COMMENTARY

In Poor Countries, "Self-Sufficiency" Can Be Dangerous to Your Health

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The quest for "self-sufficiency" in international assistance programming has become fashionable. In the apparent belief that programs serving the basic health needs of the world's poorest people can be turned into mini-Marshall plans (analagous to the economic recovery strategies of post-war Europe), more and more international donors, spearheaded by the U.S. Agency for International Development, are stressing financial self-sufficiency as an important characteristic of international assistance programs.[1] This focus, when applied to preventive health care, is misplaced for at least four reasons:

1. It encourages a belief in will-o'-the-wisps, substituting unsubstantiated hopes ("self-sufficiency") for reasonable expectations (cost-effectiveness, for example), resulting in distorted policies.
2. It shifts the emphasis—even when conscious efforts to the contrary are made—away from the poorest beneficiaries to middle-income and even upper-income beneficiaries.
3. It reverses the time–task priority sequence for development programs, which calls for starting the most time-consuming tasks first. Instead, a self-sufficiency focus makes it more likely that the most difficult jobs will be left for last.
4. An over-emphasis on "self-sufficiency" distracts programmers from the more important tasks of providing the services they were trained to provide.

Facing Facts

The idea that we can recover from the world's poorest peoples a substantial portion of the costs of their own health care—particularly preventive health care—is based not in sound reasoning but in wishful thinking. We need to stop wishing and face a few simple truths.

First, low-income citizens of developing countries will always need subsidized health services, particularly in the preventive health care area and most particularly in the family planning area. This is not only because they are poor, but because preventive health care measures are seldom a high priority for people living near the subsistence level. Food, shelter, and curative medicine come first: survival demands it. This point seems so obvious that *The Lancet*'s editors recently characterized as "patently ridiculous" the idea of self-sufficient family planning programs "for people who struggle to survive on a dollar a day" (p. 659).[2]

For further evidence on this point we need only look at health services in the industrialized world. *All* of the world's wealthiest societies subsidize health care for their low-income citizens, most of whom are enormously affluent by less developed country (LDC) standards. In light of this, to expect the poor of developing countries to pay the full costs of their health care seems ludicrous.

Subsidization of such services does constitute a developmental investment. Low-cost family planning, like disease eradication and education, strengthens both families and societies.

Second, "self-sufficiency" is promoted as one of the ways of phasing out development assistance programs. But won't such assistance continue? Apart from a genuine desire among the people of industrialized countries to provide international assistance for humanitarian reasons, foreign aid is in the long-term self-interest of the wealthier nations. Not only do powerful special interests (like the farm lobbies in the United States) benefit directly from certain of our foreign assistance programs, but it is increasingly recognized that the improved economic well-being of the LDCs will serve the economic interests of all: More prosperity abroad means bigger markets for everyone. It therefore seems foolish to base our program policies on the assumption that important developmental efforts like family planning will be phased out any time

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soon. Far better that we should work to maintain these programs and to make them more effective.

Next, it is incorrect to describe "self-sufficiency" as occurring when one source of subsidy is substituted for another. Financial self-sufficiency for a particular activity means that the consumers of a product or service pay the full financial cost of that product or service. The fact that we may be able to persuade another government or another agency to share the cost of subsidizing such services, admirable as that may be—and it usually is—has nothing whatever to do with "self-sufficiency."

Finally, our intellectual laxity on this matter is increasingly exhibited in such phraseology as "working toward" self-sufficiency. One frequently hears that, while we may not be able to achieve "complete" financial self-sufficiency for a given activity, we can "do more" or "work toward" such a state of affairs. This is doublethink. The fact that some family planning programs, for example, are able to recover some portion of their operating costs from customer payments may be wholly appropriate and desirable. This has nothing to do with working toward self-sufficiency if the program or activity is based on serving the health needs of the poor. "Cost-effectiveness" is relevant and important. "Cost recovery" may be useful. But these do not constitute steps toward self-sufficiency in a program whose very premise is that the poor need, and will continue to need, subsidies for certain priority things.

Forsaking the Needy

The concern with self-sufficiency tends to shift the focus of development programs away from the poor toward the middle- and even upper-income classes. Development assistance to low-income countries has frequently been criticized, often with good cause, as having done little for the really poor and much to support cumbersome bureaucratic governments and unelectable dictators. Such programs, often funneling large amounts of funds through inefficient government ministries, have served local governments and their bureaucracies very well; some, of course, have served the poor also, but often not well enough.

Given this history, there is even less justification for diverting the attention and energies of those who supervise family planning programs to matters of "self-sufficiency" because this inevitably means making contraceptive services more expensive, which, in turn, means that fewer and fewer low-income consumers will be able to afford them. This occurs even when we arrange reassuring categories for our programs that seem to cover all bases. I have, for example, encountered program representatives who comfortably assert that the "free" family planning or health projects will "take care of" the poor in that society and that other components of the project need not be priced so as to be affordable to low-income people. This is wrong. Donor-supported family planning and related health services should always be priced to be affordable to the poor. The rich can take care of themselves. They do not need international assistance. While there is nothing wrong with providing different contraceptives at different prices in order to make contraceptives more available generally (and to invite higher-income people to pay a higher price rather than to take advantage of the subsidy intended for someone else), this never relieves development program administrators from the absolute necessity of keeping their fundamental focus on activities that the poor can afford.

Symptoms of this problem abound. A recent example is a report from the International Science and Technology Institute, which, in a review of selected countries, points out that the only family planning programs that have become self-sufficient are those that "have moved from the lower-level economic groups to [upper economic groups]...who can afford the higher cost" (p. vi).[3]

First Things First

The time-task priority chart, sometimes called a PERT chart, is a device that permits managers to assess those tasks that will take the longest and that, assuming they do not require the completion of other tasks as antecedents, should be started first. If, for example, a program's objective is to increase contraceptive prevalence in a particular society, it makes sense to begin the work of reaching the hardest-to-reach clients from the first. This normally means the lowest-income, most remote rural consumers. While it is seldom possible to design programs to address such beneficiaries exclusively, it makes sense to work in this general direction. Even if urban users are expected to lead the way, the rural, low-income populations are almost always more numerous, less educated, and less convinced about family planning. Their needs should be addressed early.

The "self-sufficiency" focus turns this around. By stressing cost recovery, programmers automatically tend to swing their attention toward consumers with high income because these are the ones who can most quickly provide movement toward self-sufficiency. This is a mistake, because these people are easiest to reach. The more remote populations, on the other hand, who require a greater expenditure per capita to reach, are the very ones whose participation in a family planning program is usually most important. This is not only because their poverty makes them higher priority targets for subsidized services, but because, in general, their fertility and their numbers make them greater contributors to population growth. If program plans include these poor rural consumers from the outset, as they should, an obsession with "self-sufficiency" will become impossible, as it should.

Getting Distracted

Finally, if we ask program managers to generate income, we are asking them to vitiate their expertise and their focus. Generating income is not always compatible with providing optimum services. This is not to suggest that family planning programs should be unbusinesslike. On the contrary, such programs should be run with vigorous attention to cost-effectiveness and maximum efficiency. It does mean that, to the extent that we divert focus from the real task at hand to ancillary activities designed to respond to the issue of "self-sufficiency," we will be mitigating our programs' impact.

What, Then?

Self-sufficiency is an appropriate point of focus for *economic* assistance programs that have economic activity as their central purpose. Thus, the Grameen Bank in Bangladesh, which makes small loans to low-income women to start or expand mini-enterprises, should have the economic self-sufficiency of those projects very much in mind. Similarly, programs designed to improve agricultural practices may use self-sufficiency—indeed, improved profitability—as the proper yardstick to measure their success.

However, when it comes to *social services* like health programs and family planning, self-sufficiency simply does not apply. For these activities we must ask: How many people are we reaching? At what cost? Do the results contribute to a more prosperous, healthier society? Happily, family planning programs are especially susceptible to this kind of analysis. Costs per acceptor and, especially, costs per couple-year of protection can be calculated for almost all programs, providing a very vigorous cost-effectiveness yardstick.

These are the fundamental questions for social service programs. "Self-sufficiency" should simply be dropped from the family planning lexicon.

Notes

1 See, for example, "Self-sufficiency in CSM," *Social Marketing Forum*, No. 16 (Spring 1989): 3.

2 The comment appeared in the editorial "Nothing is unthinkable," *The Lancet* 335, 8716 (15 September 1990): 659–661.

3 International Science and Technology Institute (ISTI), Inc., *Contraceptive Social Marketing (CSM) Assessment, Volume I* (Arlington: Population Technical Assistance Project, 1988).