

FOREIGN AFFAIRS

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Foreign Assistance
in an Aging World

Susan Raymond

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FROM MONTERREY TO MADRID

AT THE International Conference on Financing for Development held in Monterrey, Mexico, last March, the Bush administration promised it would request a \$5 billion increase in the U.S. foreign assistance appropriations for those countries "making the strongest possible commitment to development." A month later, the UN Second World Assembly on Aging in Madrid, Spain, cast a spotlight on a global trend that has been accelerating for a decade: the graying of the world's population. Both a robust increase in money for development and an acknowledgement of what has long been the reality of population aging were major departures from past U.S. policy and recent global health priorities. Headlines did not link the two meetings, but they should have.

Fundamental changes in basic population trends and public health are transforming much of the developing world. Over the past four decades, discussions of health problems in developing nations have centered on communicable diseases and the needs of children and vulnerable women of childbearing age. Accordingly, these diseases and this limited population have been the focus of the health care programs supported by foreign assistance. But this focus needs to change. Over the next 20 years, fertility will drop sharply in the developing world, and the number of children under the age of five will decline both

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as a percentage of the population and in absolute numbers. Foreign assistance programs must recognize these new realities.

The growing challenge, in turn, will be managing adult health and the expanding ranks of the elderly. By 2020, there will be more people over 65 in the developing world than children under 5. Chronic conditions such as heart disease and diabetes, which are already more prevalent causes of disability and death than are communicable diseases in all regions except Africa, will become even more widespread. As this trend unfolds, the lifetime costs of treating these ailments will far outpace the costs of managing communicable diseases.

This changing pattern of disease and vulnerability will also make more obvious the intersection between health and the economic potential of the developing world. In the next several years, before the numbers of elderly start rising dramatically, falling birth rates will provide a window of opportunity for developing nations. Those economies will be responsible for fewer dependents, and health investments will potentially bear greater returns. Maintaining the health of working-age adults will therefore have a profound economic impact.

The implication for foreign assistance is clear: Donors must recast public health programs as part of an economic strategy targeted at the work force, not just as the provision of care to women and children. But implementing that shift will require both an expansion in the substance of health assistance and a more dramatic (and difficult) correction in the decades-old culture and traditions of foreign assistance itself.

INVESTMENT BEYOND CHARITY

THE POOR will always be with us, and disasters will always happen. The humanitarian impulse to help people must and will remain a core American value. But this discussion is not about charity. It is about strategies for health investment among nations that seek to foster economic growth and create mutually beneficial self-reliance.

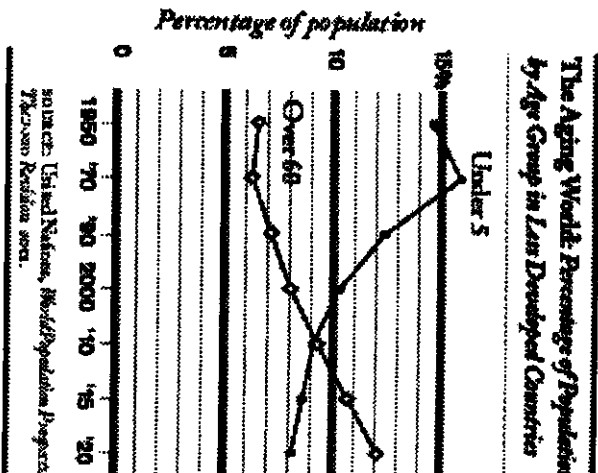
This division between charity and investment bears further elaboration, because failure to make the distinction regularly muddies the waters of foreign assistance debates. Since the 1960s, foreign assistance has generally treated whole categories of nations and peoples as dependent. Magnanimous "donors" give; vulnerable "recipients" receive. The

magnanimity of donors is questioned only in its quantity: Do donors give enough? Giving more is clearly more magnanimous than giving less, so giving more is meritorious and giving less is iniquitous. For their part, recipients have been largely passive: they simply receive and become grateful. This is charity, and it has its place.

The term "foreign assistance" itself reveals its underlying assumption: it is charity to foreigners. Recipients are residents of other nations, so from the point of view of the magnanimous donor, they are foreign. But the demographic and health changes in developing nations demand mutual investment, not charity. They call for collaboration among nations for whom there are no "foreigners." Rather, equal stakeholders need to agree on dismantling the critical barriers to economic progress, a course that would be mutually beneficial. All parties involved have joint capacity to tackle these challenges, and all parties should be ready to commit their own assets in relative proportion to their likely returns. "How much?" is no longer the standard by which resources must be judged. Increasing economic welfare, not piling on transfer payments, is the objective, and judgments on effectiveness must be made rigorously as the basis for continued investment.

BABY BUST

HEALTH PROGRAMS account for more than half the U.S. foreign assistance budget. But too few Americans pay attention to the startling new trends in the demographics of developing nations, even though demographics set the stage for health policies. First and foremost is



declining fertility. The UN-designated "high fertility" nations (where birth rates are not expected to fall to two children per woman, or the replacement rate, by 2045-50) make up only 4.4 percent of the world's population today; given current population growth rates, they will represent only 5.2 percent in 2020. Even more striking are UN projections that fertility rates in the developed and developing worlds will converge by 2050. For the HIV-intense nations of Africa, the fertility decline will be even more dramatic. By 2020, the UN expects that fertility in these nations will decline by between 23 percent and 39 percent—compared to a 21 percent decline for Africa overall.

Except in the HIV-intense nations, moreover, people are living longer. In 1950, there was a 30-year difference between the life expectancy of a newborn in the developed world and that of a newborn in the developing world. By 2020, that gap will narrow to 10 years in all but the least developed nations.

The consequences are equally monumental. The very population structure of the developing world will shift as the numbers of old overtake the young. This crossover between aging and youth has already occurred in some developing nations, especially in the Caribbean and South America. Furthermore, by 2020 the absolute numbers of children under the age of five will begin to decline.

These changes will confront developing nations relatively rapidly. In the United States, for example, it took 70 years for the 65-and-over population to grow from 5 percent to 12 percent of the population. Latin America, by comparison, will have only 35 years to master this same growth of the elderly within its population. And the clock there started ticking in 1995.

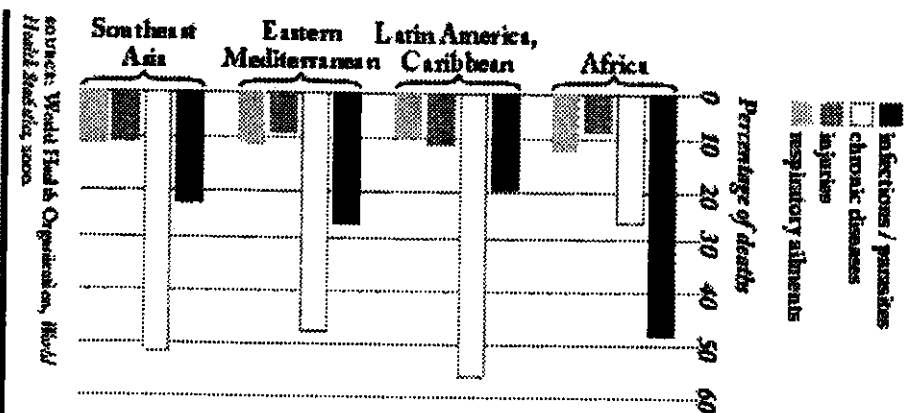
This demographic shift has profound economic implications. Until 2025, a larger work force will be carrying a smaller social burden of the young and the elderly; investments to lift productivity will have higher economic payoffs because fewer resources are needed to care for dependents. Beginning in 2025, however, the pattern will shift toward greater dependency, as the ratio of the elderly to the work force doubles. At that point, the costs associated with high dependency ratios will return with a vengeance. The housing, living, and health care costs of the elderly far exceed those of the young. The less developed world will have greater numbers of elderly, and the old there will

live longer. These elderly and their families will not escape the cost consequences. Hence, economic policymakers must take advantage of the demographic shift during the next 25 years—when dependency is at its lowest.

This approach assumes that the work force is healthy. But this assumption should be challenged as well. Overall, of course, there has been remarkable improvement in global public health. Infant mortality rates have been halved in the past two decades and are projected to drop by three-quarters by 2020. Global child mortality has dropped by 43 percent. Communicable disease control has also achieved notable successes. Since 1980, immunization coverage has risen from less than 20 percent of children to nearly 80 percent. But exceptions do exist, and where they exist they are striking: Ninety percent of malaria deaths occur in Africa. Among the very least developed nations, infant and child mortality rates remain at global highs, and significant declines, especially in HIV-intense nations, are not projected for the next several decades.

One way to maintain public health is through traditional measures such as continuing immunization and related efforts. Child survival has been the central objective of foreign assistance for several decades, and global health advocates have widely attributed progress purely to

Percentage of Deaths by Cause Among Populations With High Mortality Rates, 2000



public health interventions such as immunization and oral rehydration. But important as these programs are, other measures may be equally important. Education, for example, is the central factor in reducing infant mortality—far more significant than the degree of poverty, family size, or the proximity of health facilities. Babies of mothers with six or more years of education are less likely to die compared with those of mothers with little or no education. The International Food Policy Research Institute has found that nearly half of the decline in malnutrition in the developing world in the last several decades is explained by female education alone. The UN projects that two-thirds of developing nations will have achieved female literacy rates of more than 75 percent by 2005. As education spreads, mortality will continue to decline. Moreover, educational progress is spreading across generations. Not only are more girls literate, but more girls have mothers and grandmothers who are literate. As women's literacy becomes intergenerational, education will become the booster rocket for public health progress among mothers and children in the developing world.

DEATH AND DISABILITY

As a POPULATION AGES and mortality declines, causes of death change. Most life expectancy estimates are based on either mortality models or on calculations of disability-adjusted life-years, commonly known as DALYs. Mortality rates take death as their endpoint, whereas DALYs measure the number of years lost to disability from any particular disease. These two approaches can result in widely different evaluations of the impact of disease. A head-on car collision at 70 miles an hour, for example, results in death, but zero years are lost to disability. A diagnosis of Alzheimer's disease will also result in death, but only after many years lost to disability. Thus the two methods can provide different rankings of various diseases in measuring their relative importance to health patterns.

Interestingly, this division is hardly distinguishable in data on the developing world. Research by the World Health Organization shows similar patterns regardless of which measure is used. But that same research shows that, with Africa excepted, the chief culprits

of mortality are not communicable diseases. Rather, noncommunicable diseases—chronic conditions such as cardiovascular and hypertensive diseases, diabetes, and cancer—account for more deaths and more DALYs than do infectious and parasitic diseases such as measles or malaria. The WHO has also made disease-specific comparisons across regions for populations with similar overall mortality patterns. The upshot is that even among subpopulations with high mortality rates (usually the poor), noncommunicable diseases are more significant than infectious diseases as causes of either death or DALYs. This is a dramatic shift from the profile of a generation ago.

Another important factor is the stunning acceleration of urbanization in the developing world. By 2025, two-thirds of the population of the developing world will live in cities—a transition that will bring with it the associated sedentary lifestyle and nutrition changes. In India, for example, only two percent of the rural population has diabetes, whereas urban rates are five times that number. The WHO projects that the incidence of diabetes in the developing world will increase by 170 percent by 2025, which means that up to 30 percent of India's city dwellers will have diabetes.

How do lower mortality rates and changes in disease patterns affect the growing work force that will drive future economic progress? Here the indicators become troubling. Although overall death rates in developed countries are higher than those in many developing countries, death rates in prime labor-force years are higher in developing countries than in developed ones. For example, if death rates are compared for Portugal (a less well off developed country) with those of several developing countries, the contrast is stark. Portugal's overall death rate is higher than that of any of the developing nations, but the death rates in prime labor-force ages in all of the developing nations are higher than those for Portugal. This pattern is true for women as well as men, and for younger workers as well as older ones.

Specific chronic disease examples further illustrate the contrast and its implications for developing nations' economies. Among middle-aged workers in developing nations, death rates from circulatory diseases and diabetes are as much as seven times higher than Portugal's. Moreover, in nations with a history of vulnerability to communicable diseases, such as Thailand or the Philippines, death

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rates from circulatory diseases and diabetes in the labor force are between 10 and 100 times the death rates for infectious diseases such as pneumonia or malaria.

Even more striking are the economic implications of such death rates relative to the onset of disease. Unlike some infectious diseases such as pneumonia, chronic diseases usually kill many years after they are first detected. If men and women are dying of circulatory diseases in their mid-40s, then the onset of the disease probably occurred more than a decade earlier. Therefore, these labor-force death rates imply that people at the beginning of their productive ages (30 or 35 years of age) are further along the chronic disease curve than are their developed-nation counterparts—further along than they have any reason to be.

Here is where the convocations of Madrid and Monterrey passed each other silently in the night. Monterrey promised more money for foreign assistance, but it did not appreciate that this money must be spent on a new and emerging set of chronic-disease problems if it is to have an economic impact.

WHY CHANGE MATTERS

WHAT ARE THE CONSEQUENCES of these shifts in disease and mortality patterns? First, lower productivity and early death in the work force could reduce the opportunity for investment created by declining birth rates and reduced numbers of dependent children. At the very point at which economies can invest more of every unit of earnings, those who earn are dying. Justifiably, much has been made of this danger in discussions of the impact of HIV in Africa. But virtually nothing has been made of the very same danger regarding the growth of chronic diseases in the work forces of the less developed world.

Second, treating this changed health and disease pattern will get very expensive, very quickly. Chronic diseases build over many years. If treated when full-blown, they are costly. A full round of immunization costs about \$30, whereas treating and rehabilitating a stroke victim costs exponentially more. Equally important, those cost burdens are nearly at hand. The early stages of chronic illness are hidden just below the surface in the lives of many workers in their 30s, especially

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in urban areas of developing nations. It may be too late for prevention in this generation. Only aggressive identification of risk factors such as smoking, poor diet, and obesity can delay the onset of chronic diseases already present in young workers and prevent the debilitating event (such as a stroke) that triggers high-cost care. Recurrent costs will also rise, because those with chronic diseases will need constant treatment.

This second category of costs—health resources—comes with an added dimension that has long been ignored as developing nations have fought health battles over nutrition, public education, and infectious-disease prevention. Diagnosing, managing, and treating chronic diseases will require capital. But capital financing has not been a concern of global health specialists for many years. Infrastructure was seen as the white elephant of health care, something to be elbowed aside by a more nimble strategy of cheap interventions. But budgeting for oral rehydration packets of sugar and salt to cure diarrhea must give way to finding the resources for rebuilding the laboratory and medical infrastructure needed to diagnose, monitor, and treat chronic diseases.

Productive economic enterprise and health care budgets will not be the only areas needing extra attention as health needs change. Given the scope of the problem, we should expect that at least some of the chronic disease burden will take the form of disability. A 50-year-old diabetic amputee may have 20 more years to live, but he or she has little remaining productive opportunity. Where social security systems are in place, the cost of supporting that life will fall on disability payments. But in many developing nations, such systems exist on paper only and remain largely unfunded. Where the systems are funded, costs will rise, perhaps further and more quickly than planned. Social security systems themselves will be threatened. In either event, the cost of disability will affect the recipient's family the most. In turn, families will find themselves with larger numbers of dependents, comprising not children but disabled relatives and a growing number of elderly. The cost of disability will reach its fingers into the only wallet left: the family. The ability to reinvest earnings in productive enterprise or consumption will decline—and once again, the window of economic opportunity created by a changing demographic structure will begin to close.

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WHY CHANGE MATTERS TO AMERICANS

AMERICA FACES its own dilemmas of aging, chronic diseases, health-care cost containment, and Social Security insolvency. Why should these same trends in developing nations vie for the attentions of foreign assistance strategists? The reasons are at least threefold.

First, compromised economic capacity is in no one's interests. With the exception of most of Africa, developing nations' economies have grown in the last decades; indeed, some of the highest growth rates in the 1990s occurred in the developing world. Maintaining and even increasing that growth is good for everyone, including those who produce and export goods and services in the United States. The global economy insulates few nations from the economic woes of others.

Second, the rising tide of chronic diseases and its financial undertow will exact a social price in the developing world. Supporting disabled adults will be economically expensive, but not supporting them will be politically volatile. Furthermore, changes in disease patterns will take place alongside striking changes in education in developing nations. According to the UN, roughly half of developing nations will have achieved literacy for 80 percent of their populations by 2005. In only 12 percent of developing nations will less than half of the population be literate. Knowledge and expectations will rise. Failure to meet adult health needs and the insolvency of social security for the work force will be recognized. Public reaction is not likely to be positive.

Third, the United States should pay attention because the changes represent opportunities as well as problems. Although Americans have long struggled with ways to implement systems for disease prevention, they know a great deal about disease management. Two decades of cost-containment pressure have forced them to learn how to identify and control risk factors, and how to address chronic diseases successfully using a combination of prevention, therapy, and management.

The United States has created a strong network of institutions and professional associations dedicated to managing and preventing chronic diseases. The additional value these institutions bring to the development table is not strictly medical; most developing-nation physicians know circulatory disease when they see it. Rather, these institutions bring decades of experience in managing the struggles among disease, aging, lifestyles,

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and money. The priority is to build strong professional relationships across borders in addressing these problems. In turn, these relationships will create bridges of a different type, fostering understanding and empathy between individuals who are also often leaders in their communities, and between institutions that often enjoy prestige. They build bridges not only in areas such as technical understanding but also in values regarding open societies, human rights, individual accountability, and institutional transparency. All of these are key to resolving the central barrier to progress in the developing world: good governance.

There is precedent for just such strategies. In eastern Europe and Russia, a series of such medical partnerships has been created with support from U.S. foreign assistance. These partnerships have linked U.S. physicians and nurses with their counterparts abroad to address a range of health needs. By and large, U.S. participation has been pro bono; participants share their insights not for contractual gain but because the ethic of the profession is to share skills and knowledge for the mutual gain of all providers and all patients.

THE VISION THING

DESPIRE THE successes of this small precedent, U.S. foreign assistance today is engineered to respond neither to changes in health patterns nor to their economic implications. Its policy priorities, human resources capacity, and professional networks are geared to address the past, not the future.

For a quarter of a century, U.S. foreign assistance in health has been focused on child survival and population control. Overall, health programs represent 52 percent of the U.S. foreign assistance budget, and child survival and population control account for nearly two-thirds of health expenditures. Such a concentration of resources and interests results in part from micromanagement by Congress. In part, it also stems from the aforementioned confusion between charity and development in foreign assistance thinking. And it is a result of organizational self-interest: repeated recipients of funds tend to have vested interest in the continued flow of those monies.

Whatever the causes, the result is a foreign assistance culture that does not encourage professionals to be attuned to changes in disease

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patterns, shifts in affected population groups, or emerging knowledge and capacity within the United States itself. Concentrating huge resources on narrow problems over long periods of time has created both tunnel vision and significant vested interests in those problems among those who disburse the funds and those who win the contracts to implement the programs.

More importantly, the past quarter-century of effort has not prepared U.S. foreign assistance experts to appreciate and act on the growing link between changed health patterns and economic development. "Health" has been seen as a matter of conveying vaccines, contraceptives, technical skills, and planning skills to ministries of health, government providers of health care, and community organizations focused on health care. Yet in traditional areas of foreign assistance concern such as child survival, long-standing research has shown that women's education matters as much as or even more than other factors in reducing infant mortality. Nonetheless, those findings resulted in neither resource shifts away from health inputs and into women's education nor widespread partnerships between education and health ministries.

The existing foreign assistance culture and traditional health program strategies map poorly onto the changes in the developing world. Chronic disease management will require more than individuals changing on a variety of nonhealth fronts such as diet and behavior. Governments will also have to reevaluate a variety of more complex public policies not directly in the control of ministries of health, such as taxes on alcohol or trade policies regarding tobacco. Better management will also mean working closely with leadership whose constituencies are not women of reproductive age and children but urban workers—employers, social security administrators, insurers, and organized labor. A sensible health strategy for future foreign assistance may, in fact, be to move money out of U.S. foreign assistance budgets dedicated solely to health and into other areas of economic investment and growth—where health can be a component of a multitermed U.S. initiative.

Finally, health care strategies have poorly prepared U.S. foreign assistance programs to recognize where money currently comes from—namely, the private sector. World Health Organization data on health-

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resource flows and World Bank data on income show that, on average, 52 percent of health expenditures in developing countries came from private resources, representing \$120 billion each year. Only 16 percent of developing nations get less than a quarter of their health resources from the private sector. For the poorest nations, the private-sector average is even higher, at more than 60 percent of resource flows. In the future, affording the higher costs of the current health transition will require a deep understanding of private expenditures.

WHAT CAN BE DONE?

IF DEMOGRAPHIC CHANGE is striking and its economic implications important, and if traditional assumptions and mandates impede an effective U.S. foreign assistance response, what can be done? Bureaucracies and vested interests do not change easily. When they are tied to congressional mandates, they do not change at all. Where will the needed leadership be found?

The Bush administration is to be applauded for beginning to think differently about old foreign assistance paradigms. The creation of the Millennium Challenge Account links new U.S. assistance to developing nations' performance based on good governance. This move is an important break with past "magnanimous donor, grateful recipient" approaches. Perhaps more important, the administration's recent announcement that the account will be administered by a new and independent government corporation provides hope that old ways will not entangle new ideas. Perhaps then, when women's literacy is shown to be the decisive factor in infant survival, women's literacy will be supported. For such new beginnings also to seed new disease priorities for new categories of people and overcome hide-bound approaches to health, however, the aid community should take three concrete steps to transform U.S. foreign assistance into development investment—rather than the charity-based approach of foreign assistance—and help tackle the emerging generation of health problems in the developing world.

First, all parties with operational responsibility or with concrete relevant experience should define the problems collaboratively. Rather than consult beltway contractors, development institutions

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should gather together the leaders of private associations (medical, insurance, business) from the United States and their counterparts from nations facing the most immediate health and disease transitions. These leaders should discuss face-to-face the coming priorities and share perspectives on how to collaborate on improving chronic disease management, work-force behavior, and the long-term financing problems that developing nations will face. U.S. development institutions must define what can be done by development investments through the leadership of those who know the problems and who will implement the solutions.

Second, these institutions must experiment and then evaluate. Using those deliberations, they should develop and fund experimental programs to address the new generation of health problems among men and women of working age, ranging as far beyond traditional health boundaries as logic dictates. If literacy is the barrier, for example, then let literacy be the solution. The experiments should have a fair but finite lifespan and a careful design, and they should be evaluated mercilessly. Chronic disease management is intimately interwoven with professional capacity, medical infrastructure, and human behavior. Program effectiveness is a matter not of mobilizing armies to vaccinate babies but of identifying health crises that are hidden until they kill, monitoring those problems over time in adults who have choices about whether they will cooperate, and getting people to change fundamental behaviors such as diet. The hardest problem for U.S. development investment is not gaining more understanding of the health care future of developing nations but using money to change that future. And the taxpayers footing this bill are owed honest and open evaluation of their money's effectiveness.

Third, more knowledge is needed. The data is poor. Apparent trends in chronic diseases are striking, but their details are elusive. U.S. development policymakers should establish a five-year "studies fund" along with experimental programs. The objective is not to fund dissertations but to pursue practical insights and questions that will illuminate the nature of current trends—or even disprove them altogether. The fund would seek to generate better information and seek it quickly. Anyone from anywhere could

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apply. Study parameters would be clear and funds would be limited; time frames would be relatively short. An outside peer-review panel, consisting of members with no past or current financial interests in any U.S. foreign assistance programs, would judge applications and determine awards. Awardees would present findings directly to development investment policymakers from both the United States and from the nations in which the work takes place. Perhaps as important, awardees would be encouraged to publish in professional journals any and all data generated. Over five years, such an accumulation of knowledge would lead to a better grasp of the problems of health transitions and a better understanding of effective program approaches cultivated through project experiments.

These three efforts together will create a new cohort of people with professional interests and experience in the health care changes that link the United States to developing nations. These people can then begin to move U.S. foreign assistance into a new age. ☉