science and technology are enabling tools in a responsive marketplace. They enhance flows of information that lower costs and guide entrepreneurial energy, underpin innovation, and facilitate the creation of new public services and products in response to individual choice and freedom. They are indispensable to a healthy independent sector, providing balance for what is retained by more powerful interests and fostering a culture that need not take received wisdom for granted.

4. Criteria for selection, design, and conduct of programs.

— *Favorable policy environment.* Most important for development initiatives are fiscal and monetary policies that promote noninflationary, sustained economic growth; trade favoring competitive excellence in domestic industry; efficient use of resources; and protection of property rights.

— *Ecological and social sustainability.* Today's choices about economic and social development expand, rather than restrict, the choices available to future generations.

— *Building capacity to solve future problems.* An essential aim of cooperation in development must be to enable partners to make and act on their own choices.

— *Partnerships as the premise.* Partnerships forged between countries should be such that the expectations of the partners are clear, each has something to gain, each has a clear responsibility, and each is accountable for progress toward goals in the program.

5. Determinants of current government program content. The report is sharply critical of three considerations that set the basis for U.S. government development assistance:

— *Earmarking.* Congressional earmarks or "functional accounts" reserve monies for issues favored by particular domestic constituencies and interest groups. This process has created such de facto priorities as agriculture, child survival, and women's programs. About 85 percent of the current U.S. foreign assistance budget is locked by earmarking processes into specific sectoral programs or countries.

— *Dated definitions of needs.* Since legislative action in 1973, the major U.S. foreign assistance priority has been "basic needs": food and nutrition, population control and health, and basic education. This formulation has been applied globally to developing countries, and the definition of "basic needs" has not altered in 20 years, despite striking changes in the world and the status of many countries.

— *Obsolete geography.* Most U.S. government development pro-

grams group nations by geography alone rather than by economic or social criteria. For example, Thailand has more in common with Brazil and Mexico from a development perspective than it has with its neighbors, Laos and Cambodia.

6. Resulting mismatch. These determinants, in combination, limit the effectiveness of U.S. cooperation for development, most critically in the specification of expenditures for particular countries and sectors. This drives programs to respond to legislative requirements rather than to the conditions in the country. Thus, though the nature and level of U.S. development cooperation are, in that sense, largely predictable, the problems to be addressed often are not.

7. New approach. Entirely new approaches are needed. The critical international boundaries are not geographic, but economic and social. Development programs must be updated to recognize diversity among developing countries and their problems as their economies and societies evolve. This implies the following:

— *A full spectrum of partner countries*. This includes the economically advanced, middle-tier, and poorest countries.

— *Adaptive programs.* This means flexibility according to development needs as seen by the countries, rather than according to a few centrally chosen formulas.

— *No more "top-down" management*. The blunt instrument of top-down management is antithetical to the concept of development cooperation based on partnerships.

8. Bottom line. Rapid and widespread change logically requires that the United States unbind its approaches to cooperation for development and adapt them to new landscapes of political, economic, and technologic opportunities. Cooperative development programs must effectively balance growth with equity, management with participation, large-scale with small-scale endeavors, and global campaigns with local needs.

COMMENTARY

The Carnegie report brings a clarifying perspective to the larger concepts of development. Although much of its content is devoted to concerns for the U.S. government's overall approach to development assistance (with which we do not deal here), the Commission's overall analysis of the development arena and its recommendations are rel-

evant to broader international concerns about cooperation for development. It is on these issues that we will focus this commentary and later reflections.

The report's rationale for partnerships for global development is succinctly stated: "The most fundamental principle of cooperation for development is to foster the balanced development of the public, private, and independent sectors, pluralism within these sectors, and creative interaction among them."

A central part of the report's analysis is its depiction of the ways in which patterns of development have been shifting away from bilateral and multilateral modes of development assistance that focus on yesterday's patterns whose relevance is diminished. Striking changes have been taking place in the global development environment, particularly in the increasing diversity among developing countries and the range of their needs as they move ahead in their development trajectories. Thus, a fully fresh conceptualization of development is required—in objectives, components, participants, processes, and context, whether those are local, national, or global.

In keeping with its broad-spectrum view of diversity, the report urges the involvement of developing countries at all levels—advanced, middle-tier, and poorest—consistent with the view that countries at different levels need different approaches that are tailored to the unique characteristics of each and encompassing the public, private, and independent sectors functioning interactively. The report underscores the value of science and technology as contributors to those sectors: science and technology are crucial enabling tools in a responsive marketplace and indispensable to a healthy independent sector.

The report confirms the strategic importance of a vigorous U.S. response to the challenges of underdevelopment. The social, economic, and humanitarian benefits to the United States are great; the cost of not addressing them could be tragically high.

Strategies for Sustainable Development

U.S. Agency for International Development. March 1994. Strategies for Sustainable Development. Washington, D.C.: U.S. Agency for International Development *The Foreword to this document notes that these papers reflect a great deal of work and wide consultation with members of U.S. Congress and congressional staff, representatives of other U.S. government agencies, members of the development community, and the U.S. Agency for International Development's (USAID's) own experts, in the United States and abroad. It presents an integrated approach that defines long-term objectives, specifies their relevance to U.S. interests, describes the ways in which those objectives are to be pursued, and identifies mechanisms that can be used to implement the approach and standards for measuring success. This document was distributed in March 1994 and the policies and programs of USAID could be expected to change over the time that has elapsed. Nonetheless, the document is included as a thoughtful piece of analysis feeding into a rapidly changing policy environment.*

OBJECTIVES

- To cope with threats to peace, stability, and the well-being of Americans and people throughout the world.
- To constructively address the pollution of the seas and the air, overburdened cities, rural poverty, economic migration, oppression of minorities and women, and ethnic and religious hostilities.
- To articulate a strategy for sustainable development in partnership with those whom USAID assists.

CONCLUSIONS

- Threats to development come from many sources: continuing

poverty; population growth and rapid urbanization; inability to read, write, and acquire technical skills; new diseases and endemic ailments; environmental damage; and absence of democracy.

- Americans cannot isolate themselves from these conditions, which, in one way or another, sooner or later pose a perhaps costly strategic challenge to the United States.
- Effectively delivered, development assistance is a powerful means of addressing, ameliorating, and even eliminating the problems of rapid population growth, environmental degradation, endemic poverty, debilitating hunger, mass migration, and anarchy.
- This work is both altruistic and self-interested. Successful development creates new markets for exports and promotes economic growth in the United States, and America's poor increasingly benefit from development methods that have been pioneered abroad.

RECOMMENDATIONS FOR POLICY AND ACTION

1. Operational approaches

— Sustainable development. Sustainable development is economic and social growth that does not exhaust the resources of a host country; respects and safeguards its economic, cultural, and natural environments; creates incomes and chains of enterprises; and builds indigenous institutions that involve and empower the citizenry.

— Partnerships. Sustainable development is built on a sense of ownership and participation. It will be increasingly implemented by nongovernmental organizations, whose effectiveness depends in large measure on their institutional autonomy and protection from USAID micromanagement. The active participation of private enterprise will also be encouraged.

— Integrated approaches and methods. The fundamental building block of USAID's programs will be integrated country strategies that take into account the totality of the development problems confronting a society, developed in close cooperation with host governments, local communities, and other donors.

— Areas of concentration. USAID programs will focus on three kinds of countries: (1) sustainable development countries, where assistance is based on an integrated country strategy with clearly defined program objectives; (2) transitional countries, which have recently experienced a national crisis or a significant political transition, where timely assistance is needed to reinforce institutions and national order; and (3) countries where aid to nongovernmental sectors

may facilitate emergence of a civic society, alleviate repression, and meet basic humanitarian needs.

2. Programmatic areas fundamental to sustainable development

— ***Protecting the environment*** by reducing long-term threats to the global environment, particularly climatic change and loss of biodiversity, and promoting sustainable economic growth locally and regionally by addressing environmental, economic, and developmental practices that impede development or that are unsustainable.

— ***Building democracy*** by focusing on problems such as human rights abuses, lack of experience of democratic institutions, and disenfranchisement of women and minorities, and by concentrating on building local democratic capacities and on appropriate technologies that can be maintained locally.

— ***Stabilizing world population growth and protecting human health*** by concentrating population and health programs in two types of countries: those that contribute the most to the global population and health problems and those where population and health conditions impede sustainable development.

— ***Encouraging broad-based economic growth*** by emphasizing (1) strengthening markets, including improved governance and local empowerment; (2) expanding access and opportunity, including small business development and microenterprises; and (3) investing in people, including enhancing education for the poor, women, girls, and minorities, and providing market-oriented technical and vocational training.

— ***Aiding in postcrisis transitions*** by providing humanitarian assistance that saves lives; reduces suffering; helps victims return to self-sufficiency; reinforces democracy; and includes disaster preparedness and mitigation, timely delivery of disaster relief, preservation of basic institutions, and building and reinforcing local capacity to anticipate and deal with disasters and their aftermaths.

— ***Measuring results***. Inputs are meaningless without reference to effects, so that the success of foreign assistance is measured by its impact on nations. USAID will measure results by asking how programs achieve discrete, agreed objectives. This forces all involved to focus on how projects actually affect how people live and to distinguish between self-sustaining and ephemeral accomplishments.

COMMENTARY

Strategies for Sustainable Development begins by acknowledging the profound changes under way—a social, political, and economic metamorphosis throughout the world—and states that USAID has redefined its mission and charted a plan to achieve it.

The key shift in emphasis is to sustainable development, defined as development that permanently enhances a society's capacity to improve its quality of life and enlarges the range of freedom and opportunity, day to day and generation to generation. When sustainable development is the goal, the focus moves from projects to the web of human relationships affected by those projects.

Given its commitment to sustainable development, USAID sees the fundamental building block as integrated country strategies that account for the totality of development problems confronting the society. These strategies are to be formulated in partnership with host governments, communities, and other donors and are to consider how social, economic, political, and cultural factors combine to impede development.

In short, the focus is not on discrete problems but on development, recognizing that the mix of factors that impede or support development will differ from country to country and can be effectively addressed only in the context of each country and in partnership with the people of that country. The emphasis is on three types of countries and four types of programs, in each instance proceeding to where help is most needed and where it can make the most difference. This "matrix" of countries and programs provides considerable flexibility, as well as opportunities for targeting by need. The fundamental thrust is toward building indigenous capacities; enhancing participation; and encouraging accountability, transparency, decentralization, and the empowerment of communities and individuals.

II

The Documents Considered: Reflections and Implications

The Documents Considered: Reflections and Implications

INVITATIONS TO FURTHER INQUIRY

This *Synthesis* has reviewed 10 reports, each of which makes a valuable contribution to health and social development. Each document presents a distinct set of concepts, methods, and strategies, and raises questions about how its recommendations are to be made operational and what factors might help or hinder those processes. Each also raises concerns that stand on their own as crucial questions in health and social development but that remain inadequately explored or essentially unresolved. We think of these as "invitations to further inquiry" and have identified 10 such ideas or themes that emerged, explicitly or implicitly, in the group of documents taken as a whole. Our premise is that these are "hinge" issues for considering the future of global health.

Changing Dimensions: New Needs in Development

At a meeting held in Ottawa in 1993 whose purpose was to start following up on the *World Development Report (WDR):* the World Bank and World Health Organization (WHO) advanced the position that, although generic methods and models can be enormously helpful, no universal solutions to health development are applicable to all countries. Because individual countries are proceeding along individual development trajectories, with growing diversity in their patterns of

development and needs for development assistance, those "individualities" must be recognized and solutions must be tailored accordingly. In other words, unidimensional patterns of development and development assistance are yesterday's patterns. In the view of the participants, this meant that two new "needs" must be taken into account:

- A need for international agencies to change their development support strategies to include greater attention to building local capacity for policy reform and implementation, so that countries can formulate development strategies that are appropriate to their own needs; and
- A need for international agencies to move their development support strategies away from independent and often isolated approaches toward closer collaborations with one another, whether on a regional or a global scale, so that whatever is done is more coherent and more effective.

Like most development ideas, neither of these is wholly new, but taken together, they are a persistent message throughout the *Synthesis* documents about new ways of doing development business. The broadest area of further inquiry is: How to do it?

Models and Methods: Going Beyond the Generic

The documents that we reviewed present approaches with real potential for health development, but being generic, they are hard for many countries to absorb. Overcoming this disjointedness between some generic ideal and national specifics raises questions about how to achieve the flexibility and adaptability that will be needed by those who offer these approaches and those who want to use them.

Implementing Change: What Are the Issues, and What Skills Are Needed?

Achieving better health for national populations demands the ability to analyze, formulate, and implement policy. Implementation presents especially complex challenges for the least-developed countries, where decision makers must act with resources that are limited in every respect. As concepts and methods evolve, special attention will have to be paid to how the most useful and relevant of these tools can be absorbed into the development processes of those countries best able to benefit from them. Other countries will need help in building basic capacities for both the independent and collaborative application

of new development tools; thus, the producers and promoters of such tools must be alert to what sorts of basic, country-based capacities will be required.

Defining a Country-Based Agenda

Key areas of support would include organizational, managerial, and financial innovations to support more equitable and cost-effective health systems. WHO suggests four categories in which assistance could be particularly helpful: broad policy formulation, priority setting, assessments of existing health systems, and design and implementation of system change. The first two categories have to do with improving transparency and rationality in policy making; the remaining two have to do with more adaptive and pragmatic issues of institutional assessment and improvement.

Partnership for Health System Reform: Collaboration and Networks

A pivotal question has to do with the extent to which members of the international development assistance community might join in collaborative approaches to speeding up the pace of reform, particularly in countries in greatest need. A range of possibilities is suggested, from networks for sharing information and ideas to the explicit establishment of a dedicated international forum on capacity building for health system reform. It could be asked whether the sense of mutual confidence among the international players is sufficient to warrant a strongly structured forum, especially with any one agency in the lead, or whether a more widely acceptable direction might be shared leadership and agenda setting. How this question is settled will have much to say about possibilities for new directions in development assistance.

WDR Methodologies: Contributing to Global Mechanisms

The emergence and reemergence of infectious diseases as major epidemiologic players, on the global stage have raised the need for global mechanisms very explicitly. A multidonor-sponsored meeting in Bellagio, Italy, in 1993 and a growing number of meetings since then have centered on elaborating mechanisms for bringing the research, disease control, and donor communities into coordinated action around these problems. More generally, the Bellagio meeting also pressed for ways that the methods and analytical framework of the *WDR* might be used in the fashioning of national and global action

agendas. The basic premise was that the content of the *WDR* is too important to be left to find its own way to where it is needed most, yet its applications are too complex for developing countries to absorb easily. The urgency of a shift toward global coordination among donor agencies is fully expressed here, with the suggestion that the coordination be among the research, control, and donor communities and between essential national health research and global health research activities. The meeting then focused on how applications of the *WDR* could lead to global strategies and methods for coordinating international resources and recommended the following:

- that the international health community take *WDR* as the basis for formulating national and global action agendas and that the conceptual and analytic frameworks of that document be used as the foundation for the creation of a global health system dedicated to objectively identified priorities;
- that a global health information network be established to help collect, analyze, and interpret data on the absolute and relative burdens of threats to health at the local, national, and global levels and on the effectiveness and costs of interventions and systems intended to reduce those threats;
- that national and global mechanisms be put in place for formulating research priorities according to the burden of disease, adequacy of response, and risk factors for multiple infectious diseases, since there is no mechanism for setting global health research priorities that could complement national health research efforts;
- that there be mechanisms for strengthening coordination among the research, control, and donor communities to increase the efficiency of resource allocation and return on investment; and
- that an initiative funded by the World Bank, WHO, the United Nations Children's Fund (UNICEF), and the United Nations Development Programme be put into place to carry out and oversee the recommendations of the *WDR* and the Bellagio meeting and to take responsibility for leading the implementation of the *WDR* recommendations.

Work has advanced since the Bellagio meeting. Articles describing the methodologies and preliminary results of an implementation team comprising representation from the WHO, World Bank, and the Rockefeller Foundation have been published. The Pew Charitable Trusts is pursuing an endeavor entitled Foundations for Global Research. Several countries are attempting applications of the burden-of-disease methodologies in their own national settings, and there is an informal network that is sharing the findings and evolving ideas

emerging from these applications. Networks of various sorts are also coalescing around the subject of emerging diseases.

The Health Transition: Waiting for Attention

The question of what has come to be called the "health transition" that is occurring as a consequence of demographic and epidemiologic changes is widely recognized internationally as a dominant theme in development processes, since countries and agencies alike must characterize these transitions and readjust policies, technologies, and programs to accommodate them.

Because of the changes in population structures as more of the world's populations survive to live longer and experience the disabilities and chronic diseases of greater age, the study of the health of adults in developing countries makes the shifts in the determinants of disease and the consequent changes in epidemiologic patterns plain to see. It also points to the extent of the shortfall in the responses to those changes. The study of flows of overseas development assistance to the health sectors in developing countries and their relationships—or lack of relationships—to some of the realities of disease burden reveals major gaps between resource allocations and significant epidemiologic needs.

These authors point to a research and policy vacuum at many points along the continuum from the collection and analysis of fundamental data through every stage of program implementation. There is the intimation that these matters are urgent: With rising demand for care emanating from vulnerable and politically vocal adult populations, there is a distinct risk that choices will be made, under pressure, in ways that are erratic and perhaps unwise and that these choices will sometimes be difficult to reverse.

There are at least three critical questions: How can existing health care arrangements be modified to incorporate responses to the problems of transition rather than creating new and separate mechanisms? How can this be done without prejudicing the unfinished agendas for the care of mothers and children and the control of communicable diseases? And to what extent can the handling of these transitional problems be facilitated by stronger mechanisms for international coordination?

Coping with Violence: Rising Problem, Complex Response

Violence is a new topic for health sector attention and it is mentioned in virtually every document that we reviewed as an area of

mounting concern. Violence—in the home, in communities, on the streets—is rising in frequency, variety, and virulence and is one of the most complex public health problems that the world faces. No setting or level of society appears immune, yet the social, economic, and political impact of violence, its prevalence, and its determinants are not well understood. The documents which address the topic of violence point to poverty, marketing of drugs and arms, social instability, discrimination, hopelessness, abrogation of human rights, population displacements, and lack of opportunity. The classical public health approach—define the problem, identify risk factors, develop interventions, take action, evaluate—may be as valid here as with any public health problem, but the social, economic, cultural, environmental, political, psychological, and educational parameters are different. Because understandings here are so indeterminate, diverse kinds of science and partnerships with real communities would seem to be essential. Because developed countries are in no way free of violence, understanding and addressing it is an area apt for international sharing and interdependency.

Strengthening Health Systems: The Necessary Pathway

Some of the documents reviewed give limited attention to health system development, yet the health care system is a necessary pathway for bringing health care interventions to populations in need. A key challenge for every health system is how to address the matter of equity and how it is to be defined, an issue raised in both the 1993 *WDR* and the WHO *Ninth General Programme of Work*. The WHO definition emphasizes the output side of *equity* and defines it essentially in terms of *in*equity, that is, as objective differences in health status that are unnecessary, avoidable, and therefore unjust. "Equity" may also be applied conceptually to the input side, for instance, universal coverage, health care according to need, or provision of equal access to health care. It may refer to some process of bringing health care to the most fundamental level, which implies a basic set of preventive and curative health services and referral processes that reach every community and, ideally, every household. It may be considered relative to cost and quality, or it may be scrutinized in connection with specific system components; for example, *Health Research: Essential Link to Equity in Development* stresses the centrality of research in equity-oriented health systems in each of these components.

However elusive the concept of equity and its achievement may be in the health sector, it generally includes some notion of health system components that can embrace defined populations, identify those in

greatest need, and extend care to them in an appropriate context of financing, quality assurance, and cost containment. In the discussions of health system reform that appear in most of the documents analyzed, cost containment is a dominant theme, always with a caveat about the risk of compromising other qualities of care. Thus, the point can be made that issues of equity become more and more complex as health systems differentiate. Health care reform in various shapes—changing government roles, greater privatization, and a more active independent sector—will have to be monitored not only for effectiveness and efficiency but also for equity, since pressures for reform can overwhelm concerns for the last of these.

Universities and Nongovermental Organizations: Essential Partners

A theme pervading all the *Synthesis* documents is the urgency for collaborative partnerships. Governments and international organizations are obvious partners, and the private sector receives increasing encouragement, but universities and nongovernmental organizations (NGOs) receive less attention. Many universities are serious players in health and social development and have traditionally contributed to the health sector, in health system research and education, research on health problems that governments have been unable to contain such as infectious diseases, and training programs to support specific health care programs. In each of these roles, universities have worked with governments or with NGOs in the capacity building that is repeatedly emphasized in all of the documents.

Nongovernmental organizations—international and indigenous—are also traditional players, committed to working at the grass roots, and are generally seen as trusted partners. As governments realize that they cannot do all that is developmentally necessary, they have turned outside the public sector for complementarity. The *Human Development Report* singles out NGOs for special mention and points to their clear impact in advocacy on behalf of the disadvantaged, the empowerment of marginalized groups, reaching the poorest, and providing emergency assistance. All will be highly relevant, if not essential, as development agendas shift and as governments increasingly decentralize services and emphasize community involvement and capacity development.

Ethics and Human Rights: Expanding Concerns

Issues of ethics and human rights surface in different ways in the

Synthesis documents, for the most part indirectly, in the context of the meaning of equity in relation to health care and, possibly, its "rationing"; in connection with ideas about community participation, including community participation in research; relative to differential values placed on human lives in quantifying burdens of disability and mortality; and in the context of human rights violations as determinants of disease and injury, notably issues concerning the status of women, such special disease conditions as human immunodeficiency virus (HIV) infection and AIDS, and the generation and consequences of violence. Extension of these issues will eventually involve bioethical concerns emerging outside the developing world, for example, decisions on patient care and patient autonomy; truly informed consent; and the tension among the moral rights of individual carriers of infectious disease, disease screening, partner notification, and the safety of communities.

These questions and intimations are proliferating, and some already command international attention. A Global Bioethics Agenda was proposed at the 1994 World Health Assembly, and collaborative approaches to such issues as the ethical ramifications of policy choices—unthinkable a decade ago—are edging to the forefront.

External Assistance: Magnitude and Directions

Part of the burden-of-disease exercise was to group the many components of burden into categories, which could then be used for various comparative purposes. When the burden was sorted into categories of communicable disease, maternal and perinatal causes, noncommunicable diseases, and injuries and these were then matched with resource allocations, it became apparent that, at least according to the best data available as of 1990, some health problems seemed to be receiving disproportionate shares of external assistance compared with their potential contribution to reducing the overall burden. In other words, diseases afflicting a relatively small number of individuals seemed to be getting relatively large allocations, with others getting allocations that were quite small compared with the sizes of the afflicted populations. There were also great disproportions in the structure of external health sector assistance relative to the growing proportions of the global disease burden attributable to noncommunicable diseases and injury. The proportion of all external assistance in 1990 for noncommunicable diseases and injuries combined was just 1.8 percent (1.6 and 0.2 percent, respectively). This amounts to less than $0.05 per Disability-Adjusted Life Year, although those two categories

accounted for 50 percent of all disease in developing countries as of that year.

The *Synthesis* documents that apply the *WDR* DALY metric illustrate its potential not only for measuring the burdens of disease and the cost-effectiveness of interventions but also for illuminating mismatches between those burdens and values and international investments in particular disease entities. The question that remains is how that metric can be made operational in guiding policy formulation and resource allocations nationally and internationally, since its utility—and utilization—will necessarily vary among countries, and, indeed, is still a matter of probing debate. Some countries may be able to apply the DALY measure quite literally; others may see it as primarily of heuristic value; still others may use it as a point of departure toward better ways of focusing and organizing national-level data collection.

Health Research: Large Returns, Small Investment

The 10th idea has to do with global investment in research and development (R&D) for health, a theme in all of the documents reviewed, subdued in some and a focal point in others. The basic contention in all instances is that research pays off in terms of human health in a large and compelling fashion.

Amidst concerns about the hypermedicalization of health and, increasingly, the impact of high technology on the costs of health care, it is easy to forget that it was the R&D investment in vaccines, diagnostics, preventive and curative therapies, contraceptives, medical devices, and drug delivery systems that spurred quantum advances in human health status. It is hard to imagine that these advances would have occurred without that investment. Further, many of these technologies have proved to be, more often than not, cost-effective. It is also true that the discoveries of medical science have evoked powerfully efficacious public policy responses to such general health needs as environmental sanitation and safety, as well as somewhat wiser management of high-risk behaviors by individuals and population groups. Another crucial consequence of health R&D in both the developing and established market economies has been the formalization of a culture of inquiry, the basis in any society for the human and institutional ability to address threats to the health of its population.

There is justifiable concern about the potential of health care reform and cost containment for inhibiting the pace of innovation and its adoption. Still, the momentum of discoveries in genetic research, computer and communications technologies, combinatorial and synthetic peptide chemistry, and recombinant DNA techniques, as well the wid-

ening spectrum of diagnostic possibilities, seems to be well and irreversibly established. The remaining questions—which are large—have to do with how much, how far, how fast, and to whose benefit.

Yet, despite the high past and potential returns to health R&D, the amounts and proportions of external assistance devoted to the health problems of developing countries are erratic; in some cases poorly correlated with the size of disease burdens and the real needs of health systems; and, for the well-being of the global commons, seriously inadequate. This is most unfortunate, for even limited external funding, which may be quite marginal in terms of overall national budgets, can pay off significantly when it is allocated—wisely—to building local research capabilities and executing nationally relevant research. It is this sort of capacity that becomes the receptor for the transfer of health technologies, as well as the generator of indigenous solutions to indigenous health problems. Absent such capacity, it is hard to imagine how the world will deal with the enduring challenges of infection, undernutrition, and unintended fertility; threats of emerging and reemerging diseases; epidemics of noncommunicable disease and injury in industrializing societies; the violence that is shaking so many societies; and the nearly ubiquitous inefficiencies and inequities in health systems.

A NEXT AGENDA: CONVERGENCE, DIVERGENCE, AND CHANGE

This *Synthesis* was motivated in large measure by the perception of an intriguing concordance of thought in a set of documents that were appearing as the Board on International Health of the Institute of Medicine was considering preparation of a report on the state of affairs in world health and the role of the United States in those affairs. In a field fractionated by divergent institutional agendas and intellectual premises, it seemed to us that it might be especially worthwhile to call attention to what was *not* divergent. After all, these documents had evolved from an iteration between theory and practice over several decades through the efforts of many individuals who cared deeply about the furtherance of what we have been calling "international health." As a compendium of collective wisdom and thought about the role, importance, and principles of international health, the documents could be expected to reflect ideas about what had proved to be desirable and effective, as well as ideas about what had been thought to be feasible and appropriate but proved to be less so. Reflections on the full range of these experiences would be essential to any contemplation of what should happen next.

At the outset of this report, we commented that two aspects of the documents commanded particular attention. One was the broad spectrum of constituencies and points of view that they represented; the other was an apparent convergence on what seemed to be key principles and development themes. The latter raised the interesting possibility that the fact of this convergence could, in effect, make the collection greater than the sum of its parts. With this possibility in mind, we proceed here to examine the nature of that convergence, as well as the character of the environment in which it has unfolded.

Zones of Convergence

Principles, Values, and Goals

The Alma-Ata Legacy Although the goal of Health for All has not been accomplished, it has achieved intellectual and practical prominence as an ideal. It was at the International Conference on Primary Health Care sponsored by UNICEF and WHO in 1978 that Health for All was expressed in the key principles of the Alma-Ata Declaration:

- Universal access to health services, with priority assigned to those most in need, to be pursued mainly through basic health services and a strong emphasis on prevention, usually referred to as "the primary health care approach";
- Effectiveness and affordability of services;
- Community involvement, self-reliance, and self-determination in the development of services; and
- Intersectoral action on health-related matters.

In subsequent implementation of these principles, the concept of equity came to be seen as a cornerstone of their central intent. As that concept crystallized, it grew beyond the fundamental notions of equality of access to a focus on those most in need and to the incorporation of some sense of fairness and justice, an orientation applicable in both developed and developing countries. Two later meetings—in Riga, Latvia, in 1988, and again in Alma-Ata, Kazakhstan, in 1993—reviewed progress toward the Health for All goals. Each meeting provided an opportunity for a recommitment to the Alma-Ata Declaration's principles, and at each meeting, participants made it clear that those principles were not a passing exercise in rhetoric destined for policy oblivion but, instead, were permanent fixtures in international health policies and programs. At the same time, equity remains a complex and labile concept with many definitions. A cur-

rent WHO effort to clarify the concept so that equity can be monitored focuses first on the reduction of unfair and modifiable disparities by providing the most vulnerable groups some minimal level of health and social services and second on striving to reduce the size of the gaps in health status and access to health services between more and less privileged groups and areas.

Over the years, the streams of thought from Alma-Ata have been joined by others. Each successive iteration of the *Human Development Reports* and *The State of the World's Children* has called attention to notions of empowerment and people-centered development. The World Bank documents reviewed here repeatedly emphasize equity and propose methods and policy reforms for pursuing it. The WHO, as noted above, is shaping a New Global Health Policy predicated on concepts of equity and solidarity. Throughout all of the *Synthesis* documents runs a theme of health as more than just a function of medicine and as something to be ensured by other sectors and such crucial externalities as education, employment, women's participation in development, safe water and sanitation, and environmental protection. Other organizations and agencies have come to accept these principles and values as synonymous with appropriate development and to incorporate them into development-related programs as a matter of course. All in all, it is hard to remember that, not so long ago, the principles of Alma-Ata were matters of hot and lengthy debate.

Although these principles endure generally unchallenged, there are large changes in the kinds of problems to be addressed through health care and how those are to be responded to in different settings. The *Synthesis* documents make it clear that the Alma-Ata Declaration's principles alone are not the answer: While a system not founded on those principles may fail in its impact, without a system to make them appropriately operational, those principles are empty. The present challenge is to find ways in which the Health for All principles are retained at the same time that the health sytems that they inform must adapt to new societal and epidemiologic requirements. There will be more and more instances in which linking principles with practice will require dramatic departures, well beyond the familiar forms of primary health care, to innovations in policy, finance, and management that can somehow merge the concepts of equity, efficiency, cost-effectiveness, affordability, and sustainability.

Finally, there is the growing momentum around the need to pay attention to matters of biomedical ethics and human rights as imperatives, including such principles as the right to informed consent, protection from harm, the right to beneficial care, and distributive justice,

so that human rights language is more and more prominent in formulations of health and social development.

Tools and Mechanisms

The second zone of convergence is around the demand, relentlessly reiterated in every *Synthesis* document, for building the capacity in developing and developed countries for taking charge of their own development goals and processes. Part of the generation of capacity has to do with transferring the tools, mechanisms, and operational perspectives that make the most sense in terms of their potential for rethinking and recrafting approaches to health development. These candidates are offered:

- The concepts of the global burden of disease and the DALY, for defining changing patterns of disease and related resource allocations to adjust key targets for policy change and action;
- The nurturing of health research, for clarifying those problems that are most pressing and shaping the design and evaluation of interventions in shifting environments;
- Strengthening of capacities for policy making and management and for integrating epidemiology, economics, and the behavioral sciences with newer management methods, information systems, and organizational innovations, to set the stage for grappling with local challenges to health and social development;
- Formation of training "chains" and teams of health personnel, including professional, paraprofessional, and community resources, to bridge the span from technologically advanced facilities to local settings where people's needs are most strongly expressed and where returns on health investments may be realized most effectively;
- Partnerships between the public (government), private (corporate), and independent (universities, NGOs) sectors as critical tools for strengthening a range of national capacities and, most importantly, for grappling with problems beyond the reach of government and in overseeing policies and programs that ensure equitable coverage of populations; and
- Global networks for a range of ad hoc and longer-term activities that could profit from collaboration, for example, research, setting research priorities, expanding information systems, and professional education and practice, to enhance intranational and international capacities for dealing with change.

Each, and therefore all, of these considerations is presented as being essential to a well-balanced and effective approach to health and social development in a changing world. They are organizing devices or, at a minimum, integral parts of capacity building, not as something held by any single organization or nation but as tools to be shared and accessed through different sorts of partnerships.

Priorities

The third zone of convergence has to do with priorities among diseases, hazards to health, and obstacles to development. Although priority setting is most acutely difficult under conditions of instability and scarcity, and although priority setting must vary according to local circumstance and preference, the *Synthesis* documents suggest that there is still a cluster of what might be called "generic priorities," which will likely matter in virtually every situation:

- The utility of applying the global burden-of-disease methodologies to priority-setting processes, defining magnitudes of disease, cost-effectiveness of interventions, and related allocation of resources;
- The importance of the health and well-being of females throughout their life span;
- The concern for the health and well-being of children in particularly volatile environments where mortality is surging, as in areas with high prevalences of malaria, AIDS, tuberculosis, acute nutritional deprivation, and mass displacement of populations;
- New disease patterns associated with the health transition, most particularly the health of adults and the diseases of chronicity;
- The public health significance of violence, a problem long present but increasingly recognized in most countries and requiring deeper understanding in all of them;
- The persistence of AIDS, with its devastating impacts on many populations and its defiance so far of virtually every effort in health and development research, policy, and action;
- The urgency of reforming health systems and their financing and the associated reallocation of resources and restructuring of the systems themselves;
- The requirement for paying special attention to Africa, where the need to reduce suffering and strengthen development is of global concern;
- The need to incorporate ethical guidelines into assigning priorities and choosing those priorities that best respond to criteria of equity and justice; and

- The inseparability of poverty, population growth, and environmental degradation.

This admittedly redundant list is not intended as a formal analysis of priority issues. It is meant to express the fact that contributions to a major body of literature, generated by a variety of agencies and individuals with disparate mandates and disciplinary orientations, coincide in some fundamental view on what areas must not be left untended. That multiple actors have independently come to similar conclusions so that it was even possible to make such a list suggests that the selection of priorities for health and social development might now profit from international dialogue and some shared policy making.

Divergence: A World Awash with Change

We could be lured by our perceptions of convergence into concluding that the future of what we have been calling "international health" is now straight and clear. This would be an incomplete and inaccurate interpretation both of the *Synthesis* documents and of the current environment. Each *Synthesis* document refers to great changes in the climate around international health and notes that in some way those changes motivated and shaped it.

At the same time, the documents do not react to that recognition at the same level. Some urge modifications in analytical and policy approaches to health problems stemming from that altered climate and in the strategies for implementing those approaches. Others insist on radical shifts in the fundamental vision of development and in the factors of change themselves—the very context in which any fresh strategies would be made practice. Yet, none of the documents states that all that is needed is modest retrofitting of what is already being done. All at least intimate that the entire health development endeavor may need to be pursued, in substance and in process, in new ways.

One reason for engaging in the *Synthesis* exercise was to gather up the strands of current thought in the field as a basis for asking "What next?" To answer that, we will first have to challenge the meanings and authenticities of the convergences that we have identified. If the global health agenda is to be reconceptualized, are those areas of convergence adequate as a point of departure and might they constitute a platform for the rethinking process? Or, are the extent and depth of change so great that the past is not particularly instructive as prologue and the value of the *Synthesis* is largely as a picture of where we

have been? How do we preserve what remains pertinent and focus energy on what must be totally redone?

The response to such questions is conditioned by the kinds of changes that we are talking about and whether those are specific to the health sector or are driven by larger, more commanding realities that lie primarily outside of that sector. A look at those realities with the most immediate relevance suggests that the latter case prevails:

- *Changing states of development,* as some countries, like many of the countries of Southeast Asia and Latin America, vault ahead, whereas others, such as those in Africa, fall sadly behind; as formerly socialist states struggle with rocky transitions; and as inequalities, among and within countries, abound and intensify;
- *Changing status and meaning of the "nation-state,"* with proliferation in the sheer number of states; much internal fragmentation and, in some cases, actual failure; and the rising importance of what might be called "non-national actors," that is, class strata and interest groups that have more affinity across national boundaries than they do within them;
- *Changing political and ethnic relationships,* leading to strife, violence, discrimination, massive displacements and migrations of people, and abrogation of a wide range of human rights;
- *Changing access to information* through an explosion of new and expanding communications media, with many more people having greater and easier access to information but multitudes still left out; and
- *Changing health problems and epidemiologic patterns* proceeding from changing global demographic and environmental dynamics, with the aging of populations and the accelerated transfers of all sorts of risks across permeable and fluid national frontiers.

Among the consequences of these contextual shifts are shifts in basic perspectives that have special relevance to the health sector, though they are hardly limited to it. The following are the most important:

- *Changing concepts of "development"* with challenges to the notion that it necessarily leads to progress and stability or that there is some imperative economic model on which it should be based, or that the notion of sustainability is an essential defining component;
- *Changing ideas about development processes,* for instance, people-centered development and other responses to democratization

and the tension between such ideas and more market-centered orientations;

• *Changing organizational structures and management approaches* in both the corporate and public sectors, often entailing radical downsizing and decentralization for greater efficiency and competitiveness, resulting in the restructuring of bureaucracies and the larger labor force within the health sector and outside it;

• *Changing roles for government* in relation to the private and independent sectors, with government accepting that others will have a larger place in health development, not only in financing but in risk sharing and all aspects of the delivery of health care;

• *Changing approaches to the financing of health care*, for example, greater privatization, more managed care and fewer fee-for-service arrangements, and movement away from the concept of universal coverage;

• *Changing concepts and tools emerging from the laboratory* such as new vaccines, therapies, diagnostics, and drug delivery systems; wide-access information systems and friendlier software; and freshly conceptualized methods for building and analyzing databases, measuring disease burdens, and guiding allocations—which remain, nonetheless, largely unassessed for their cost-effectiveness in producing better health outcomes for more people; and

• *Changing views on the connections among ill health, poverty, and social pathology,* with more disposition to see ill health as a consequence of poverty and inequity, irreconcilable with authentic development and often requiring both social policies and health policies for any resolution. Although there is ongoing debate about what are fundamentally social problems and what are health problems, as well as about how and when both social and health policies should address them, few are totally prepared to resist the conclusion that many of the major social problems of our time have immense health outcomes and that many of our major health problems have social origins and social consequences. In this connection, perhaps the harshest reality is that the most powerful levers for achieving durable improvement in human health status in any country—that is, poverty, education, demographics, and domestic and community environments—lie outside the health sector.

Implications for the United States

Until recently, the vision in the United States of where the country stood and where it had come from with regard to international development was based on what is, historically, an atypical sampling: the

period from 1945 to 1975, a time of great prosperity when the United States was enormously dominant in the world and could, in effect, write the story of what social and economic development should be all about.

That picture is much altered. The collapse of the communist regimes in the Soviet Union and the Eastern Bloc opened a huge zone of political instability, uncertainty, chaos, and civil war and shook the systems that had stabilized international relations for some 40 years. The weakening of the nation-state as an unquestioned political force, shifts in the center of economic gravity, and a series of socioeconomic and political events have made it clear that the development story is not always written in the same fashion, nor is any story immutable or complete. At best, "development" is a complex, various, elusive, and difficult notion, particularly in a new, confusing, and unpredictable multipolar world.

The traditional yardstick of an exceptional period of stability for the United States serves only poorly in understanding—and affecting—today's powerful intersections among politics, economics, and health. The current drive toward fiscal austerity, the ongoing redefinition of the role of the federal government vis-à-vis the states and municipalities, and the relative roles of the public and the private sectors have contributed to particular instability in the health sector, where de jure efforts at reform have given way to de facto free market adjustments. That picture is likely to remain fluid, with considerable repercussion and little sign of imminent reversal. Such changes and the larger issues of how to sustain appropriate levels of investment in the social sectors are not solely U.S. phenomena; they are questions of capacity, choice, and political will for all countries.

The economic participation of the United States in bilateral and multilateral assistance to other countries is also much in flux, mostly because of internal preoccupations and political differences. What seems to be a trend toward reduced funding is likely to continue. This has contributed to and in the future will be affected by two other substantial changes that have much to do with the character of the U.S. role:

- *Changing global patterns of external assistance,* with some countries and their aid agencies receding and others advancing in the amounts and patterns of their contributions, as the United States engages in a radical review and probable restructuring—conceptually, organizationally, and financially—of its directions in foreign aid; and
- *Changing configuration of the world health system toward greater pluralism*, with less emphasis on bilateral cooperation, greater

presence of multilateral agencies, and more attention to involvement of the corporate sector.

What is striking about the *Synthesis* documents is that although only some of them directly address the role of the United States in global development processes, they contain little that is irrelevant to U.S. development policy. Their critical messages are that the consensus that can be found in them is no less applicable to the United States than it is to any other country disposed to participate in external assistance and that, overall, the meaning of that consensus for the health sector is much the same as it is for any other sector. The United States, like other nations, is caught in the tension between the practical realities of living in a "global neighborhood" and whatever dispositions there may be toward inwardness. Despite struggles with defining the *whether* and *why*, the major question for the United States about external assistance remains: *how* to be engaged?

The most compelling of the implications for the United States that can be drawn from the *Synthesis* deal with content, financing, partners, methods, values, and risks of noninvolvement and are essentially statements about ways in which things simply cannot stay the same.

- The first implication is simply that older development emphases must yield to newer ones—the push for growth better balanced with equity, management with participation, efforts large in scale with those smaller in scale, and global orientations with local exigencies. Some of the documents point to the immense capacities of the United States to do this because of its relevant experience, technological know-how, and sector-specific resources, as well as its ability to harness the power of its own pluralism across the lines of its own institutions— its federal, state, and local governments and its large private, for-profit, and independent sectors.
- The second implication has to do with funding. The *Synthesis* documents that address this topic make the point that almost no developed country invests a proportion of its gross national product in the area of global development that is commensurate to the needs of the less developed countries. For example, less than 1 percent of the federal budget of the United States goes for all of its foreign assistance, that is, economic, military, bilateral, and multilateral; no member country of the Organization for Economic Cooperation and Development spends more than 2 percent of its gross domestic product on such assistance. An even smaller—and ever more miniscule—portion of that assistance is dedicated to research in areas of keenest rel-

evance for developing countries and, most important of all, in fostering an indigenous capacity for understanding and resolving indigenous needs.

- The third implication pertains to recognition of the simultaneous marginality and importance of external assistance. Economic assistance may be critical for the lowest-income countries, where it can constitute a significant proportion of national budgets. For other countries, the value of economic assistance is at the margin, where it can nevertheless affect national policies, the generation of new knowledge, and the building of indigenous capabilities for understanding and resolving indigenous needs.
- The fourth implication has to do with acknowledgment that all approaches to development must shift, if only partially and incrementally, away from focused development projects and toward integrated development strategies that are the products of shared planning among cooperating countries.
- The fifth implication goes toward affirmation of a basic principle of development cooperation as fostering creative interactions among the public (government), private (corporate), and independent (NGOs, foundations, universities) sectors, an implication of notable importance for the United States, where the corporate and nongovernmental sectors are so prominent.
- The sixth implication relates to crediting the importance of measures of disease burdens and their use in guiding policy formulation and resource allocations, especially as constrained resources and shifting priorities promote the urgency of greater allocative efficiency.
- The seventh implication is for understanding that science and technology are crucial enabling tools for national and global development and that the United States has particular (though not exclusive) strengths for sharing scientific advances and helping countries build research capacities relevant to their own development needs.
- The eighth implication addresses appreciation of the critical role of the United States, in partnership with other countries, in addressing the serious problems of health and social development on a global scale with, again, special (though not exclusive) concern for those countries and populations that are most vulnerable and deprived.

A Final Note

CONVERGENCE ON UNCERTAINTY: THE PARADOX OF THE NEXT AGENDA

The documents reviewed and the ideas presented in this report signal a world of great and accelerating change whose effects pervade the fields of health and social development. History does not tell us what is coming next, but one thing is sure: Our time is one of profound uncertainty, ambiguity, diversity, disorientation, and varying degrees of disaffection. It can be argued that the world has been ever thus, but we are still driven to ask about the kind of changes we face and how those might affect global health, since any new global health agenda—a *Next Agenda*—must build from such understandings.

The paradox—one we tentatively view with hope—is that, amidst volatility and frustration, and partly because of them, consensus has evolved nonetheless and in some generally common directions: toward fuller comprehension of the hard demands of development, the potential of more effective methods for coping with its obstacles, and more awareness about the larger global context in which development must be addressed. There are also glimpses of a new language around these issues, one that substitutes cooperation for assistance; global for international; and terms more balanced, fine-grained, and reflective of contemporary reality than "Third World" and "developing countries."

There is a tradition in the health sector for some reports to make a difference. The 1910 Flexner Report revolutionized the education of

health professionals; the Alma-Ata Declaration revolutionized thinking about health care delivery worldwide. The 10 documents reviewed here can also make a difference. Their content, together with the areas of inquiry, zones of convergence, reflections on change, and the implications that we found in them, offer a plausible and flexible framework for a *Next Agenda* that can encompass

- The emerging problems that directly threaten human health, ranging from infectious diseases, to the triad of poverty-population-environment, to the unfolding mysteries of the human genome;
- The global uncertainties that threaten human well-being less directly, though no less surely; the irrelevance of yesterday's solutions to today's problems; and the social and political instabilities impinging on opportunities for constructive action; and
- A new and evolving organizational, financial, and policy "architecture" for dealing with global perspectives; with fresh forms for collaborative sharing of ideas, resources, and programs; with common as well as discordant values; and with the need for sustained and open dialogue about development and what it means.

Every *Synthesis* document refers to the necessity for collective action. Unfortunately, the current vocabulary—terms like "collaboration," "coordination," "cooperation," and "partnerships"—have become so hackneyed by overuse and underimplementation that they seem unreal or empty, or are seen as all too real and menacing to national, sectoral, or institutional autonomy. Yet, the *Synthesis* documents also counsel us that, given the complexity of the problems, the certainty of uncertainty, the urgency for allocating all manner of resources more wisely, and the rapidity of movements of people and information, separation from collective action makes scant sense. Indeed, it is difficult to imagine significant advances from those documents without a truly interactive global community honestly, modestly, and realistically engaged in the further elaboration and pursuit of the *Next Agenda in Global Health*.