A Partnership for International Health Care

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IN THE WORLD TODAY more than a billion people live in absolute poverty. At least 250 million people contract malaria, 200 million have schistosomiasis, and tens of millions of these people are afflicted by other infectious and parasitic diseases. In several African countries, for example, 50 percent of all children born still die before age 5. Throughout the world millions of children die from preventable disease, many simply because more than 90 percent of the 80 million children born each year in developing countries are not immunized against these diseases. Despite our significant efforts to alleviate world hunger, more than 300 million children annually continue to suffer the effects of malnutrition. The effects of water-related diseases such as dysentery, gastroenteritis, and various skin infections could be avoided with clean water, a basic human need denied roughly 71 percent of the human family worldwide.

The United States cannot ignore these conditions. Our response depends on securing answers to a number of basic questions about developmental strategy, foreign policy, the role of private individuals and organizations in international health and, overall, the effective use of Government resources. In search of these answers, I have recently completed a study at the request of the President.

The focus of the study was directed to inventorying the existing resources currently being expended by the Federal Government in international health and considering ways in which they could be used more efficiently and with better coordination.

It addressed the questions of how governmental and multilateral development strategies could be reoriented more significantly to affect health and how the welfare image of international health assistance could be dispelled and the economic development aspects emphasized and reinforced.

We also looked at how we might involve the significant and unique capacities of private persons and organizations and what conditions or situations best suit their specific talents for timely, sensitive, and innovative work at the grassroots level.

And, we analyzed how we might bring the full potential of the diverse spectrum of governmental programs and resources in biomedicine, food, population, trade, and related policies to bear on improving the status of health of United States citizens and foreign nationals.

This study is the first time that an analysis of all public and private international health programs and activities has been undertaken by the Federal Government. We hope that the result will be an integrated U.S. international health policy. The report, which will be made widely available this winter, brings together in a single document what I consider to be a new area of responsibility that Congress and the Executive Branch have never before examined in any depth as a single functional responsibility. It is my hope that this report will result in eliminating forever the notion that international health is the stepchild of other Federal agency programs and begin the process of establishing accountability for international health policies in the Executive Branch and Congress.

I fervently hope that this effort will begin a national public debate which will culminate in executive, congressional, and international actions to establish a dynamic, changing, but realistic U.S. international health policy.

The extent of U.S. involvement in international health activities includes, surprisingly, some 23 different Federal agencies (see chart, page 116). Total expenditures of $528 million were identified as being international health-related, with an additional $625

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million in Department of Defense expenditures for health care provided overseas to eligible beneficiaries. U.S. contributions to health expenditures through international financial institutions are estimated at $49 million. These expenditures come to a total of $1,202 million.

Coordination between and within Federal agencies directly involved in international health is marginal at best. Although a concerted effort has been made by some individuals and some agencies to plan and coordinate the use of their resources, there is no single agency that has governmentwide accountability and responsibility for international health. Several agencies heavily involved with international policy acknowledge that they lack any in-depth health expertise on their staffs and that, up until now, they have never regarded health differently from other sectors of the economy.

As I mentioned, the scope of the report is not limited to international health activities in the public sector. The private sector's international health involvements are also carefully examined. From a financial perspective, private sector involvements in international health are more extensive than those of the public sector. By comparison, whereas the private nonprofit sector agencies rank high among developed countries in their contribution to international assistance, the U.S. Government's effort ranks only 12th among the 17 member countries of the Organization of Economic Cooperation and Development in the amount of Government aid contributed abroad as a proportion of the gross national product (GNP). In the for-profit sector, exports worth an estimated $1.9 billion and imports worth $.7 billion of medicine and medical supplies took place in 1976. Overseas sales of U.S. ethical pharmaceutical companies alone in 1975 were estimated at $4.7 billion and, in the same year, these companies spent $144 million on health research in foreign countries.

Churches, voluntary agencies, foundations, and universities are extensively involved in international health. Throughout the developing world there are about 4,000 church-related health facilities, ranging from those for village workers to medical and nursing schools.

Health of U.S. Citizens

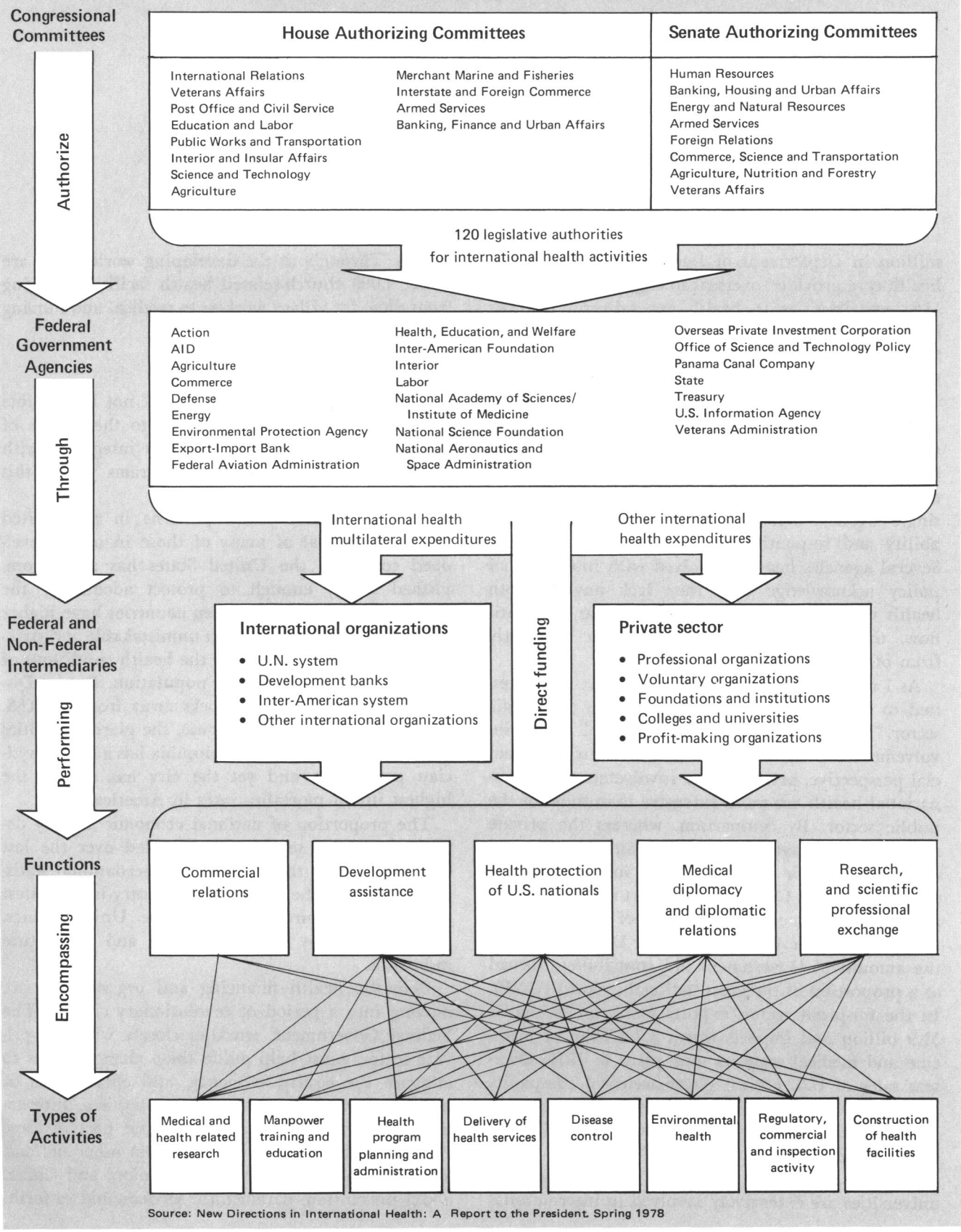
An international health policy will not be credible to other countries nor acceptable to the people of the United States if it is not fully integrated with a strategy to improve health programs within this country.

Although health status patterns in the United States are typical of many of those in other developed countries, the United States has not accomplished nearly enough to protect adequately the health of its citizens. Eighteen countries have higher life expectancy for males. An unmistakable and striking disparity exists between the health conditions of minorities and the general population. In the District of Columbia, only blocks away from the U.S. Congress and the White House, the glaring realities haunt us. The District of Columbia has a large physician population and yet the city has one of the highest infant mortality rates in America.

The proportion of national economic activity devoted to health services has doubled over the last 40 years, despite these local and international statistics. Currently, the health care industry is the fastest growing and third largest in the United States, preceded only by the construction and agriculture industries.

Domestic health financing and organization are moving into a period of revolutionary change. The Federal Government, working closely with the private sector, must help guide these changes so as to enhance the equity, efficiency, and effectiveness of health care and preventive health services. International health should play an integral part in these efforts. We have much to learn from other nations, especially in Europe, the Soviet Union, and China, about prevention, paramedical services, and so forth.

United States Government role in international health



Source: New Directions in International Health: A Report to the President, Spring 1978

• Access to health care must be improved for all people of the United States. Underserved groups of people—including inner-city minority citizens, rural Americans, travelers, and foreign nationals—will require special approaches which can, in many cases, be drawn from the experiences of other countries.

• Quality and efficiency of care will increasingly be improved by collaboration and exchange of ideas with other countries. Although many countries share the same high standard of medical care, they do so by widely varying processes. Our efforts to build effective health maintenance organizations and health systems agencies can benefit greatly from other countries' experiences. As a step in this direction, the Department of Defense will study the feasibility of making some of its health facilities around the world available for joint use by host country health professionals and U.S. clinical fellows and scholars.

• Prevention—the most promising and least well understood area of health services—requires a renewed drive through use of the best available techniques from throughout the world. Here again, some of the most effective prevention programs are to be found overseas. For example, AID developmental assistance programs are using U.S. mass media campaign approaches to achieve successes in teaching preventive health practices in maternal and child health. These experiments and projects overseas would bring significant improvement to our domestic efforts in prevention if we would bring them home.

Health Manpower

Today, health manpower problems are viewed as a major factor hindering the development and provision of health services throughout the world. Forty-three of 79 developing countries have fewer than 1 physician per 10,000 people. Ten countries, 8 in Africa, have fewer than 1 physician per 50,000 people. To make matters worse, more than 75 percent of these physicians are located in the larger cities where only 25 percent of the population resides. And it is unlikely that significant changes in these ratios can be achieved before the end of the century.

For support or auxiliary health personnel, the statistics are no less reassuring. In a recent American Public Health Association survey it was found that shortages of health workers other than physicians was the factor most responsible for impeding success in some 180 overseas projects examined. In some countries there are as few as 1 auxiliary worker per 10 physicians, and many countries still have no training programs for auxiliaries.

Given that the greatest need in most rural populations is for simple primary and preventive health care, environmental sanitation, and proper nutrition, this lack of mid- and community-level health workers presents the most serious, worldwide problem hampering efforts to develop health systems. At the same time, however, the condition which finds more than 200,000 physicians practicing outside their home countries must also be addressed. We must be aware of the significant subsidy these migrants and their countries provide. In the United States alone between 1973 and 1975, the 31,000 physicians who came here to practice represented a savings in educational costs of nearly $1.5 billion—much more than the funds allocated for health in the U.S. budget for foreign assistance for the same period.

In examining these and other conditions, we have concluded that a U.S. strategy for international health manpower must encompass the following aims.

• Strengthen institutional capacities in developing countries to train and employ their citizens as mid-level and community-level health workers to meet the health needs of their rural populations.

• Expand the availability of the more highly skilled health professionals from the United States to work in those countries with the greatest shortage of health professional manpower.

• Increase the opportunities for exchange training in the United States of health professionals from the developing world who need advanced training for jobs in their countries.

• Broaden U.S. private sector training relationships with other countries to include all manpower for health care and support systems at all levels and pay special attention to the training of local country researchers who can work on local health problems.

In pursuing these elements of a U.S. strategy, we must adhere to certain principles:

• The United States must rely on its own citizens to meet its domestic and international health manpower needs.

• Because of the nature of international health work, the personal backgrounds and heritage of U.S. health professionals who work in other countries must be viewed as at least as important as their technical, scientific, and managerial skills.

• More, rather than just a few U.S. Government and private sector organizations and people must be brought into international health work.

Development and Application of Research

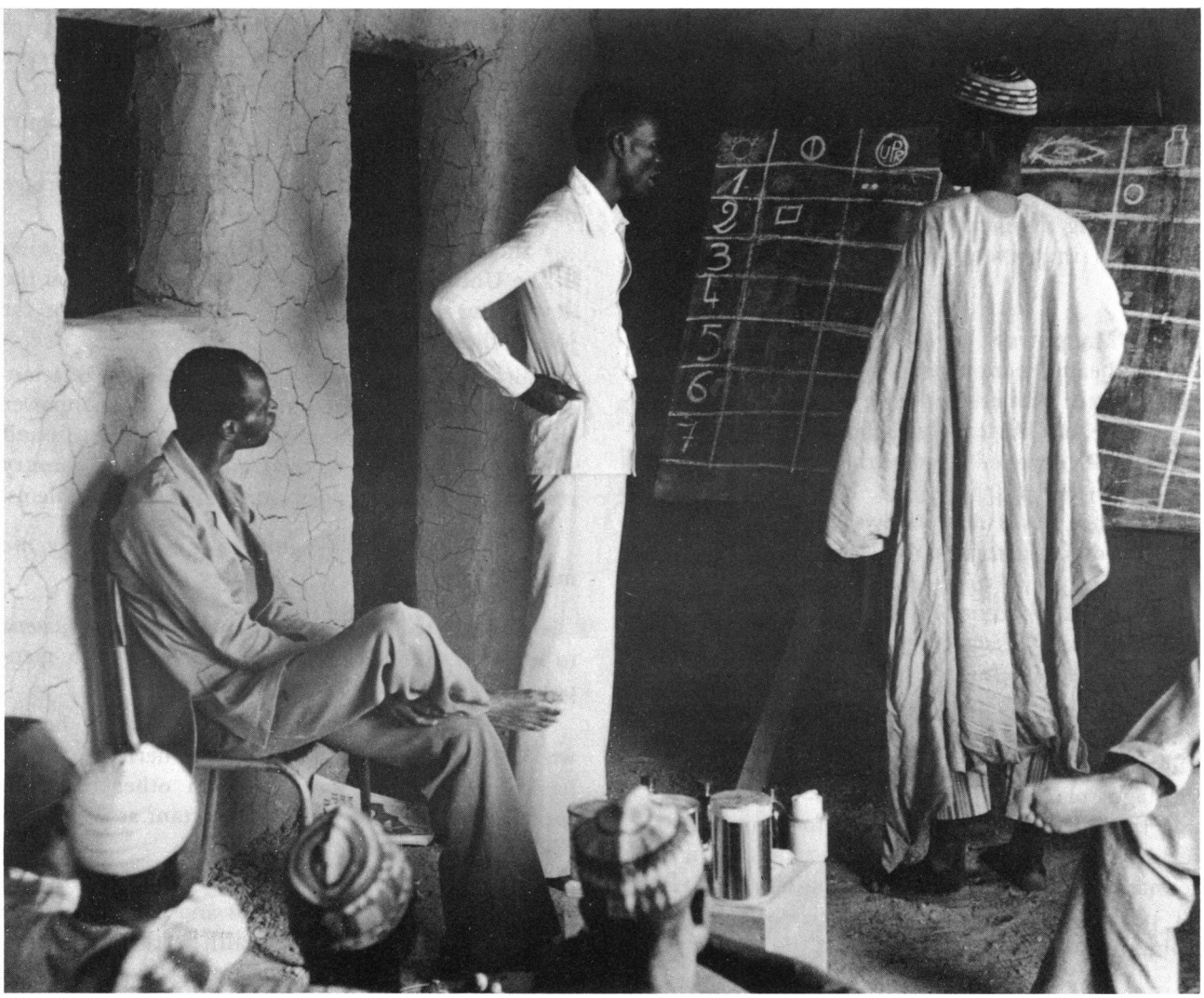
Basic and applied research on international health problems represents a major U.S. strength in global health collaboration. Eleven U.S. agencies now conduct such research; they funded nearly $111 million for this work in fiscal year 1977. U.S. pharmaceutical companies spend more than $1 billion on all their research activities and $133 million in foreign countries on pharmaceutical research.

There is no consistent U.S. strategy to relate these substantial efforts to coherent goals. Research priorities are set agency by agency and relate to each agency's specific missions. These disparate efforts have contributed to reluctance in the private sector to participate in international health research in no more than an ad hoc fashion. We must develop a strategy to dissolve these inconsistencies and such reluctance to participate. And we can do so without stifling initiative or hampering our capacity to meet important mission requirements.

An overall U.S. strategy for research in international health must be related to U.S. policy for international health. The strategy would include:

- Relating all U.S. research activities in international health to clear priorities set collaboratively with all countries and all U.S. agencies and organizations. The U.S. Government, through its own work and that work which it supports in the private sector, should increase its emphasis on those problems in developing countries for which biomedical approaches seem most likely to succeed, and which affect the largest number of people.

Village health workers in Torodi, Niger, attend a course on primary health care. The teacher is a qualified male nurse. Emphasis on training primary health workers stems from the realization that simply providing more physicians and nurses will not solve the health problems of developing countries.



• Specific targets for research should be chosen according to these criteria, and long-term commitment and support should be programed for them for work in basic research and for demonstration and application of solutions. U.S. participation with other nations in the successful global effort to eradicate smallpox is perhaps the best illustration of the effectiveness of such an approach.

• U.S. research capacity on these problems should be strengthened in academia and other private sector organizations. Much can be accomplished with greater commitment to an organized attack on the most serious problems in the developing world. Areas most in need of emphasis include delivery of health services and the planning and management of health systems as well as certain compelling problems such as malaria, schistosomiasis, malnutrition and human growth and development.

• The United States should strengthen its 15 existing research centers in foreign countries, including the Department of Defense's research laboratories, the National Institutes of Health's centers for medical research, and the Center for Disease Control's research station in EI Salvador.

• Legislative authorities for international health research in U.S. agencies should be recast to improve the compatibility of activity governmentwide.

• The United States should seek greater collaboration with multilateral efforts, most notably those of the World Health Organization. Increased funding support, indirect support of the research work of other governments, and increased opportunities for private sector participation are possible and effective means for this purpose.

We recognize that more than unilateral commitment is required. The Government, the U.S. private sector, international organizations, developed countries, and developing countries must form a true partnership to secure these goals. Outside of particular and massive global problems which require the continuing attention of all countries and organizations, U.S. research efforts must be directed to the development of knowledge that the people of other countries can use to establish self-sufficient and self-sustainable health systems to meet their ongoing health needs.

Commerce and Finance

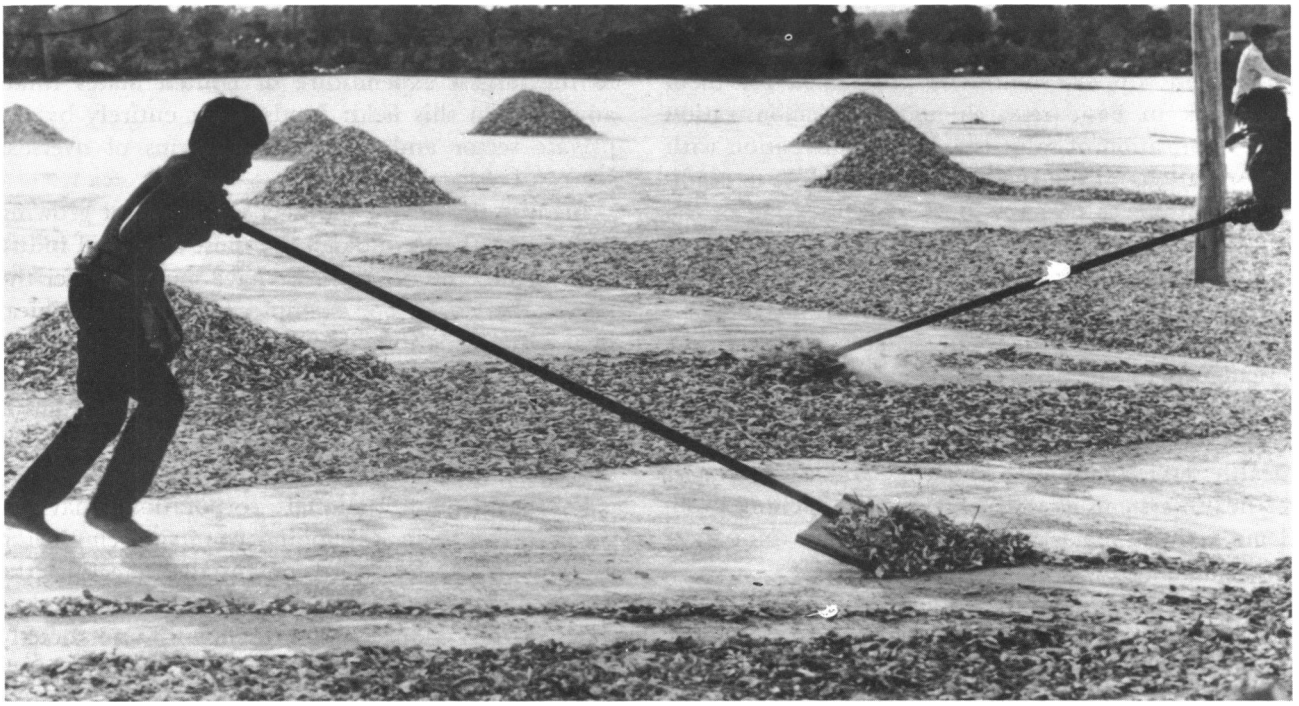
The commercial and financial aspects of international health policy perhaps illustrate best the lack of understanding or appreciation of the scope and complexity of international health policy. No one is truly repsonsible for this area. There is no critical mass of staff or expertise analyzing what amounts to the largest expenditure of United States funds anywhere in this field: funds spent entirely by the private sector and measured in terms of overseas sales and research.

Because the health industry is the fastest growing and one of the technologically most advanced industries in the United States, we have much to offer the rest of the world. For example, total sales of ethical pharmaceuticals abroad by U.S. companies were more than $5 billion in 1976. Most of these sales were made by overseas subsidiaries because a host of tariffs and nontariff barriers to trade in drugs precludes direct exports from the United States.

U.S.-based multinational corporations have a major presence in developing countries, employing millions of persons and potentially affecting the health of nearly all through the goods and services they provide. Many such firms finance and directly provide health services to employees, their dependents, and occasionally to the community. In one recent survey of Latin American branch offices of 117 large U.S.-based firms, 40 percent of the respondents reported providing health services in company facilities, and 73 percent reported paying for some employee health services. The U.S. Government must explore opportunities to stimulate these companies to more vigorous health promotion.

Private industry, therefore, can play a key role in international commerce and health. Federal agencies should give special consideration to health in setting international economic policy and in promoting the economic growth of American business. Two of the most prominent reasons for such consideration are (*a*) health initiatives are essential aspects of a basic human needs strategy and (*b*) health products and services, a field in which the United States has demonstrated a comparative advantage, appear to have tremendous potential for improving the global health picture if wisely marketed.

A principal U.S. goal should be to interrelate international health policy with resource management policy. Financial and commerical objectives should recognize the role of health in our international human rights policy and accommodate our unique resources in the health sector as well as addressing the exigencies of the availability of resources. Through such integration, the United States can advance significantly in its efforts to achieve an economically responsible basic human needs policy and a morally and ethically responsible policy in international resource managment.



Peasants in northeastern Thailand harvest cassava, a staple of the local diet. Improved methods of farming will have a direct impact on the local population.

Developmental Assistance

The forecast for health in the low income countries in the next decade is not a bright one. The complex of poverty, underdevelopment, and poor health cannot be easily broken. Rapid improvements in health are going to require a concerted effort on an international scale unprecedented in modern times. The entire community of donor nations will have to back such an effort with a concentrated program of foreign assistance oriented to meeting the basic human needs of poor people throughout the world.

Unfortunately U.S. foreign assistance has not kept pace with inflation and economic growth in this country; the last decade saw a consistent reduction of the portion of gross national product devoted to foreign assistance; it fell from 0.49 percent to 0.26 percent between 1965 and 1975. On the average, other developed countries have continued to devote about 0.4 percent of their GNP to foreign assistance, but the United States has fallen behind in the portion of resources devoted to official development assistance. The United States must increase the proportion of its GNP allocated to development assistance.

Health considerations must be more fully integrated into developmental assistance programs. The United States and other donor nations can encourage less developed countries to improve health by identifying existing opportunities and offering incentives in the form of financing and technical assistance. The United States must begin to use its good offices to encourage international financial institutions to play a larger role in health assistance. Also, the role of U. N. agencies in providing technical assistance in health needs to be given special emphasis and support.

In all developmental assistance, however, health, population, and nutrition programs need to be carefully balanced and integrated. These are complex relationships involving decisions which require careful planning and analysis. In our zeal, we must be careful to insure that mistakes of the past are not repeated.

We have been particularly alarmed at the burdensome administrative procedures currently in place for the management of U.S. development assistance programs. Weaknesses in health sector staffiing within AID are also very much apparent. We need to address these problems and streamline our assistance so that AID programs are more responsive to a basic human needs strategy. The time is now right for a thorough reassessment of U.S. development assistance programs as well as our present policies for support of the United Nations and its specialized agencies.

The fundamental principle in international health assistance must be respect for the sovereignty of other countries. When developing countries invite foreign participation, it is possible to work together to help meet the basic biological human needs of the poorest majority of the world population. Whenever possible, such efforts should be directed at making developing countries self-sufficient to deal with their own health needs on a continuing basis. Only in exceptional situations should the United States take responsibility for the operation of health services in developing countries; the duration of operating responsibility should be short and explicitly defined beforehand.

The United States and other donors can encourage developing countries to improve the health of their citizens by identifying problems and opportunities, as well as by offering incentives of partial financing and technical assistance. In many cases, we have seen that a small contribution of foreign assistance can stimulate the host country to make larger contributions to valuable programs. Criticism by many developing countries has focused on the lack of continuity in developmental programs. The United States should encourage continuity by supporting for 5 to 10 years programs aimed at reforms of the health service system or at extending services nationwide. Obviously, such programs should include careful evaluation of progress, both to encourage continuity of activity by the host country and to assure proper use of U.S. resources.

If developing countries can sustain a major effort, essential government commitment, and increase their resources and if donors cooperate, the following achievements in health may be possible in 10 years:

- Increase in life expectancy by 5 to 10 years for those countries with an average life expectancy at birth of less than 60 years.
- Reduction in infant mortality by 5 to 10 deaths per 1,000 live births per year for countries with infant mortality above 50 per 1,000 live births.
- Decrease in the death rate among children ages 1 to 4 by 1 to 3 deaths per 1,000 children per year in countries with preschool mortality above 6 deaths per 1,000 children.
- Decrease in the birth rate by 1 live birth per 1,000 population per year for countries with crude birth rates more than 25 per 1,000 population.

I emphasize, however, that rapid improvements in health would require concerted effort on an international scale. The developing countries themselves would necessarily have the major responsibility for achieving such improvements; they would have to show exceptional discipline and interest in allocating more resources and sustaining programmatic efforts. The entire community of donor nations would also have to back such an effort, with a concerted program of foreign assistance oriented to meet the basic human needs of poor people.

Medical Diplomacy

The role of health and medicine as a means for bettering international relations has not been fully explored by the United States. Certain humanitarian issues, especially health, can be the basis for establishing a dialog and bridging diplomatic barriers because they transcend traditional and more volatile and emotional concerns. Medical diplomacy can be the vehicle by which channels of communication can be established between nations when international relations are strained or severed. Nations cannot be expected to become close members of the global community when there is no dialog or interchange between them. A first step is to recognize that mutual national interests do not stop with weapons sales; health offers perhaps the best avenue with minimal political overtones.

Medical diplomacy can take many forms and, since this represents a relatively little used area in United States diplomacy, alternatives need to be carefully evaluated. The United States should reject the notion of using health sanctions in bilateral diplomacy. National leverage in international relations gained at the price of other people's sickness and pain is a price that no humanitarian country with high moral standards such as ours should be willing to pay.

We now realize that for the United States to launch an expanded program of medical diplomacy, our nation must first overcome several bureaucratic constraints that exist. Likewise, we must put in place a mechanism to help plan and coordinate the variety of programs supported by the U.S. Government directly or indirectly through multilateral organizations. We have discovered that there is presently lacking within government an authoritative focal point for international health policy. In the State Department alone, responsibility for international health matters is diffused among several bureaus; none of them have sufficient staff capable of providing the necessary expertise. Similarly, the Department of Health, Education, and Welfare (DHEW) lacks sufficient expertise necessary to provide policy advice in this area.

Summary

President Carter's commitment to deal with basic human needs throughout the world is clear. In his inaugural message to the world he pledged our support to "guarantee the basic right of every human being to be free from poverty and hunger and disease and political oppression."

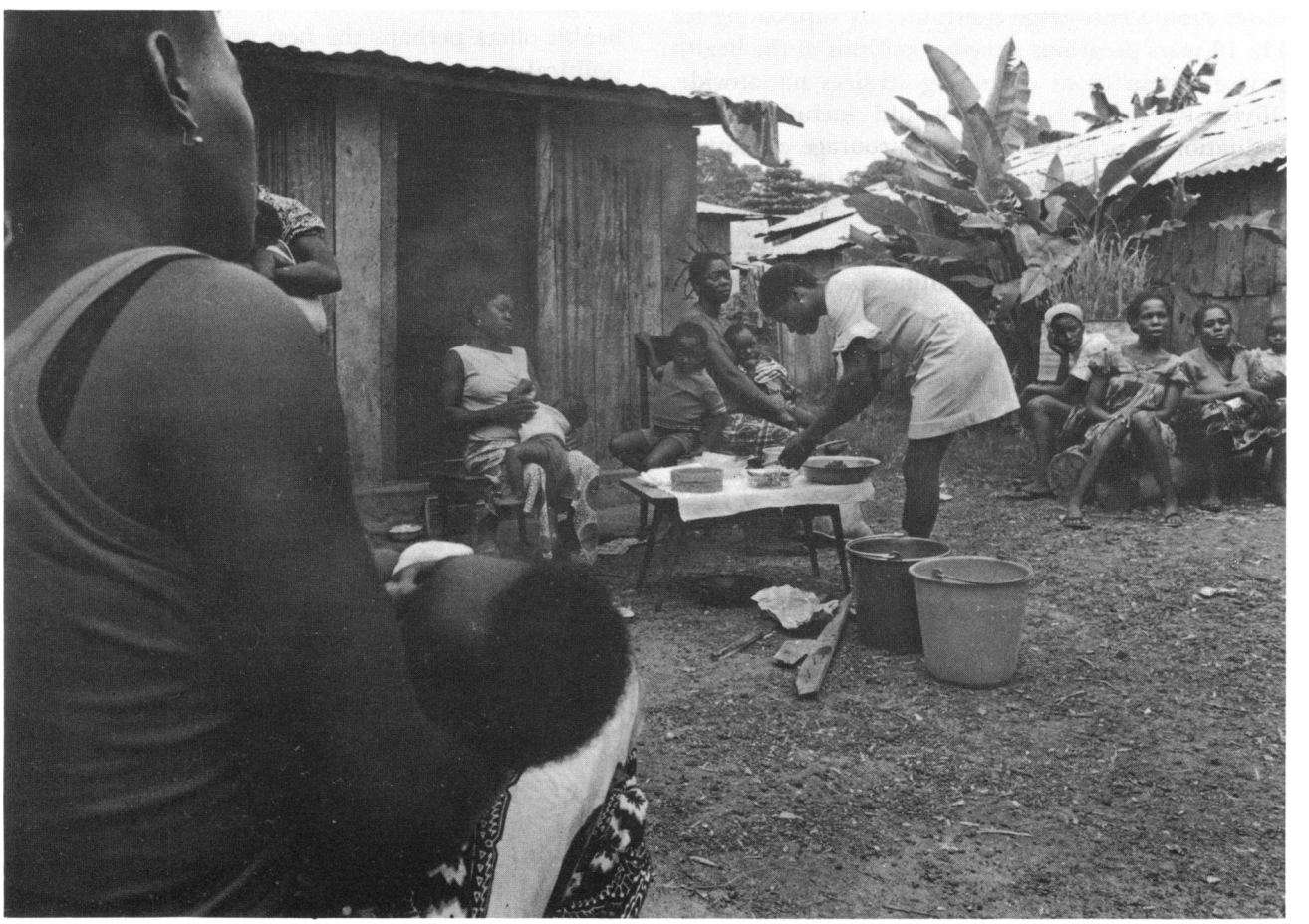
Although we must accept our share of the responsibility to meet those basic needs, it must be a shared goal and a shared responsibility with other nations. We believe that all nations and all international organizations must give increased attention to the poorest of the world. Efforts at building new economic infrastructures have sometimes helped the elite of a country, but benefits were frequently slow in reaching down to the poorest citizens. Our country's concern for human rights extends not only to those who are brutally tortured, murdered, or detained without trial, but also to those who are deprived of the basic needs of life. The poor people of rich countries should not be taxed to benefit only the rich people of poor countries.

In our bilateral discussions, through our memberships in development banks and in the United Nations and its specialized agencies, I believe we must attempt to insure that more programs are aimed directly at the poorest of the world's people and to insure that the benefits actually arrive where they are intended to go. How we actually pursue a strategy of reaching the world's poorest 1 billion people has been a paramout concern of the current Administration since its inception.

The following Twelve Point Proposal does, I believe, provide a framework for establishing a governmentwide international health policy. These 12 actions, when fully implemented, will provide a positive first step in the formulation of a new and vital U.S. international health policy.

1. We should obtain a firm commitment from key executive and legislative leaders to support an inter-

Primary health worker at a West African social center advises mothers on the care and feeding of their children. An urgent worldwide problem is how to achieve better delivery of health care, especially in rural districts of poor countries.



national health policy to foster the improved health of U.S. and foreign citizens, promote international cooperation, expand economic opportunities for U.S. business, and strengthen our national security.

2. We should formulate an appropriate relationship between international health related and development programs and U.S. foreign policy and take the necessary actions to strengthen the organization, management, accountability, and professionalism within the State Department, AID, DHEW, Treasury, Commerce, and the Peace Corps. The first step should be the establishment of a central focal point for policy formulation and coordination government-wide.

3. We should encourage the Defense Department (DOD) to become a full participant in the cause of peace by engaging, through its vast medical resources, in humanitarian and research concerns overseas that provide direct benefit to citizens on whose soil we have a presence. In the last analysis, improving relations with our friends and allies is our best defense. Enrolling DOD in such a mission can be accomplished without diminishing our national military preparedness requirements.

4. We should begin to formulate reasonable and achievable short- and long-run goals in health, nutrition, and family planning in consultation with developing and developed countries and international organizations. Only by establishing such goals will we be able to evaluate accurately the success of our various programs and plan for new directions.

5. We should establish a focal point in Government to handle private sector affairs—a place where businesses, universities, foundations, and private voluntary organizations engaged in international health can come to seek advice, information, and assistance. We should begin to study and understand the dynamics of private voluntary contributions to programs of development. Once we better understand them, we will have a stronger basis for seeking further support of these organizations in Congress and the Executive Branch.

6. We should establish planning requirements and improve accountability for results by requiring an annual international health report to the President and Congress on our goals and objectives, actions completed, the benefits to U.S. citizens, and proposed future plans. All agencies involved in international health should be required to participate in the preparation of the report. There should also be significant private sector input.

7. We should initiate a thorough assessment of career ladders, or lack of them, in both the Civil Service and the Foreign Service personnel systems and improve recruitment and personnel requirements to strengthen the public sector's capacity for evaluating technology issues directly related to foreign policy. The issue of appropriate technology transfer is crucial to the furtherance of international health; perhaps even more important, the transfer of inappropriate technologies can actually retard overall developmental objectives by draining the costly and scarce resources of developing nations. We must insure that the public sector maintains the competence and expertise to evaluate these important decisions properly so that U.S. international health assistance is appropriately and effectively utilized.

8. We should undertake a total, ongoing inventory of U.S. capabilities and resources in international health. Periodic inventories will strengthen the Federal Government's capacity to provide information to anyone, anywhere, on such matters as (*a*) purpose for which United States funds are being spent, (*b*) training capabilities, (*c*) disease trends, (*d*) vaccine development, (*e*) research, and (*f*) manpower programs. The Federal Government cannot now provide this information in a timely and effective manner.

The U.S. Government should be able to serve, quickly and accurately, a clearinghouse function for the community of users in the international health field throughout the world. Such a function would also serve as a check on possible duplication of activities across agencies and with international organizations and would enhance effectiveness.

9. We should revise the charter of DHEW and particularly the Public Health Service to include special authority to engage in activities which have global health dimensions. There are capabilities and expertise within DHEW that are unduplicated anywhere in the world; however, these resources have not been fully mobilized in the cause of international health. In some instances, legislative restrictions limit the types of involvement that Federal agencies are permitted in international health matters and, where this is the case, we must move vigorously to remove these constraints.

10. We should begin at once to reorient and expand the health manpower training programs currently in operation in DHEW, DOD, AID, and the private sector to help meet the requirements of developing nations.

11. We should harness our immense research talents to grapple with those diseases that affect the majority of the world's inhabitants.

12. Finally and, perhaps crucial to the success of our efforts, we must organize an effective constituency to support sustained efforts in international health.