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Future Partnership for the Acceleration of Health Development

Report of a Conference

18-20 October 1993
Ottawa, Canada

Futur partenariat pour accélérer l'amélioration de la santé

Rapport de la conférence

18-20 octobre 1993
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Future Partnership for the Acceleration of Health Development

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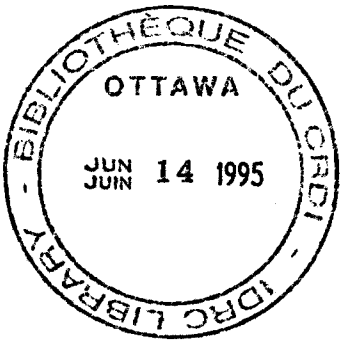

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Future Partnership for the Acceleration of Health Development

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Executive Summary

More than 150 individuals from developing countries, multilateral and bilateral development-assistance agencies, and international organizations and foundations met in Ottawa, Canada, from 18-20 October 1993, to promote and increase the effectiveness of partnerships for improving health in the developing world. This Conference on a *Future Partnership for the Acceleration of Health Development* was co-sponsored by Canada's International Development Research Centre (IDRC), the World Bank, and the World Health Organization (WHO). Building on the World Bank's 1993 *World Development Report* (WDR '93) *Investing in Health*, which has generated considerable interest among policy makers, development agencies, and the research community, the Conference sought to examine weaknesses in national and international programs for equity-oriented health development in developing countries, and to agree upon practical steps to increase the scope and effectiveness of partnerships and investments for health.

Taking the *World Development Report 1993* as their point of departure, Conference participants analyzed three interrelated problems. In renewed partnerships for equity-oriented health development:

- How can we build capacity in developing countries to undertake health policy reform in support of sustainable health development?
- How can we strengthen the relevance, coordination and contribution of health research for health reform in developing countries?
- How can we increase, redirect and enhance investments in health development?

Cutting across all three themes was a common concern for ensuring that both national and international resources for health be used in a manner that would move the health sector toward the following:

- Greater access and equity for health care.
- Greater congruence with the needs of populations.
- Greater effectiveness and efficiency in allocation of resources.
- Greater participation and accountability to the people being served.

- Greater sustainability for the long term.

Such guiding principles of equity-oriented health reform would maximize health gains for the 5 billion people living in developing countries and, especially, for the more than one billion poor.

The Conference began with opening remarks from the Conference chairperson, Professor Vulimiri Ramalingaswami, Professor Emeritus of the All India Institute of Medical Sciences; Dr Keith Bezanson, President of IDRC; Dr Jean-Paul Jardel, Assistant Director-General of WHO; and Mr Armeane Choksi, Vice-President for Human Resources Development of the World Bank. Mr Choksi defined the main objectives and themes of the Conference in his address to the participants. This was followed by presentations and initial discussion of papers specially commissioned by WHO, IDRC, and the World Bank, respectively, on the three central themes. The participants then met in three separate working groups. The main findings and recommendations for action were presented for discussion to a plenary session at the end of the second day. These recommendations were synthesized into a draft report, which was discussed, revised and generally supported by the participants on the final day of the Conference.

Broad Conclusions

The Conference was intended to generate a sense of the general principles for the way forward from WDR '93 and achieved remarkable consensus on both principles and general directions:

- First, there was consensus that WDR '93 has opened a window of opportunity to take renewed action and apply increased energy to strengthen and support health policy reform and equity-oriented health development. There is unprecedented need to take advantage of this opportunity arising from the strong and growing interest in health policy reform in both the North and the South, and from an increasing commitment to partnerships for health as a key part of human resource development. Nevertheless, it was also a point of consensus that there is no need for new, large, or costly international institutional structures to address health policy reform.

- Second, it was further recognized that immediate action is needed to determine and articulate the way forward, and that energy-intensive leadership on this front must be generated quickly before the opportunity

passes. There was consensus that this could be best initiated through the immediate establishment of one, or possibly two, participatory working groups or task forces under the auspices of WHO and the World Bank.

- Third, there was consensus that there is no magic formula, no simple path, no single route forward and no declaration of an easy solution. What emerged was reinvigorated determination and recommitted partnership to tackle the complex and difficult problems of health sector reform for equity-oriented health development without an exaggerated reliance or focus on a handful of selective technologies, disease approaches, or slogans. It was recognized that reform would involve difficult choices, to be made in partnership, in redirecting investments at both national and international levels.

Action Items

The foregoing points of agreement and the following action items suggest and recognize that an integrated approach to the three health development sub-themes of the Conference, capacity building, research and resources, is possible and desirable:

1. On how can we build capacity in developing countries to undertake health policy reform in support of sustainable health development:

   There was support for the establishment of a Network for Health Reform Capacity Building. It was agreed that a temporary Working Group needs to be established immediately to conceptualize and draft a detailed proposal for such a Network. WHO, in consultation with the World Bank, will take the initiative in convening this Working Group. Several guiding principles were offered for consideration in this process and are contained in this report.

2. On how can we strengthen the relevance, quality and contribution of health research for health reform:

   It was agreed that an open and participatory review of current international health priorities for research should be conducted in light of the analytic framework presented in WDR '93, and additional innovative approaches or refinements that need to be developed. Ideally, this review

should be completed for the World Summit for Social Development in March 1995. Following the recommendation made at the Bellagio *Conference on Strengthening Research and Control of Infectious Diseases*, held in September 1993, WHO should serve as the Secretariat for this *ad hoc* review of health research priorities. Several guiding principles regarding the scope of research required in association with these priorities are contained in the report. A group of donors has agreed to fund this initiative. It is recognized that this review of health priorities from the international perspective will be complementary to that derived at national level (for example, via the Council on Health Research for Development (COHRED) and the Essential National Health Research (ENHR) strategy). It was further suggested that consideration be given to mechanism(s) to monitor domestic and international flow of funds to global and national health research and research networking.

It was agreed that joint support was needed for testing the development and implementation of the nationally-defined health intervention package(s), health policy reform and improved donor coordination, in 6—10 interested countries. In this respect, the Canadian International Development Agency (CIDA), IDRC, the World Bank's Population, Health and Nutrition Department, several WHO programs and other interested agencies will work together in one such initiative. The initiative could entail estimates and analyses of national burdens of disease, development of adapted public health and clinical intervention packages, working with countries in the pilot implementation of the packages and research efforts to evaluate the approaches. This would allow the drawing of generic lessons for possible application in other countries.

3. On how we can increase, redirect and enhance investments in health development:

A Working Group is needed to examine issues related to increasing and redirecting investment in equity-oriented health development, some of which are outlined in this report. The World Bank, in consultation with WHO and major donors, will take the initiative for leading follow-up work in this area.

Recognizing that such capacity building, health research, and increasing and redirecting investment in health are linked and necessary for health policy reform, WHO and the World Bank will determine whether the foregoing efforts will require either separate working groups or secretariats coordinating closely with each other, or one umbrella group.

Capacity Building for Health Policy Reform

To support and accelerate health policy reform, resources need to be redirected both domestically and externally to improve the evident mismatch between the need for health policy reform and the low levels of capacity for undertaking this effort in countries at different levels of development. International agencies are already facing a high and growing demand for technical assistance in this area.

The discussion was divided into two sections: the first on identifying the kinds of capacity building that are needed, and the second, on identifying how to implement these suggestions.

What Kind of Capacity?

The concept of capacity building has three components: human resources development, institutional development and (the creation of) an "enabling environment." Four steps in the reform process were discussed in relation to the components:

- Developing a health sector/policy framework;
- Priority setting;
- Organizational assessment and identifying options for change; and
- Implementing change.

Different actors in the change process have distinctive training needs in management skills, in health economics, in understanding the role of other sectors on health, and in adapting tools for priority setting.

Capacity building methods discussed ranged from the use of intercountry comparative experiences, short seminars for senior-level policy makers and basic training in relevant technical disciplines. Essential National Health Research (ENHR) was felt to have an important role. ENHR is particularly important in the priority-setting process and also in the contribution to the other components of the reform process. Clearly, policy-relevant research plays an essential and reinforcing role in integrating improved financial investments for health, capacity building for health development and sector reform, as well as obviously improved quality research.

In organizational assessment and in the implementation of change, the contributions of behavioral, political, and management sciences were recognized. The importance of developing problem-solving training approaches was also emphasized.

How Can Partnerships Be Developed?

International partnerships between institutions from developing countries and industrialized countries, as well as multilateral organizations potentially could strengthen national efforts and help increase the resources devoted to the process of reform. Organizational mechanisms need to be set up that facilitate consensus building and balancing of interests and expertise. There was support for the idea that a network be established. A Working Group will be convened to take on the task of drafting a detailed proposal for a Network for Health Reform Capacity Building. WHO, in consultation with the World Bank, will take the initiative for convening this working group.

Several guiding principles were suggested which would direct the functions and tasks of the network. These are:

- to focus on equity-oriented strategies (including gender disparities);
- to ensure partnership in governing the network; and
- to increase country capability for undertaking health policy reform, for example, by strengthening evidence-based decision-making capabilities.

The functions of the network will be:

- To act as a clearinghouse to improve sharing of:
  - (a) Information;
  - (b) Technical assistance; and
  - (c) Experiences on health policy reform.
- To support and assist countries in the formulation and implementation of health policy reform; and

- To help develop, refine and promote the use of tools and strategies for health policy analysis and reform.

The institutions participating in each node of the network, and the network as a whole, should have clearly defined functions. The network requires a central pivot or hub. Most importantly, the network should provide a clearinghouse function (access mechanism) through which developing countries implementing health policy reform can share other countries' similar experiences and concerns and gain access to institutions in the network for information, technical advice and long-term funding.

To support and steer such a network, an international initiative for health policy reform could be developed with the support of a core group of sponsoring agencies and developing countries committed to providing financial and personnel resources.

The core group could also guide the initiative on behalf of a larger group of participants, including collaborating institutions, developing country representatives, representatives of bilateral development agencies and other United Nations organizations. This larger group might be convened as a global advisory panel. An independent expert group could advise and guide the initiative. This would be a group of persons acting in their individual capacities as experts not only in the public health arena, but also in the area of health policy reform.

The initiative would require a network secretariat that would facilitate:

- Research and development to improve analytical and implementation tools for policy reform;

- Channelling support to strengthening national and institutional capacities for reform (particularly, but not exclusively, in developing countries);

- Analysis of country experiences to further our understanding of health policy reform, and

- Promotion of and participation in reform within countries.

The size and functions of the network secretariat would need to be agreed to by the core donors but, at a minimum, a clearinghouse function would be required, and the research and development work on such methodological/analytical tools as the global burden of disease and the cost-effectiveness of interventions presented in the *World Development Report 1993* should be continued in partnership with other collaborating institutions. WHO has agreed to undertake the task of defining a proposal on the composition, functioning and resource requirements of the network. It will be presented for consultation to the interested parties.

Relevance and Contribution of Health Research

Research is an essential input to further health policy reform and health development.

The following describes guiding principles, identifies key issues, and collects main conclusions of the discussions as part of an effort to maximize the opportunity provided by the release of WDR '93 to strengthen health research initiatives already underway and to accelerate national health development.

Scope

- Improvements in health are not brought solely by changes in the health sector. Thus, other sectors, such as education, agriculture and water, must be included in the agenda for research in order to drive and advance health-related development.

- Research is needed at the community, country and global levels.

- Better rapid assessment-type research methodologies are needed to support decision-making. Biomedical, as well as applied, public health, health promotion, and qualitative, participatory and community-based research are all important forms of health research. Greater emphasis needs to be placed on social and behavioural science approaches to health research.

Priority-Setting

The Commission on Health Research for Development and the WDR '93 draw attention to the mismatch between the global burden of illness, which occurs predominantly in developing countries, and health research funding priorities, which are predominantly directed to problems of industrialized countries. Within developing countries, relatively small amounts of health research are dedicated to the problems of greatest concern to the populations and policy makers. Thus, there is a need to develop methods and approaches for priority setting that take into account issues such as local burden of disease, opportunities for cost-effective impact, comparative advantage and leveraging of resources.

Community, National, and Global Levels

- Health priorities set by communities may differ from those that emerge from burden of disease and cost-effectiveness analysis. There is a strong need for more micro-level, socio-cultural-economic research to identify local priorities.

- Countries need to be supported in setting national health research priorities (for example, Essential National Health Research strategy). The international community should respond to country priorities by making funds available to assist in building capacity to set such priorities and to implement research. If countries have their own national health research plans, donor priority setting will be facilitated.

- There is an urgent need to review current international health priorities for research; and this should be conducted in the light of the analytic approach illustrated in WDR '93 and additional approaches that need to be developed. Ideally, this review should be completed in time for the World Summit for Social Development in March 1995. Following the recommendation made at the Bellagio *Conference on Strengthening Research and Control of Infectious Diseases* in September 1993, WHO should serve as the Secretariat for this *ad hoc* review of health research priorities. A group of donors has agreed to fund this initiative. This review of health priorities from the international perspective will be complementary to that derived at national level (for example, via COHRED and the Essential National Health Research strategy).

- The review should be an open and participatory process that will allow full involvement of agencies and organizations engaged in national and international health policy and research (especially WHO, the World Bank, the United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), the European Community, COHRED, etc.).

Integration/Coordination

- Certain problems need to be approached comprehensively by involving various types of research (biomedical, clinical, health systems, field, socioeconomic, etc.) to better understand the complex determinants of health and health intervention possibilities.

- Now more than ever there is an excellent environment for coordination, linkage, and collaboration between researchers and research networks at national and international levels.

- Existing networks, such as WHO Special Programmes (HRP, TDR, and GPA), COHRED, Social Sciences in Medicine, University Partnerships Project of the Network of Community-Oriented Educational Institutions for Health Sciences, and the International Clinical Epidemiology Network (INCLEN) could provide better support to national and international research. These links will also provide support to Essential National Health Research strategies in country-level priority setting.

- There is a need to support studies on priority-setting processes for the global agenda. This should involve other agencies and have strong links to COHRED. In the process, coordinating mechanisms, such as COHRED, must be strengthened. Countries could organize donor round tables to extend support to national agendas of research and research capacity strengthening. These round tables should be linked to broader donor coordination processes at the country level.

- At a minimum, coordination could involve the exchange of information. This would allow identification of unnecessary duplication or gaps and could eventually lead to collaboration and improved coordination. Coordination can also play a major role in integrating research across sectors.

Increasing and Redirecting Investment

We need to help:

- to promote healthy public policy formulation within countries which is more research or evidence based.

- to better balance the allocation of research funding between current problems of North and South, while recognizing the need to address problems emerging from the current health transition.

- to mobilize domestic resources for country research priorities. In addition, we need to recognize fully the "in kind" contribution of recipient countries used in support of their own priority research.

- to monitor domestic and international flows of funds to global and national health research and research networking.

Increasing and Redirecting Investment

Principles, Issues, and Conclusions

- Improving *domestic* policies, resource mobilization and resource allocation are central to health development. Nevertheless, external assistance can play an important catalytic role in health policy reform.

- External assistance has, in many instances, not been conducive to the development of equitable and gender-sensitive health policies and has not sufficiently focused on support for institutional capacity building for health policy reform and sustainable health development. Narrow technical, epidemiological and economic approaches need to be replaced by a broader approach that recognizes the complexities of health institutions and systems.

- Improvements in resource allocation, both from domestic and external sources, are needed. Packages of highly cost-effective public health interventions and clinical services should be developed at the country level and should be funded by public-sector financing and external assistance before new public investments are made that support less cost-effective services. Private funds and cost-recovery schemes can be used to finance other clinical services. In general, development partners should strive to promote greater equity and efficiency in public investments, accelerating the provision of basic services for all while restraining the growth of publicly funded, specialized services that primarily benefit the well-to-do.

- The donor community needs to reconsider how external assistance can more effectively support the reform processes. This calls for longer-term commitments and more flexible, cooperative mechanisms based on agreed-upon objectives and priorities. The donor approach should be more program oriented, reflecting country priorities.

- Donors and ministries of health need to improve their ability to negotiate for additional funding for health, based on the strong arguments for the role of health in improving welfare, economic growth and reducing poverty. The economic arguments presented in the *World Development Report* provide good rationales for investing in health. A broader audience could be reached by developing alternative communication channels (simple visual presentations, or more sophisticated videos or computer software) with the report's messages. The point is to reach out broadly, beyond the health community, to decision makers at donor and developing country level.

- Donors need to focus more effort on strengthening and building developing country capacity to negotiate, manage, coordinate and account for internal and external resources.

- In addition to resource reallocation, incremental financing should be encouraged from: (a) new donors, (b) the private sector and (c) continued growth in financing from multilateral aid agencies. It is recognized that in the current environment of increasing competition for limited resources, traditional donors may not be able to increase significantly their external assistance; however, if a good case can be made for investments in health, reallocation from other sectors is possible.

- The pros and cons of setting up a new global fund (like the Global Environmental Fund) to support certain types of high-priority health activities were discussed. Before thinking about this new mechanism, articulation of a strategy for this is needed that includes assurance that these resources will be additional. Existing funding efforts must not be weakened.

- Donor coordination has much scope for improvement; this needs to be at the country-level and led by governments. It does not require expensive, new international mechanisms.

- The potential for establishing or improving existing information systems to monitor aid flows, projects in the pipeline, country policy work and the impact of investments needs to be examined.

- Well articulated country-specific health policy/priority *frameworks* would help guide domestic policy as well as enable donors to justify increased funding. Donors could assist countries in the development of these frameworks. The *World Development Report 1993* and other documents such as The World Bank's *Better Health in Africa* can be useful in assisting in the development of such frameworks.

- Efforts should be directed in donor countries to boost public awareness and support for external assistance for investment in health.

- It was agreed that joint support was needed for testing the development and implementation of nationally defined health intervention package(s), health policy reform and improved donor coordination, in 6—10 interested countries. In this respect, CIDA, IDRC, the World Bank's Population, Health and Nutrition Department, several WHO programs and other interested agencies will work together in one such initiative.

- The challenges of new and existing health problems, public-sector reform and health-reform efforts are placing demands on donors' skills and experiences. Donors can reach out more to collaborate with other institutions, particularly at the local level, to improve the quality of their efforts toward sustainable development.

- Although the setting of global financial targets for external assistance may be inappropriate, the setting of targets for external resources at the *country* level for specific programs and types of assistance may be quite useful.

- It was recommended that a working group be set up (either as part of a larger working group emerging from the Conference or as a separate working group coordinating closely with others) to examine these and other issues related to increasing and redirecting investment in equity oriented health development.

Appendices

Conference on a Future Partnership for the Acceleration of Health Development, October 18-20, 1993, Ottawa, Canada

Conférence sur un futur partenariat pour accélérer l'amélioration de la santé, du 18 au 20 octobre, Ottawa, Canada

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Capacity Building for Health Systems Reform

The World Development Report 1993 is a major platform for identifying and prioritizing goals in the health sector. But these goals can only be reached through deep reform and improvement of existing health systems; and such reform can only be implemented at country level. Capacity building in national health systems is therefore fundamental to the implementation of the WDR agenda. This paper addresses four questions:

1. *What are the objectives of capacity building for health system reform?*

2. *What are the components of the reform process, what are the greatest challenges, and what knowledge is available to assist reform?*

3. *Given the requisite knowledge, what people need which skills, where may these skills be found, and what new training approaches are needed?*

4. *What are the options for a closer partnership to support capacity building for health system reform?*

1. What are the objectives of capacity building for health system reform?

The World Development Report 1993 has demonstrated beyond doubt that an investment in health is an investment in development. Yet the health of the people of many countries is weakened as much by institutional incapacity to deliver appropriate disease prevention, control and treatment as by disease and disability themselves. Governments and donors will continue to be unwilling to invest more in health if health systems continue to perform with great inefficiency.

For example, at a recent meeting on "Global Infectious Diseases: Strengthening Research and Control" (convened by the Rockefeller Foundation in Bellagio, Italy, on 30 August - 3 September 1993) identified "a much better job can be done if assessing the extent and intensity of the morality and disability due to these diseases; of setting priorities for applying available knowledge and technology through public health and primary health care programs; and of marshalling the political and economic support required to translate those priorities into effective action".

These goals apply not just to infectious diseases, but to all aspects of health, particularly in developing countries; and they apply not only to global and regional assessments, but above all to national policy and health systems.

Action to improve health must finally be taken at country level; and it is there where capacity must be built. Any coordinated system of capacity building for health policy reform must therefore aim at least to:

- Increase knowledge and country capacity in the four components of the reform process: establishment of a health policy framework, priority setting, assessment of existing health system organizations, and the implementation of reform.
- Increase the transfer of practical experience among countries.
- Increase the availability of international expertise for assistance at national level.
- Increase short-term and long-term training in relevant disciplines such as economics, epidemiology, the behavioural, social and political sciences and law.
- Develop more cost-effective training methodologies - such as distance learning.
- Increase the availability of resources available to health.
- Strengthen international collaboration on health policy reform, health systems development and institutional arrangements.
- Further refine techniques to assess disease burdens, and adapt and apply them at country level.
- Further develop cost-effectiveness studies, particularly on clustered interventions (to share delivery costs), and adapt and apply them at country level.
- Develop effective methods of health system decentralization and their relation to local political institutions.
- Improve methods of efficient distribution of health technologies, at international and country level.
- Develop methods of information gathering and monitoring which meet the needs of the periphery and the centre.

2. What are the components of the reform process, what are the greatest challenges, and what knowledge is available to assist reform?

The establishment of a reform process requires *four steps* to be taken in every country, each of which has its own requirements of skills and knowledge:

- The establishment, of, and commitment to, a health policy framework.
- The setting of priorities within that framework.
- The assessment of existing organizations.
- Most difficult of all: the practical implementation of change.

The World Development Report 1993 has made a major contribution to the second of these - priority setting - but if reform is to become a reality, knowledge and country capacity must be increased in all four areas. Moreover, reform must be seen as *a continuous process*; countries are constantly changing in their political, social, environmental and economic circumstances, and capacity building for reform must be seen as a continuous rather than a singular event, and will require the establishment of an intelligent and flexible *responsiveness* in countries as well as at the global level.

Here we address the four components of the reform process in turn, and consider what new knowledge is required to guide effective reform.

2.1 Establishment of a health policy framework

A health policy framework establishes commitments. It gives operational definition to a country's (or region's) notions of equity and efficiency, and sketches the responsibilities of different government and non-government actors, and of the public. Such frameworks are a valuable means for eliciting support from important interest groups, and for establishing vision and leadership.

To create a health policy framework is primarily a *consensus-building* activity on the principal axes for change, and serves to set out the targets, organizational changes and new policy instruments in broad terms. Important *political skills* and processes are involved in the agreement of the policy framework, and in the subsequent building of support and consensus around it.

Available knowledge and technical guidance in this area is slight.

2.2 Setting priorities within the framework

The second component of reform is the *setting of priorities* consistent with the health policy framework. Priority setting must be based on a recognition of overall resource shortage in relation to need, and an acknowledgement that transparent, consistent procedures for setting priorities are important for greater political accountability.

Available knowledge and technical guidance in this area is strong, but largely limited to global priority setting. The World Development Report 1993 provides important technical support with its approach to the measurement of disease burden and the cost-effectiveness of interventions. Substantial supporting literature on priority setting also exists, and much has been used in the past in assessing resource allocation priorities for health at country, regional and district level. This is thus an area in which a relatively good basis of technical knowledge for capacity building exists.

However, the indicative global priorities set out in World Development Report 1993 should be used for national or sub-national priority setting only with appropriate adaption, both to local data, and to local perceptions of what constitute priority problems. Unless local expertise and experience is included in the process of priority-setting, an approach by pure principles to the problem will inevitably exclude country-level decision-makers from a sense of ownership and therefore of conviction about the priorities.

2.3 The assessment of organizations

The third component of reform is the assessment of the strengths and weaknesses of existing health system organizations.

Available knowledge and technical guidance in the analysis of health system organizations is considerable, but not always appropriate. A wide variety of tools and techniques exist, though the majority are driven more by the concerns of external assistance agencies than the concerns of health system managers, and few have found their way into routine use as assessment tools. Much remains to be achieved in identifying organizational and financing mechanisms which will create incentives for the adoption of more sustainable cost-effective practices. However, a considerable body of knowledge and experience has been generated about the barriers to the adoption of such practices.

2.4 Implementation of reform: the key task

The fourth and most difficult component of the reform process lies less in analysis than in *implementation*: in this process, policies and priorities can be modified or destroyed. Implementation is a special problem in the least developed countries. In addition to the handicaps of worse health, less resources, and fragile organizational structures, decision makers in poor countries have jobs which are in some ways *more complex* than those of their counterparts in industrialized countries. For example, they have to contain or control external donors who, with their command over money, become alternative sources of policy and implementation in the health sector. In addition, the negotiation of new responsibilities, design of new structures and procedures has to be undertaken - and resolved - with a range of individuals, professional groups and organizations inside and outside the Ministry of Health, necessitating a range of skills outside the medical or public health curriculum.

An environment of "loose organizational loyalty" in much of the public sector of developing countries has also been described by a senior health planner[1] as contributing to a lack of concern with the public objectives of the organization, or to the needs of the consumer. This will interfere with the adoption of rational techniques of decision-making at all levels.

Health sector managers in poor countries thus have a bigger job, a growing set of tasks, and a working climate whose ethos may be much less "results-oriented" than that of public bureaucracies in richer countries. Implementing reform therefore entails government having the capacity to make and manage its own policy, to negotiate and coordinate the separate priorities and accounting requirements of external assistance, and to cope with an often unsupportive bureaucracy.

Available knowledge and technical support on implementation issues is conspicuously weak. The World Development Report 1993 brings powerful analytical tools to bear on the problems of resource allocation in the health sector, but has little to say about the short-term steps to better management, or to managing the transition to a more cost-effective set of services.

Building capacity for implementing change is, in general, an area poorly supported by guidance, despite sometimes over-enthusiastic claims. We do not yet know, for example, whether or how a large scale cost-recovery system can be designed that will cover its own costs, retain the funds to improve services at local level and result in better access to care for the poor. Nor do we know with any accuracy what the economic and administrative capacity of a country or region needs to be for a social insurance mechanism to be a viable and sustainable means of financing health services for the whole population. Above all, we should be clear that the "answers" to strategies to improve implementation are not likely to be the property of a single group of actors, whether academic centres or international agencies. The experience of health sector managers who have implemented change in their own country (for example New Zealand, Ghana, Sweden, Chile, UK, Canada, Hungary), may be of direct interest and value to other countries. New sources of transferable experience, including from political, legal and managerial perspectives, are urgently required.

2.5 The need for new knowledge

As the above paragraphs demonstrate, the tools and experience needed for health policy reform are unevenly developed and distributed. In existence, or under development, are tools and methods for better understanding the impact of macroeconomic trends and policies on health, for projecting revenue and cost trends, for understanding treatment-seeking behaviour, for making a comprehensive analysis of health related activities at the local level, for priority setting, estimating the burden of disease and the determinants of ill health, and for measuring the cost-effectiveness of individual interventions and of intervention packages. Generic and

[1] Asamoa-Baah, A: *Identification of Needs in Health Economics in Developing Countries*, paper produced for WHO Task Force on Health Economics, August 1993.

national research is needed to identify the legal, organizational and financing changes which will support and encourage the adoption of acceptable packages of priority interventions, in both the public and private sector. Comparative analytical work must also be undertaken to understand what works, what does not work, and why.

3. Given the requisite knowledge, what people need which skills, where may these skills be found, and what new training approaches are needed?

The use of disability-adjusted life years (DALYs) in World Development Report 1993, as one step in the process of priority setting, combines the approaches and data of *economics* and *epidemiology*. These two disciplines are necessary for a holistic approach to health sector reform, but as has been illustrated above, they are not sufficient. The perspectives of *behavioral science* and *management sciences* are also necessary, together with important inputs from *political sciences* and *law*. Transfers of experience, from practitioners (as opposed to teachers) of health system reform, are of great importance. However, few, if any, health sector specialists can be expected to combine and use all of these perspectives.

3.1 What sort of people need which skills

At a global level, a rough schematization of skill needs may be helpful (see following table), but will always require adjustment to take account of individual countries' differences in size, educational levels, etc. Few people, if any, need a working familiarity with the whole range of reform-relevant skills.

Decision Level	Skills needed (type and level)
Top decision makers (Minister) PS, Cabinet, health and related sectors	Awareness of contributions from economics, epidemiology, social, legal and political sciences
Directors of Planning, budget, health sector	Working technical competence in one or more of above, ability to assess technical material from others
National/regional health directors, categorical program chiefs, district management team	Working competence in epidemiology, resource allocation principles, management information systems, personnel, logistics, etc.
Specialist skills (inside or outside health sector)	Health economics and financing, management accounting, contract setting, organizational behaviour, industrial relations, etc.

3.2 Where may these skills be found?

Existing capacity building of the formal type - training and policy-related research - is provided by a wide variety of institutions in developed and developing countries in all these areas, but rarely, if ever, with the rationale of supporting health reform. Partly as a result of training in developed country institutions, and partly through developing their own training activities, a number of developing countries now have a nucleus of policy-analytic skills with a specific focus on health (for example Thailand, Philippines, Kenya, Mexico). These undertake both applied research and training. A much larger number of countries have reservoirs of analytical and managerial skills which, with relatively small investments to orient them towards health issues and the health sector, could become powerful domestic bases for the debate and analysis of health reform (for example India, China, Egypt, Brazil, Russia).

External support for capacity building has come from relatively few sources. Only the International Health Policy Program (IHPP) is a "dedicated" capacity building agency in this area, and IHPP's focus has been on learning through policy-relevant research. For several years, different programs in WHO have been supporting a number of institutions in developing countries to develop a variety of research and training activities in health economics and management, in addition to sponsoring short, country-based training on issues such as cost analysis, cost recovery and strengthening district planning and management. The World Bank, through the Economic Development Institute, has cosponsored a number of short training-in-health economics seminars, some in collaboration with WHO and other opportunities in this area continue to be in Cambridge and Boston (USA), and London and York (UK). The disciplinary focus of training and applied research on health reform issues needs to be broadened from economics and epidemiology, to include the perspectives identified in the preceding paragraphs.

Relevant skills and experience are clearly to be found in a much wider range of institutions than those university departments presently specializing in international health, or health economics:

- Some countries, developed and developing, have specialist, not-for profit health management institutions dedicated to domestic capacity building and technical advice (for example the Danish Hospital Institute; the Centre for Educational Development in Health, Arusha; the King's Fund, Britain).

- Many countries have public sector management training institutions which have, or could develop, training and research on health reform.

- Most countries have potential sources of technical support in the for-profit sector (for example in management accounting, purchasing, equipment maintenance).

- Countries which have been implementing health reform for several years have important lessons to deliver from their practical experiences.

Key individuals - advisors or managers - from these countries are important potential resources for other countries. At present, the transfer of such experiences appears to be on a small scale and ad hoc basis. Much better use could be made of existing skills and experience - in countries and among countries. A more planned and better coordinated approach by international agencies working in health could be an important catalyst for such an efficiency improvement.

3.3 What new training approaches are needed?

Current practice includes many different capacity building strategies, from postgraduate degree programs to on-the-job learning. Existing courses often cater to people from a wide variety of backgrounds with very different responsibilities.

There appears to be big potential gain from rethinking capacity building from the perspective of individual countries, in addition to defining a curriculum around a topical (and genera) set of issues. Training through courses or applied research seems to be dominant at present, though this may be simply because such activities are easiest to identify.

There has been little evaluation of the effectiveness of different training options and institutions, and little experimentation with, for example, distance learning methods, training of trainers or institutional development strategies. Closer consideration of the cost and effectiveness of country-based training, intercountry training, and international training activities is therefore necessary. A review of methods and their effectiveness, as well as target groups and areas of content, is also needed.

4. Options for a closer partnership to support capacity building for health system reform

The essential support for health system reform at both national and international levels is an *international partnership* to ensure that an appropriate amount of resources is devoted to the process, and to ensure that these resources are efficiently and effectively utilized.

This partnership must balance the work and research needed on *generic, global issues* which can be analyzed and promoted from central level, and the need for *essential country-level work* - particularly on implementation problems - which are rooted in the economic, political and cultural realities of each country.

To best serve the needs of national programs as well as those of the international development community, the organizational mechanisms which are established will need to provide for "ownership" by many participants, including major donors and developing countries themselves. The owners should be expected to contribute resources, but also to play a key and influential role in the policy reform process itself, so an appropriate balance of interests and experience must be established.

Three main procedural options are possible. The first, "least change" possibility is simply to use the impetus from the World Development Report 1993 to signal the need for greater priority (and resources) for those agencies currently working towards the development of analytical capacity for health policy making and implementation in the developing world. Periodic international meetings would be necessary to bring the main actors together, possibly to consider joint activities. Agencies would continue to tackle the above questions much as they always have done.

The second option lies at the other extreme: the creation of a special-purpose entity with a global mandate based on the same objective. Such an entity could have various forms. It could be an International Committee, with resources and an agenda, rather like the Independent Commission on Health Research, whose tasks would be established and monitored by an advisory body representing groups such as those at Ottawa. Or it could also be a larger and more permanent construct, such as the Africa Capacity Development Foundation.

The problem with the first option is that it lacks punch and continuity. The second option certainly involves duplication - few of the agencies participating in this meeting will consider themselves wholly inactive in the field of capacity building for health policy analysis, and at least one agency, the International Health Policy Program, is already dedicated to the above overall objective.

The third option would be to adopt a *network* approach. The many interested parties would be involved in a *network* in which each *node* of the network, and the network as a whole, would have clearly defined functions. The network would need an identifiable central pivot or *hub*. And most importantly, the network should provide an *access mechanism* through which developing countries implementing review and reform can achieve access to other countries with similar experiences and concerns, and to institutions in the network for information, technical advice, and long-term funding.

To support and steer such a network, an international initiative for health reform could be developed with the support of a *core group of sponsoring agencies* committed to provide financial and manpower resources.

The core group of sponsoring agencies could also act to guide the initiative on behalf of a *larger group* of participants, including collaborating institutions, developing country representatives, representatives of bilateral development agencies and other United Nations organizations. This larger group might be convened as a global advisory panel, but could evolve later on as a "Joint Coordinating Board" (to use the term for the analogous structure in the UNDP/World Bank/WHO Special Program for Research and Training in Tropical Diseases - TDR). An independent *expert group* would also be envisaged to advise and guide the initiative. This would be a group of persons acting in their individual capacities as experts in this field.

The rationale for such an organization would not be to empower a large central bureaucracy, but to empower a *network* or consortium of collaborating countries and institutions which would be the main strength of the initiative and provide the major foci for research and development, data acquisition, debate on generic issues of policy reform and implementation of reform activities in countries, *directed to overcome identified barriers* to better health and health-care delivery.

The initiative would require a network secretariat which would catalyst (through the network) and itself participate in several key areas: research and development on improving policy analytical and implementation tools; channelling support to strengthening national and institutional capacities for reform (particularly but not exclusively in developing countries); analyzing the information received in order to play a leadership role in setting the agenda for policy reform; and promoting and participation in the actual reform processes within individual countries.

The size and functions of the network secretariat would need to be agreed by the owners, but, at a minimum, a *clearinghouse* function would be required, and the *research and development work* on the global burden of disease and the cost-effectiveness of interventions begun with the World Development Report 1993 should be continued in partnership with other collaborating institutions.

WHO sees its own immediate role in this process as two-fold: firstly, intensifying its own country-specific support activities for health sector reform; and secondly, securing a more regular, systematic and long-term set of linkages with other partners around the globe, in both the developed and less developed countries.

As a contribution to the discussions which will need to take place, WHO can offer its own vision of one option in which WHO - in close partnership with the sponsoring agencies - would house the secretariat for the initiative. But this certainly does not preclude other options being discussed.

Strengthening the Contribution of Health Research

Issues, Needs, Options, Questions

I. Issues

Health research can clearly make an important contribution to development and human well-being. The World Bank's 1993 World Development Report (WDR) on health presents persuasive evidence concerning the importance of better health for development; and it cites numerous examples to support its conclusion that "investments in health research and development have yielded high returns in better health."[1] In doing so, the WDR confirms the findings of the earlier, 1990 report of the Commission on Health Research for Development (the Commission).[2]

The instances where research has contributed to health advances are many. The WDR refers to one important set of examples in noting that "the programs for tropical disease research and human reproduction funded by donors and executed by WHO have produced a number of improved drugs and diagnostic tests ..."[3] The Commission report describes the central role of research in the successful global anti-smallpox campaign: the development of freeze-dried, heat-stable vaccine, the bifurcated needle enabling briefly-trained workers to immunize large numbers of people; and field research that shifted the program's focus from mass immunization to surveillance.[4] Many other examples come readily to mind: for instance, the development of oral rehydration therapy at the International Centre for Diarrhoeal Disease Research, Bangladesh, and cooperating institutions.

Yet despite these impressive contributions, no one, least of all the authors of the two studies just cited, would claim that the world's health research programs as they currently exist are realizing more than a fraction of their full potential. With improvement, the world's health research system could be making a much greater contribution than it has to date. Some of the most frequently-cited areas for improvement are:

A. Quantity and Quality

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[1] International Bank for Reconstruction and Development, World Development Report 1993: Investing in Health (New York: Oxford University Press, 1993), p. 168.

[2] Commission on Health Research for Development, Health Research: Essential Link to Equity in Development (New York: Oxford University Press, 1990).

[3] 1993 World Development Report, p. 168.

[4] Health Research, p. 15.

A. Quantity and Quality

While data limitations prevent firm conclusions, the quantity of research on developing country health problems appears to have been stagnant or declining in recent years. As noted in the WDR (and one of the other Ottawa Conference background papers), the amount of development assistance for health -- a major source of support for health research -- has remained constant in per capita terms and has been declining as a percentage of the total.[5] Speaking more directly to the question of health research per se, the Commission observed that, "although solid data are not available, investment in research on developing country health problems has probably been static or declining over the past decade..."[6]

Both the WDR and the Commission report make strong cases for reversing this trend by pointing to numerous areas in need of further attention. In the case of the Commission, the emphasis is on research at the national level, especially on what it terms Essential National Health Research - that is, research on country-specific problems that "addresses health needs, disease profiles, resource allocation, program evaluation, health financing, and other issues concerning the objectives and operation of a country's health system."[7] The WDR both seconds this concern for national-level research and provides a discussion of research needs at the international level.[8]

Quality is as important as quantity, of course; and it is difficult to avoid the impression that much of the research now being done is of inadequate scientific quality to provide valid findings. The Commission faces this issue frankly in noting the many constraints under which developing country researchers labour and in concluding that, "research quality, admittedly a difficult parameter to measure, tends to be marginal in many cases, limiting confidence in the usefulness of research results."[9]

B. Relevance

A related, perhaps even more cogent argument in favour of reforming as well as expanding health research lies in the importance of ensuring research's relevance for health improvement. The limited relevance of much current health research is particularly obvious with respect to the health needs of the poor. As the members of the Commission reported, "we have found a gross mismatch between the burden of illness, which is overwhelmingly in the Third World, and investment in health research, which is overwhelmingly focused on health problems of the

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[5] 1993 World Development Report, p. 165.

[6] Health Research, p.36.

[7] Ibid, p.20.

[8] 1993 World Development Report, pp. 153-55.

[9] Health Research, p. 47

industrialized countries."[10] In 1986, the Commissioners determined, only 5 percent of all health research was devoted specifically to health problems of developing countries, where some 80% of the world's people live. For each year of potential life lost in the developing world, only 1/2 of 1% as much was spent on health research as was expended for each year lost in the industrialized countries.[11]

Numerous more specific illustrations of the problem are also available from the WDR and other sources. For example, population-based considerations of need or potential impact on health conditions frequently plays only a limited role in the establishment of health research priorities. As a result, many striking gaps exist, with woefully inadequate amounts going to research on many issues of particular importance to very large numbers of the poor.[12] Product development, technology assessment, and health policy are being neglected.[13] Health information systems absorb large amounts of resources, but produce little information that can be used in program management.[14]

Much health research is believed to be irrelevant in yet another sense. That is, even when it corresponds to what epidemiologists consider important issues, it can fail to respond to the health problems of greatest concern to policy makers and the population at large.

C. Coordination

Poor coordination is everyone's bête noire; everyone has his or her favourite horror stories. The WDR both speaks articulately about the dangers of fragmentation and provides illustrations of these dangers and actions that have been taken to counter them.[15]

Inadequate coordination in health research takes place at many levels, and it can obviously involve significant costs. These costs are borne both by researchers and by the donor agencies which fund them:

- For the researcher, donor fragmentation greatly increases the amount of time and effort that must be spent in putting together a coherent funding package of sufficient magnitude to permit a meaningful level of activity. This is time and effort that cannot be spent on research itself, thus detracting from research productivity. Upon occasion, the

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[10] Ibid, p. xvii

[11] Ibid, p. 29

[12] 1993 World Development Report, p. 152.

[13] Ibid., p. 169.

[14] Ibid., p. 148.

[15] Ibid., pp. 167-68.

difficulties caused by fragmentation can approach the catastrophic. For example, a prominent African field health research institute nearly went bankrupt while receiving generous project funding from multiple donors in a wide range of areas, because of inadequate support for the institute's core administrative functions.

- For the donor agency, the costs are equally significant. Anything that reduces the efficiency of the researcher produces a comparable reduction in the efficiency of any support provided to his or her research. Fragmentation and lack of coordination also give rise to the spectre of duplication and associated waste.

There can, of course, be too much of a good thing like coordination. A certain amount of diversity among donor agencies can be an important way of increasing the degree of choice that researchers having in choosing topics and research methods. Also, in a situation of uncertainty -- which is inherent in dealing with research -- concentration can greatly increase risk. To have all research funds go to support a single line of activity could be much less productive than a more diversified strategy should the one line selected not prove as promising as initially anticipated.

To most researchers and donor representatives, however, the dangers of inadequate coordination probably appear much more urgent than do the dangers of over-coordination like those just mentioned. In fact, the need for greater coordination is probably one of the few topics related to support for health research about there appears to be a consensus among donors and members of the developing country health research community.

II. Needs

For the reasons indicated, there is a clear need to strengthen the contribution of health research. Looking more closely, it is possible to identify three particular requirements, one arising from each of the three issues identified in the preceding section. These requirements need to be met at both the national and the international levels. They are:

A. Capacity Development

A concern for capacity development grows out of the need to increase the quantity and quality of health research noted previously. Capacity development has attracted particular attention at the national level, especially with respect to developing countries. It is widely viewed as the most appropriate use of the additional resources in settings where research infrastructures require strengthening in order to ensure that additional funds will lead to high-quality results. The relevance of capacity development is by no means limited to developing countries, however. It is also possible to think of strengthened international capacities for research on the health problems of poor areas -- through, for example, the establishment of international institutes in developed or advanced developing countries to undertake or serve as resource bases for such research.

Capacity development has been a particular theme of the Commission, whose report argued that, "strengthening research capacity in developing countries is one of the most powerful, cost-effective, and sustainable means of advancing health and development."[16] It and its successor institutions have actively pursued this theme, and a major strategy paper on research capacity strengthening is currently under development.

B. Priority Research

Pressing as the need for greater capacity unquestionably is, few would wish to maintain that capacity development is the whole story. For a great deal of capacity already exists, particularly at the international level and in many developed countries. As indicated earlier, this capacity needs to be applied more effectively to issues of importance for improving health conditions. There is need, in other words, for much greater relevance of the research undertaken.

This can best be illustrated with respect to disease-specific research, in which capacities have been further developed than in many other areas. From the WDR emerge three broad considerations that can help guide research and development priorities, especially at the international level: first, the amount of death and disability caused by a particular disease or condition; second, the availability of cost-effective technologies for dealing with that condition; and third, the prospects for developing more cost-effective interventions. Highest priority for research would go to developing new approaches for dealing with diseases that cause large amounts of death and disability, where present methods for dealing with the disease are inadequate, and where the prospects for the development of more cost effective interventions are promising. Annex A provides an illustration of the research priorities that might emerge from the application of such an approach.

The need for more relevant work is by no means limited to the disease-specific research, however. There are pressing needs in other areas, as well. For example, the WDR deals at considerable length with the policy issues that arise from the structural transformations from centrally-directed toward more market-oriented health systems in many parts of the developing world. Policy makers urgently want and need research from economists and social scientists to help them deal with the new questions raised by these transformations. They also need assistance from the social science research communities in dealing with the social and gender factors that determine inter-group differences in health status, and in understanding household-level behavioral considerations that play such an important role in influencing health conditions.

C. Consultation

The third need, flowing from the inadequacy of present coordination arrangements, is for greater and more effective consultation among donor representatives and those associated with research in developing countries. Certainly, a great deal of consultation is already occurring through

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[16] Health Research, p.71.

frequent, if largely ad hoc, international meetings like that taking place in Ottawa; through WHO's Advisory Committee on Health Research; and through country-level arrangements like those in Zimbabwe, Bangladesh, Mozambique, and Senegal referred to in the WDR.[17]

Yet despite all this, the coordination problems noted above continue to exist. Something better is clearly needed. The Ottawa Conference paper on increasing and redirecting external health assistance deals with country-level coordination of overall resource flows. Many would argue that there is a need for something comparable with respect to health research, at both the country and the international levels.

III. Options

Once needs have been identified, it will be necessary to consider options for filling them and to determine a suitable mechanism for this purpose. Since the options most worthy of consideration will depend upon the nature of the needs to be filled, any detailed assessment of options in advance of the discussion in Ottawa concerning needs would be premature.

It is, however, both possible and important at least to begin thinking about options. This can perhaps best be done through reference to a set of illustrative possibilities. What's presented here is a limited number of such possibilities, selected on the basis of the frequency with which they have arisen in recent considerations of relevance and coordination issues.

In any possibility that might be considered, there would clearly need to be a central role for the international agencies that have been playing such a constructive role in international health to date. These would no doubt include the World Health Organization, as the lead international agency concerned with health research; the World Bank, as the principal multilateral financial supporter of health activities and the agency that has so effectively called attention to the pressing issues noted at the outset through its 1993 World Development Report; and the United Nations Development Programme, which has a distinguished history of working with both WHO and the Bank on inter-agency health initiatives.

One option, certainly, would be to leave it to one or more of these agencies to deal with the needs that have been identified, either in the manner it best sees fit or within the framework of a specific mandate or charge recommended by Ottawa Conference participants. Beyond this are numerous possibilities based on recent experiences in health and related areas of development.

Four such possibilities for complementing the current work of the leading international agencies are presented. Each deals with a possible mechanism for dealing with the issues and needs discussed earlier. The first two possibilities concern institutions already involved with health research; the other two look for inspiration to mechanisms that have worked well in other areas

[17] 1993 World Development Report, p. 168

of development. The four possibilities are by no means mutually exclusive: it might be desirable for one to fill some of the needs referred to above, and another to be concerned with the other needs; or to turn to some alternative option incorporating be best features of each of the four.

A. Emulating the Tropical Diseases Research (TDR) Programme and the Human Reproduction Programme (HRP)

The UNDP/World Bank/WHO TDR and HR Programmes are well enough known in health circles not to need any further extensive introduction. As indicated in the passage from the WDR cited at the outset, they have produced noteworthy results.

In the process, each has developed a reputation for dealing effectively with the three needs outlined in section II, as they pertain to its areas of concern. That is, each has stimulated a great deal of research on priority issues, has been actively engaged in capacity development, and has featured active inter-donor consultation in the establishment and implementation of priorities.

One of the possibilities that could be considered is the establishment of programs like TDR and HRP in other areas of health research. For example, one might imagine a TDR/HRP-like program dealing with one or more of the important disease priorities appearing in annex A, or focusing on issues associated with health sector reform.

B. Linking with the Council on Health Research for Development (COHRED)

COHRED is a recently-established successor to the Commission on Health Research for Development, whose 1990 report has figured prominently in this paper. It is governed by a group of leading developing country health research policy-makers and donor representatives. COHRED's principal activity at present is to coordinate the preparation of locally-developed priorities for Essential National Health Research in some 15-20 countries of Africa, Asia, and Latin America. It is supported by a consortium of donors led by IDRC of Canada and SAREC of Sweden. Its small secretariat is located in Geneva.

Thus far, COHRED has been more active in dealing with some of the three needs listed in the preceding section than with others. Its focus has been on stimulating priority research at the national level; it has been less concerned with research at the international level. It has done little to date with respect to capacity building but has begun to turn its attention to this issue through preparation of the strategy paper referred to earlier. As a multi-donor initiative, it has proven quite effective in drawing together both donor and developing country representatives to deal with the issues of mutual concern.

As COHRED's leaders are among the first to point out, COHRED is just now beginning to find its way. This raises the question of how many different responsibilities it should try to take on how soon. But there is general agreement that COHRED deserves to be strengthened; and encouraging it to undertake additional functions as soon as feasible remains an important option.

C. Looking to the Consultative Group on International Agricultural Research (CGIAR)

The CGIAR is a consortium of donors providing some $260 million of support annually to nearly 20 international agricultural research centres, primarily in the developing world. The CGIAR and its centres have made widely-recognized contributions to agricultural research, notably through the development of high-yielding wheat varieties at the Mexico centre and highly-productive rice strains in the Philippines.

With respect to the three needs laid out in the preceding section, the CGIAR has been most obviously successful in dealing with two. The first has been in stimulating high-priority research with respect to individual crops at the CGIAR-assisted international centres. The second has been in facilitating coordination among a large number of donors in mobilizing financial resources to support this research. It has been less well known for developing research capacities or for assisting research at the national level.

The possibility of establishing a CGIAR-like mechanism in health has attracted widespread attention. It is mentioned in the WDR[18] and discussed in accounts of the Report's contents.[19] It is also covered at some length in the Commission's report. The Commission found the CGIAR experience highly relevant for health. In general, it favoured using it as a means of strengthening national institutions, with international centres like those supported by CGIAR being reserved for special cases.[20]

This suggests the possible desirability of a CGIAR-like institution to coordinate and raise funds for a diverse set of health research organizations. These might perhaps include leading national health research programs, some international networks dedicated to the strengthening of national research institutions (such as TDR, HRP, and networks belonging to the Puebla Group), and a few international institutes (such as the ICDDR,B).

D. Learning from the Donors to African Education (DAE)

DAE is a consortium of some forty international, national and private donor agencies formed in 1988 as an outgrowth of a World Bank report on education in Africa. Its objective is to provide a forum for policy dialogue, consultation, and joint planning between African governments and donors, and among the donors. DAE activities are directed by an executive committee of African education officials and donor representatives. The activities are of three types: continuing dialogue on policy options through regular meetings of DAE members; support

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[18] Ibid., p. 169

[19] As, for example, in the Science magazine account of the World Development Report's release. ("World Bank Report Calls for Network to Bolster Research, Science , vol. 261, no. 5118 (9 July 1993), p. 155.)

[20] Health Research, pp. 58-60.

for discussion and research through working groups dealing with particular topics (such as textbooks, higher education, capacity-building for research) and organized by different participating donors; and dissemination of the results produced by the working groups and the debates on policy options. The DAE secretariat, originally housed at the World Bank, is currently located in the International Institute for Educational Planning in Paris.

Thus far, the DAE has paid greater attention to consultation and coordination than to the other two needs for health research listed in section II. The other two -- capacity development and priority research -- have not been ignored, however. As noted, there is a DAE working group concerned specifically with capacity development for educational research; and some of the DAE working groups have been providing research support.

An unusually widespread consensus about DAE's value exists in the African education community, and this provides a basis for considering something similar in health as an option. If desired, any comparable health entity could build on DAE's strengths in the consultation area with more active capacity building and research support components.

IV. Questions

The basic question before the Ottawa Conference is which action option is best suited to the needs and issues that have been identified. This question can perhaps most appropriately be addressed in two steps. The first is to review the issues, needs, and options suggested in the preceding sections to ensure that they are the most important ones, and to modify them as appropriate. The second is to identify the particular option, from among those under consideration, that can best fill the most important needs.

A. First Step

In the first step, questions to be addressed might include:

1. *Issues*. The presentation in section I featured three issues often appearing in discussions of health research: quantity and quality, relevance, and coordination.

- Are these the most important issues, or are there others that should be given higher priority?

- Are some of the three issues noted significantly more important than others? For example, would anyone wish to argue that, contrary to the position presented in section I, most of the health research currently being undertaken is highly relevant to developing country health concerns; and that relevance is thus not a major issue?

2. *Needs*. Section II deals with three needs, derived from the three issues referred to in section I. These needs are: capacity development, priority research, and more effective consultation.

- Are these the needs that follow most logically from the issues raised?

- How important is each need relative to the others? For instance, should more importance be attached to strengthening research capacities, especially in the developing countries, or to applying the capacities that now exist to undertake priority research?

- Has each need been correctly outlined? Speaking of priority research, for example, can the most important issues best be identified through an epidemiological approach like that suggested in section II; or should primary reliance be placed on some other method, such as guidance by the views of the population served or of policy makers about issues of greatest concern to them?

3. *Options*. Section III notes the importance of the World Health Organization, the World Bank, and the UNDP in any instrumentality that might reasonably be considered. The text then goes on to suggest four possibilities, one each based on models that have worked well or appear promising in other areas of health and development: TDR/HRP, COHRED, CGIAR, and DAE.

- These are obviously but four of many possibilities that could have been put forward.[21] Are there others which are perhaps even more promising, or which contain features worthy of note?

B. Second Step

Once the range of important issues, pressing needs, and promising options has been clearly identified, it will be necessary to choose. That is, further progress will require selecting from among the available options on the basis of their suitability for the needs at hand.

The choice will no doubt be difficult and will involve answering many questions. Among them are:

- Are existing institutions and programs sufficient to increase the quantity, quality, and relevance of health research to the extent desirable; and/or to fill any other needs identified by Conference participants? Or is there a case for a special initiative?

- What should be the principal emphasis of any special initiative? For example, should it focus on essential research at the national level, or at international research on global issues? Should it give highest priority to strengthening capacities; to promoting research on high-priority issues using existing capacities; or to ensuring more effective consultation among donors, policy makers, and/or researchers?

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[21] For example, the COHRED report on research capacity strengthening referred to earlier includes a discussion of lessons to be learned from the International Network for the Improvement of Lathyrus Sativus and the Eradication of Lathyrism (INISEL).

- How should any such initiative be organized and administered? Should it be given over to one or more of the leading international organizations, or would some supplementary mechanism be more appropriate? If a supplementary mechanism, what should be its principal features?

- Who would pay? How much would the donor agencies participating in the Ottawa Conference be prepared to contribute to any attractive proposals emerging from the Conference?

Illustrative priorities for research and product development funding established by examining the burden of particular conditions, the cost-effectiveness of present interventions, and prospects for innovation.

Condition	Morbidity and premature mortality burden in developing countries*	Cost-effectiveness of present interventions	Illustrative research priorities for prevention, treatment, and case management
Perinatal and maternal mortality	125	Cost-effective interventions exist for most of this burden.	Operations research to lower intervention costs and to improve ease of delivery in rural areas.
Respiratory infections	119	Cost-effective treatment exists to deal with about 40% of acute respiratory infections (those that respond to antibiotics). Patient compliance with drug treatment is a problem.	Operations research directed at cost-effective ways to reduce indoor air pollution. Inexpensive or simplified antibiotic regimens. Inexpensive, simple, reliable diagnostics. Pneumococcal vaccine.
Diarrheal diseases	99	Oral rehydration therapy is cost-effective but only suitable for treatment of about 40% of the disease burden.	Rotavirus, enterotoxigenic e.coli vaccines. Improved cholera vaccine. Ways of improving hygiene. Better case management of persistent diarrhea. Prevention of diarrhea by the promotion of breastfeeding and improved weaning.
Childhood cluster (pertussis, polio, diphtheria, measles, tetanus)	67	Cost-effective immunizations exist, but coverage needs to increase.	New and improved vaccines to reduce number of patient contacts, delivery of vaccines earlier in life, and improve heat stability in some cases.
Tuberculosis	46	Cost-effective interventions exist. Drug resistance and compliance are problems.	Operations research on more effective compliance. Monitoring tools for drug resistance. Simpler diagnostics for use in health centres. New and cheaper drug treatment protocols.

*Millions of disability-adjusted life years

Illustrative priorities for research and product development funding established by examining the burden of particular conditions, the cost-effectiveness of present interventions, and prospects for innovation.

Condition	Morbidity and premature mortality burden in developing countries*	Cost-effectiveness of present interventions	Illustrative research priorities for prevention, treatment, and case management
Ischemic heart and cerebrovascular disease	42	Some tobacco control measures are highly cost-effective. Cost-effective post-stroke or post-myocardial infarction management is possible through behaviour modification and appropriate medication.	Research on low-cost management of condition.
Sexually transmitted diseases (excluding HIV)	41	Cost-effective treatment exists for symptomatic individuals. There are problems from asymptomatic infection, high-cost diagnostics that cannot be carried out in a health centre, and lack of a female-controlled method of prevention.	Low cost diagnostic tests for gonorrhea, chlamydia, chancroid, trichomoniasis and syphilis suitable for use in health centres. Female-controlled, nonintrusive method of prevention (e.g. vaginal virucide). Treatment algorithms for reaching asymptomatic women.
HIV	28	Some cost-effective approaches to prevention have been identified. No effective cure exists. Drugs prolonging life are very expensive.	Female-controlled prevention methods, such as vaginal virucides. AIDS vaccine for prevention, therapy, and/or prevention of transmission from mother to fetus or infant. Simplified HIV diagnostic tests with lower costs.
Motor vehicle collisions	26	Taxes on alcohol represent a cost-effective approach.	Operations research to identify and test additional cost-effective interventions such as driver education campaigns and improving highway "danger spots."
Helminths	18	Cost-effective drug treatments exist for many helminths but exclude potentially pregnant and lactating women.	Operations research directed at expanding coverage. Verification of drug safety during pregnancy to expand coverage. Multi-disease chemotherapy. Recombinant vaccines for schistosomiasis.

Source: Background material for the 1993 World Development Report

Increasing and Redirecting External Assistance for Health

External assistance for health, estimated at US$4.8 billion in 1990, amounts to a less than 3 percent of health expenditures in developing countries. But it can constitute a significant portion of the investment budget (and, in some countries, a large portion of the total health budget), and it can play an important catalytic role in health policy reform. One objective of the Ottawa Conference is to discuss and agree to actions to increase the level and improve the effectiveness of external assistance through strengthened partnerships among the international community and governments.

Currently, there is a mismatch between key international policy statements on health and trends in ODA. A strong consensus emerged in the 1980s on many fronts that investments in human development are central to economic and social development, and merit high priority for governments and donors alike. Yet official development assistance (ODA) for health as a share of total aid declined over the 1980s: health's share of ODA fell from eight percent for the period 1981-85 to 6.5 percent for the period 1986-90 after increasing steadily over the 1970s.[1] Many low income countries, particularly in Sub-Saharan Africa, will need more assistance just to reach a very minimum level of health care.

Equally important, the effectiveness of external assistance and domestic resources offers much room for improvement. There continues to be substantial donor spending on sophisticated hospitals and equipment that provide services of low cost-effectiveness, primarily to the better-off in developing countries. The efficiency of donor support is also weakened by the existing fragmentation of external assistance to many countries. This efficiency is also constrained by important gaps in donor interest and expertise, particularly in the areas of health policy reform. This paper analyzes the role of donors in helping to reshape health policies and in improving domestic resource mobilization for health in developing countries. The paper focuses on five key questions[2] that are explored in more detail in the sections that follow:

- How can donors improve the allocation of aid?
- How can they reduce the resource gap in the poorest countries that prevents them from providing a minimum package of services to the poor?
- How can they address weaknesses in donor expertise?

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[1]ODA is defined as resources administered with the promotion of economic development as their main objective, that contain a grant element of at least 25%. Total external assistance is a broader concept. It is made up of ODA, multilateral loans, and NGO flows. See Michaud and Murray 1993.

[2]These areas are intended to provide the basis for a much expanded discussion on aid effectiveness, not necessarily limited to the issues and options presented here, at the Ottawa conference.

- How can they address weaknesses in donor expertise?
- How can donors enhance country-level coordination of donor involvement in health policy dialogue and financial aid for health?
- How can they address the stagnation of overall flows for health as a share of ODA?

Issue 1: Aid is misallocated

Investments and technical cooperation are often made with insufficient attention to the cost--effectiveness and equity implications of such investments. There continues to be support for investments in new tertiary hospitals in low-income countries while the most cost-effective health interventions, delivered at lower levels of the health pyramid (communities, health centres, and district hospitals), remain underfunded. At the same time, soft investments to improve the management and efficiency of existing hospitals are badly needed.

To improve the allocation of aid, external assistance needs to be delivered within the framework of a *country-level strategic health plan.* This health plan could define the package of public health interventions and essential clinical services that the government will strive to finance, for at least a portion of the population, and specify the policies, training and physical investments needed to deliver that national package. External assistance coupled with shifts in domestic spending could then be directed to those needs.

This national package should not be defined internationally and uniformly applied to all developing countries. Countries need to take the lead in defining their own packages and the way they will be delivered locally. The World Development Report 1993 presented an illustrative "minimum package" of public health interventions and essential clinical services worthy of consideration in most developing countries, because of the magnitude of the burden of disease that they address and their high cost-effectiveness. Some of these interventions (e.g. TB treatment and STD prevention and treatment) are still badly neglected. In the case of AIDS, the World Development Report 1993 called for an additional US$ 500 million a year in external assistance to meet one-quarter of the estimated costs of stabilizing the AIDS epidemic.

Comprehensive and coherent *country-level strategic health plans* could be prepared by drawing on the country's best public health specialists and political strategists, with donor assistance as necessary. A national consensus for the strategic plan could be sought through the process of public debate of the findings and recommendations. These plans would offer many benefits. They would increase in-country ownership of the ideas and proposals and help governments take more control of domestic and external assistance priority setting. If the strategic plans were convincing in their priorities, and assured the sustainability of investments, they would provide a strong basis for donors to argue successfully for incremental resources for that country.

Within any sort of strategic plan, external assistance will need to support long-term *capacity* building, especially in health information, policy analysis and management, and training in public health and primary care. More external assistance needs to be directed at *biomedical research* to expand the range of cost-effective treatments and at *operational research* to determine how to best deliver those interventions efficiently. Both capacity building and health research will be discussed in separate working groups at the Ottawa Conference.

Identifying the right priorities is an essential first step. Another crucial step in increasing the impact of external assistance is to improve the quality of project or technical assistance design and implementation, with special attention to project sustainability. Project sustainability can be increased if there is a sound policy environment and adequate maintenance and support systems. Currently, however, donors' instruments for technical assistance and investments are often inflexible and thus reduce efficiency and sustainability. Tied procurement can result in inefficient purchases.

Restrictions on financing local costs bias projects towards capital and import-intensive goods and services that cannot be sustained once donor funding ceases.

Options for Ottawa. The donor community can do much more to improve the allocation of current levels of aid for the health sector. The Ottawa Conference could, for example:

- discuss how to encourage the preparation of country-level strategic health plans by governments over the short to medium term, and consider a choice of mechanisms to assist in the process. A global funding mechanism could be established, for example, to provide grant funding for this purpose.

- seek consensus that increased external assistance should be directed for nationally-defined packages of clinical services and public health interventions, and call for a specific target for external assistance for these packages.

- seek consensus for the need for and identify specific external assistance targets for capacity-building.

- identify measures to encourage more recurrent cost financing in the poorest countries, and to untie aid.

- agree on the need to improve monitoring of the use of external resources and establish the next steps to do so.

- reach a consensus for a moratorium on donor support for new tertiary hospitals and sophisticated medical equipment in countries where the national package is not universally available.

Issue 2: The poorest countries need even greater assistance if a minimum package is to be provided to their populations

In many low-income countries there is a significant resource gap between health care spending and the costs of the minimum package presented in the World Development Report 1993. The Report estimated that it would cost an additional US$10 billion to deliver the package in low-income countries. How far this gap can be filled by reallocation of public spending, increased targeting of the national package to the poor, and greater domestic resource mobilization for health can only be decided on a country-by-country basis. In policy discussions with the Ministries of Finance, Planning and Health, donors can try to facilitate these changes. Yet in many low-income countries greater external assistance will clearly be needed to help close this resource gap. The minimum package was estimated to cost about US$12 per capita in 1990 dollars, but at present public spending is below US$5 per capita in at least 11 African countries containing almost 60 percent of the region's population. Similarly, in Asia the public sector spends less than US$5 per capita in Bangladesh, India, Lao PDR, Nepal, and Vietnam, with a combined population of over one billion.

To help close these resource gaps, donors can increase aid flows, linking aid to shifts in domestic expenditure, and can target existing levels of assistance to poorer countries and, within countries, to poorer populations. It is well known that geopolitical and commercial considerations play a strong role in aid allocation; analyses of the relationship between ODA and per capita income find very little relationship between these two factors. Just as countries spend their resources inequitably, so do donors. Even within countries, richer regions often absorb a higher per capita share of assistance.

Table 1. Per Capita External Assistance by Region, 1990

Region	Per Capita Aid (US$)
Sub-Saharan Africa	$2.45
Latin America and the Caribbean	$1.33
Middle Eastern Crescent	$1.31
Other Asia and Islands	$0.87
India	$0.34
China	$0.07

Note: For an explanation of regions, see World Development Report 1993.

On a regional basis, external assistance has been heavily focused on Sub-Saharan Africa, making up almost 15 percent of total health expenditures in that region in 1990. On a per capita basis, as well, Sub-Saharan Africa is the largest recipient of health aid flows (Table 1). Some countries are heavily aid-dependent: in Mozambique, for example, aid accounted for more than half of recurrent spending and for 90 percent of capital expenditures for health in 1991.

Consultative group meetings can be used as a mechanism to obtain sector-wide pledging of assistance. This has been used successfully in Tanzania and Zambia. If the country's absorptive capacity for more external assistance is a constraint, consultative group meetings can also be used as a mechanism to explore how best to address this problem. Local NGOs might be able to deliver more services in cases where government absorptive capacity is constrained.

Options for Ottawa. The Ottawa Conference could discuss how external resources could be better targeted to poor countries in order to help pay for a minimum package in those countries, and how policy dialogue could encourage greater domestic resource mobilization and reallocation for health. The Conference could:

- agree to a target threshold level of services (such as those presented in the "minimum package" in the World Development Report 1993) for the poor in all countries.

- set a target of external assistance for this in the poorest countries, and identify practical steps in this direction. For example, the Conference could take steps to support the World Development Report 1993's call for an additional US$1.5 billion in external assistance for the poorest countries for the package.

- call for greater donor support of recurrent costs in the poorest countries.

- sponsor a selective evaluation of those low-income countries that have received relatively large amounts of external assistance for health but show poor results, in order to draw lessons for governments and the international community.

Issue 3: Gaps in donor expertise constrain the effectiveness of aid for health

Just as capacity building is critical in developing countries[3], donors need to build up a greater reservoir of skills and expertise to assist developing countries in many key problems facing countries today. Some of these problems have emerged from changes in the burden of disease or changes in interventions required to address diseases, such as the challenges posed by the

[3]This topic is examined in more depth in the issues paper on "Capacity-Building for Health Policy and Health Systems Reform".

spread of AIDS, the health needs of aging populations, and the steady evolution of drug resistant microbes. Other problems relate to health finance and delivery policies, and here industrialized countries are searching for answers, too. In health policy reform, donors need to avoid the temptation to promote one model, but instead encourage a diversity of approaches, drawing on the lessons learned from many countries. There is also heightened awareness of the need to address long-standing problems, such as violence against women, but tools to do so are poorly developed. And even in areas where donors have worked for some time, such as in investments in equipment and facilities, success to date in establishing sustainable maintenance systems is limited. Examples of gaps in donor expertise are presented in Table 2, and include such areas as the use of cost-effectiveness and national burden of disease methodologies for priority-setting, civil service reform, and health services decentralization.

Table 2. Examples of gaps in donor experience and expertise

Broad Areas	Gaps in experience and expertise
Health systems	Essential equipment lists, equipment maintenance, referral systems, quality assurance systems
Health policy	Civil service reform, systems to link facility budgets better to performance, cost accounting and autonomy, health services decentralization
Health research	Neuropsychiatric problems. Research priorities could be established, in part, by examining the global burden of disease and the cost-effectiveness of existing interventions to address those conditions in order to identify conditions where cost-effective interventions need to be developed.
Health information and analysis	National burden of disease. Cost accounting and management information systems. Cost-effectiveness analysis.

Gaps in donor expertise could be identified so that different donors, or groups of donors, could take the lead in building up their skills and technical assistance/investment in different areas. This would require a frank and informed discussion to explicitly identify which agency or NGO might have comparative advantage in a certain area. Comparative advantage is based, in part, on the type of instruments different agencies have at their disposal for external assistance. The UN agencies focus on technical assistance. Multilateral banks, the EC, and OPEC provide grants and loans to the health sector. NGOs have their own distinct advantages: they usually have a high proportion of field staff and are grass-roots oriented, they tend to have low operating costs, and are often independent of government politics. Comparative advantage will also depend on the experience different donors have gained to date, the skills mix of their staff (or access to contracted out expertise), how closely they work with NGOs, how many field staff they have, among other factors. The identification of comparative advantage is a process that could begin

at the Ottawa meeting and continue in the form a follow up working group. It may be desirable for several donors to work together on certain key areas. In some cases, donors have already assumed leadership in certain areas. This could be made more explicit and methods of collaboration could be identified to build on that expertise. Illustrative examples of current expertise include:

- Belgium and Switzerland: district health systems management.
- Denmark and Norway: water and sanitation.
- Germany: maintenance of medical equipment.
- Rockefeller Foundation: public health training programs.
- UNICEF: micronutrient deficiencies, immunization programs.
- WHO: essential drugs, tropical disease research, AIDS prevention.

Greater south-south collaboration also merits support in these emerging areas. Chile, for example, is implementing far-reaching health policy reforms. It has supported health services decentralization and the encouragement of privately owned and operated health insurance funds. In the process it has had to face many problems and adjust its strategy. Chile could provide guidance to other countries considering similar reforms. The Tunisian government is implementing a public hospital reform program, granting public hospitals more budgetary and administrative autonomy. It may have much to offer in assisting other countries with similar reforms.

Options for Ottawa. The Ottawa Conference could:

- systematically tabulate gaps in donor capacity at the Conference and identify what donors might take the lead in building up their skills and technical assistance/investment in different areas.
- identify a mechanism to systematically share information about expertise across donors and expertise available in the private sector.
- look to the future to assess upcoming challenges in the health sector and how to prepare for them.

Issue 4: Country-level coordination is inadequate

Poor country-level coordination of external assistance can result in heavy burdens on country governments, wasted resources, and excessive transaction costs for both governments and donors. Donor agencies often have different budgetary, procurement and accounting

requirements for investment projects and technical assistance. This can be a management nightmare for countries working with several donors. Donor demands on government officials' time can be staggering: WHO calculated that the project director of a health project in West Africa was out of post for 120 days in a year when all the donor-sponsored events were added together. Donors can also work at cross purposes to each other. The World Development Report 1993 noted that recently in one West African country three different cost recovery policies, supported by three different donor agencies, were in place in different regions of the countries. In some countries where donors each work in a different province, this can undermine the formulation of coherent national health policies. Some policy differences among donors are inevitable--donors can agree to disagree. But in other cases policy advice differs at the country-level because donors have not taken the time to work out their differences.

Recipient governments have the main responsibility for aid coordination. Donor agencies can facilitate such coordination by strengthening governments' ability to lead, supporting consultative group meetings or round tables, and cofinancing projects. They can also seek opportunities for joint policy work.

Health needs to be on the agenda of consultative groups, donor round tables, and other major fora where development assistance is discussed on a country-by-country basis. Even more important are informal country-level meetings and information sharing. Donors could help create informal local groups to meet periodically with the government to review progress and problems in the health sector, as is done in Mozambique and Senegal. Such aid coordination is facilitated by the presence of policy-oriented staff stationed in the recipient country.

Donor cofinancing of important health projects and programs can reduce administrative burdens, both to government and to donors, by unifying procedures and simplifying the dialogue between the government and international community. Co-financing has the potential to improve project quality by building on different donors' skills and expertise. Multi-donor financed health and population projects in Bangladesh and Zimbabwe attest to the strengths of on-the-ground donor coordination. Broad inter-agency agreements to co-finance can also help at country level; UNICEF's recent invitation to the World Bank to combine forces to address the problem of iodine-deficiency in several regions is one such example.

A consensus among donors on policy advice is also important; conflicting advice can often be counterproductive. Joint sector assessments and policy studies involving several donors can help to build this consensus. Health policy discussions with governments also need to take place in the context of broader debate on inter-sectoral priorities and macroeconomic policies related to domestic resource mobilization and the allocation of public spending.

Options for Ottawa. The Ottawa Conference could:

- call for the systematic exchange of planned and ongoing policy work[4], completed policy papers and strategy documents.

- identify specific mechanisms to facilitate better information exchanges among donors and to promote joint policy work, cofinancing and consultative groups, and to encourage field offices to work more closely together.

- consider the establishment of electronic mail networks to connect governments and donors (globally and in-country) for a more continuous exchange of information.

Issue 5: Overall flows for health, as a share of ODA, are stagnant or falling

The UNDP has argued for more donor spending on health in its annual Human Development Report and the World Bank has made similar recommendations in its recent World Development Reports. These and other policy documents have made compelling cases for increasing aid for health. Despite this, health assistance as a share of total ODA fell in the late 1980s, from eight percent for the period 1981-85 to 6.5 percent for the period 1986-90 after increasing from an average of three percent in 1973-76 to seven percent in 1985.[5] Bilateral health aid flows declined from about seven percent of ODA during 1980-85 to five percent from 1986-90, while multilateral health aid flows increased substantially. On current trends, the share of multilateral agencies, including nonconcessional loans, is likely to continue to grow and to account for roughly half of health ODA by the mid 1990s.

The health community might look to models in the environmental area for attracting more resources to the sector. Examples include the Montreal **Protocol, where countries pledged monies** for a trust fund to support projects designed to reduce the discharge of ozone depleting substances into the atmosphere. Similarly, the Global Environment Facility, or GEF, is another example of a trust fund to support studies and investments for environmental projects.

Better monitoring mechanisms are desirable so that both the volume and uses of aid can be monitored in a more timely fashion.[6] But more importantly, thought needs to be given to how to reinstate, or even increase, health's share of ODA. This share increase would come at a difficult time, given stagnant, or even declining aid budgets in many countries. But for the

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[4]Reporting work in progress, with the name of the person responsible, would facilitate informal contacts.

[5]For a detailed discussion of these trends, see Michaud and Murray 1993.

[6]The Development Assistance Committee (DAC) of OECD produces an annual report of ODA, but only direct bilateral assistance is broken down by sector. Multilateral assistance is not monitored by sector. Studies of health sector external assistance broken down by country or activity depend on the Creditor Reporting System (CRS). The CRS has very poor coverage: it was estimated to be only 63% complete for health. Coverage fluctuates by donor and year. See Michaud and Murray 1993, for a full discussion.

multilateral banks and certain bilaterals the total resource envelope is still growing, and increasing flows for health should be supported. The World Development Report 1993 called for an additional US$2 billion from donors annually to meet about one-quarter (or US$.5 billion) of the costs of stabilizing the AIDS epidemic, and one-sixth (or US$1.5 billion) of the extra resources needed to deliver the "minimum package" presented in the report in low-income countries.

At the same time, donors must recognize the importance of intersectoral actions for health - the need to improve the "enabling" environment for health. This includes supporting economic growth policies that will benefit the poor, expanding investments in schooling, particularly for girls, and promoting the rights and status of women.

Options for Ottawa. The Ottawa Conference could:

- consider whether it would be feasible to pursue a target of US$2 billion, or a higher one, in pledges of greater assistance to health, and within that, for certain problems and countries.

- consider the pros and cons of a new global funding mechanism ~ some sort of trust fund, and, if there is support, initiate further work to explore the feasibility of such a mechanism.

- discuss whether better external assistance monitoring mechanisms should be developed and, if so, identify the next steps.

Follow up to Ottawa Conference

If concrete action is to emerge out of our discussions at Ottawa on these five issues and on others, it will be important to prioritize where there is consensus that specific actions are needed to improve quality and to increase overall levels of external assistance in health. We will need to initiate small working groups, or a similar mechanism, to carry on with specific tasks following the Ottawa Conference. And it will be essential to establish a reporting mechanism for those working groups and identify how the donors, as a larger group, will meet on a regular basis.

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