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House of Representatives
Standing Committee on Community Affairs

AUSTRALIA'S INTERNATIONAL HEALTH PROGRAMS

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TERMS OF REFERENCE

The House of Representatives Standing Committee on Community Affairs is to inquire into and report to the Parliament on:

1. The composition and the direction of Australia's bilateral and multilateral health-related aid with a view to assessing the extent to which donor and recipient requirements are being met, and assessing whether commercial opportunities arising directly and indirectly from the aid program in the health area are being maximised; and

2. Australia's participation in multilateral health-related organisations, particularly as they relate to the Asia/Pacific region with a view to recommending to the Government ways in which national interests might be pursued more effectively.

ABBREVIATIONS

ACCIDD	Australian Centre for Control of Iodine Deficiency Disorders
ACFOA	Australian Council for Overseas Aid
ADAA	Australian Development Assistance Agency
ADAB	Australian Development Assistance Bureau
AFAO	Australian Federation of AIDS Organisations
AGH	Advisory Group on International Health
AIDAB	Australian International Development Assistance Bureau
ANCA	Australian National Council on AIDS
ANCP	AIDAB/NGO Co-operation Program
AUSTRADE	Australian Trade Commission
CGH	Coordinating Group on Health
DAP	Direct Aid Program
DFAT	Department of Foreign Affairs and Trade
DHHLGCS	Department of Health, Housing, Local Government & Community Services
DIFF	Development Import Finance Facility
EFIC	Export Finance and Insurance Corporation
GNP	Gross National Product
ICCIDD	International Council for Control of Iodine Deficiency Disorders
IDP	International Development Program of Australian Universities and Colleges
IPIN	International Project Intelligence Network
IPSS	Individual Project Subsidy Scheme
ISSS	International Seminar Support Scheme
ITC	International Trade Communications
MOU	Memorandum of Understanding
NGOs	Non Government Organisations
NHMRC	National Health and Medical Research Council
ODA	Overseas Development Assistance
OECD	Organisation of Economic Cooperation and Development
OSB	Overseas Service Bureau
PAIDS	Professional Associations International Development Scheme
PHA	Public Health Association
PHERP	Public Health Education and Research Program
PNG	Papua New Guinea

PRT	Pacific Regional Team
RACP	Royal Australasian College of Physicians
SAEDA	South Australian Economic Development Authority
TAP	Technical Advisory Panel
TDR	WHO/UNDP/World Bank Special Program for Research and Training in Tropical Diseases
THP	Tropical Health Program
UNDP	UN Development Program
UNHCR	UN High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WATCH	Women and their Children's Health
WHO	World Health Organisation

RECOMMENDATIONS

CHAPTER 2 - Historical Influences on the Health Aid Budget

1. The Committee recommends that the percentage of Australia's overseas development aid spent on health and population be increased to 7% of the budget by 1996/97, as recommended in the World Bank's World Development Report 1993. This figure should not include funding for indirect health program support, such as through the development banks. In recognition of the historically unusual nature of the PNG aid program, this figure should also discount the health component in the conversion of PNG budget support to program aid. **(para 2.50)**

CHAPTER 3 - Other Major Participants in Health Aid

2. The Committee recommends that no further negotiations for MOUs be entered into until an evaluation is made of the benefits and cost effectiveness of the existing MOUs. Once fully established, MOUs should be evaluated triennially. **(para 3.12)**

3. MOUs are significant agreements and should not be entered into lightly. Accordingly, the Committee recommends that further MOUs not be considered until core funding is pre-committed. **(para 3.13)**

4. The Committee wants to ensure a coordinated approach to the delivery of health aid and development and recommends that formalised coordination mechanisms for future MOUs be established between DHHLGCS, AIDAB, DFAT and AUSTRADE. **(para 3.16)**

5. The Committee recommends that DHHLGCS widely publicise, with involvement by AIDAB and AUSTRADE, programs considered for inclusion in MOU plans of action. This will encourage non government organisations to offer advice and enable some degree of coordination of their own programs with the plans of action. **(para 3.17)**

6. The Committee believes that the PHERP review provides an excellent opportunity for DHHLGCS to demonstrate its commitment to international health and recommends that specific PHERP funds be set aside to support Australian tertiary institutions running extensive international education and research programs. The programs should be focused specifically on the public health needs of countries in the Asia-Pacific region. **(para 3.28)**

7. The Committee recommends that such "international PHERP" funding be guaranteed for a period of at least six years to allow proper long term planning and then on a triennial basis. **(para 3.30)**

8. The Committee recommends that DHHLGCS prioritise claims by public health programs for "international PHERP" funding commensurate with the significance of the programs' teaching and research activities in the Asia-Pacific region. **(para 3.33)**

9. The Committee recommends that NHMRC give consideration to funding: (a) further small research programs or scholarships in regional developing countries and (b) applied public health research programs. **(para 3.40)**

10. The Committee recommends that AIDAB give consideration to funding research programs or scholarships in developing countries in the Asia-Pacific public health region auspiced by public health institutions in Australia. **(para 3.41)**

11. The Committee recommends that the officer exchange initiated in 1993 between DFAT and the International Branch of DHHLGCS be continued as part of a regular program of such exchanges. **(para 3.56)**

CHAPTER 4 - Delivery of Bilateral Aid

12. The Committee recommends that the Coordinating Group on Health become the principal vehicle for health coordination within AIDAB with support from the Health and Population Section. The Group should meet once a week and liaise with country program managers on all major health sub-sectors. **(para 4.14)**

13. The Committee also recommends that AIDAB extensively publicise the existence and functions of the Coordinating Group on Health through its normal channels of communication with non government organisations. **(para 4.15)**

14. The Committee believes that AIDAB needs further in-house health expertise to provide high level policy influence and coordination within AIDAB. Accordingly, the Committee recommends that AIDAB strengthen and expand its Health and Population Section by employing further public health generalists. The people employed should have skills in epidemiology, a knowledge of health policy, health economics and experience of the health problems of developing countries. **(para 4.25)**

15. AIDAB and DHHLGCS have begun exchanging staff from program areas, in a process that can only bolster the health expertise of AIDAB and the international health expertise of DHHLGCS. The Committee recommends that further staff exchanges between AIDAB and DHHLGCS be continued and expanded where appropriate. **(para 4.30)**

16. The Committee recommends that AIDAB engage in discussion with regional aid receiving governments, multilateral health organisations and interested parties in Australia to determine five or six major health priorities in developing countries in the Asia-Pacific region that could become the focus of AIDAB's health sector aid. The health areas, or "health sub-sectors", identified should take into account regional priorities and levels of Australian expertise. Possible sub-sectors could be, malaria, diarrhoeal diseases, rational drug use, micro-nutrition, immunology and HIV/AIDS. **(para 4.57)**

17. The Committee recommends that AIDAB then call for period contracts in each priority health sub-sector. The successful contracting groups would be drawn upon for all necessary project design and implementation consultancy work in each country where aid projects in that health sub-sector are undertaken. Project design and implementation should be treated separately from project evaluation which should be independently assessed. **(para 4.58)**

18. As a consequence of these proposals, the Committee recommends that the period contract system in the health sector be extended to include contracts over $75 000, reorganised along sub-sector lines. **(para 4.59)**

19. The Committee recommends that, initially, these extended period contracts be confined to the health and population sectors. If, after evaluation, they prove successful they could be extended to include water and sanitation projects. **(para 4.61)**

20. The Committee recommends that AIDAB continue to fund health projects not classed as sub-sector priorities, although as a secondary priority. The Committee believes that consultancies for such secondary projects can be tendered for under existing procedures. **(para 4.62)**

21. The Committee recommends that AIDAB nominate a position in the Health and Population Section responsible for, among other duties, health liaison. A person filling this position would be expected to provide advice on: health priorities in aid receiving countries; health related aid projects and who is running them; publicly available information held on AIDAB's databases (see Chapter 7); and AIDAB's various funding mechanisms. The Health Liaison Officer would be responsible for ensuring that all questions were followed up and answered. **(para 4.76)**

22. The Committee also recommends that AIDAB produce a document briefly describing AIDAB's role, its priorities in the health sector and the contact telephone number of the Health Liaison Officer. The document should initially be distributed to appropriate academic institutions, professional associations and aid groups and then provided on request. **(para 4.78)**

23. The Committee recommends that it be a condition of contracts entered into between AIDAB and developing countries that all assessment and evaluation reports will be made available publicly. **(para 4.79)**

CHAPTER 5 - Multilateral Organisations

24. The Committee recommends that DHHLGCS and AIDAB lobby WHO, its Australian funded special programs and the Western Pacific regional administration to develop uniform administrative procedures. This should allow a comparative analysis to be made of the programs' cost effectiveness and hopefully promote greater coordination and resource sharing. With better and more open management and budgetary procedures, donor countries, like Australia, will have more confidence in the special programs individually and collectively, and be willing to fund them. **(para 5.21)**

25. The Committee recommends that DHHLGCS and AIDAB should conduct a concurrent joint evaluation of WHO special programs supported by Australia. Funding priority should be given to those programs efficiently carrying out activity of direct relevance to developing countries in the Asia-Pacific region which complement Australia's bilateral aid programs. **(para 5.22)**

26. The Committee recommends that DHHLGCS fund a position in Manila to liaise with WHO's regional headquarters and other health related agencies. **(para 5.31)**

27. The Committee recommends that DHHLGCS compile a list of Australians working in multilateral health related organisations. The list should be compiled in conjunction with AIDAB. DHHLGCS should attempt to contact the nationals on their return to Australia to request a debriefing from DHHLGCS or, if appropriate, AIDAB. The nature and detail of the debriefings should remain flexible and left to the discretion of the returning national. **(para 5.37)**

28. The Committee recommends that DHHLGCS nominate a liaison position in the International Branch that can be used as a contact point for health professionals returning from overseas wishing to provide information to the Department. The existence of this position and contact details should be promoted to, amongst others, professional associations, appropriate tertiary and research institutions, NGO s and Australian WHO Collaborating Centres. **(para 5.38)**

29. The Committee recommends that DHHLGCS investigate the possibility of funding a scholarship for public health postgraduates to be seconded to appropriate health related multilateral organisations on a one or two year basis. The Committee believes DHHLGCS should be responsible for funding trainees in health sector activities, while AIDAB retain responsibility for trainees in other sectors. **(para 5.42)**

30. Secondments to multilateral health organisations would benefit DHHLGCS staff, and the Committee recommends that consideration be given to dedicating a proportion of the funds currently provided to WHO to sponsor appropriate DHHLGCS staff to WHO on a one or two year basis. **(para 5.43)**

CHAPTER 6 - The Commercial Potential of Aid

31. The Committee recommends that as a general policy, AIDAB identifies and uses appropriate local consultants in developing countries, wherever possible. **(para 6.7)**

32. The Committee recommends that AUSTRADE, with advice from AIDAB, DFAT and DHHLGCS, develops an ongoing public awareness program to inform Australian consultants, potential exporters of services and equipment suppliers, in the health sector at least, of the benefits to be gained from the international tendering process. AUSTRADE and DHHLGCS should be responsible for targeting the information to organisations in the health sector. **(para 6.37)**

33. The Committee also recommends that AUSTRADE includes all tenders issued by WHO, its special programs and UNICEF on the IPIN database. Providing advice on tenders is the first step in encouraging Australian suppliers and health experts to place bids for international tenders. **(para 6.38)**

34. The Committee believes that DIFF funding is of limited value in the health and population sectors and recommends that AIDAB not increase budget allocations for DIFF at the expense of health and population sector funding. **(para 6.44)**

35. The Committee recommends that DHHLGCS be brought into the formal liaison network with AIDAB, AUSTRADE and DFAT to ensure greater coordination and increased opportunities overall. **(para 6.49)**

Chapter 7 - Coordination

36. The Committee recommends that the Advisory Group on International Health continues, albeit with a more clearly defined role and with greater representation from the health sector. **(para 7.22)**

37. The Committee recommends that the major role of the AGH be to provide strategic policy advice on international health to AIDAB and DHHLGCS. In this role, the AGH could provide advice on: how to maximise the effectiveness of Australia's contributions to multilateral health related organisations; the health sector priorities that should be pursued on a regional and country basis; the distribution of international research funding to public health institutions and; standards for health database compatibility. These roles should be clearly defined and performance indicators set. **(para 7.23)**

38. The Committee recommends that the AGH meets four times a year, and makes use of sub-committees able to hold inter-sessional meetings where necessary. **(para 7.28)**

39. The Committee further recommends that AGH's membership be expanded by an additional two or three Ministerial appointees from the health community, with one of the additional appointees having direct experience in the commercial aspects of the health related aid program. Where necessary, the AGH should co-opt experts. **(para 7.29)**

40. The Committee recommends that the AGH provides an outline of its function and proposed areas of activity to be distributed to health sector organisations and institutions. This action should avoid the misunderstandings that have arisen in the health community about the current role of the AGH. **(para 7.30)**

41. The Committee recommends that AIDAB pursue a more sophisticated, multi-tiered approach to interacting with the health sector than through the purely commercial links in the contract process. **(para 7.36)**

42. The Committee recommends that AIDAB continue sponsorship and participation in professional conferences in conjunction with DHHLGCS. At such conferences, documents outlining AIDAB's health activities and involvement with the Australian health community should be provided, along with information on the role of the Health and Population Section, the Health Liaison Officer and the Advisory Group on Health. **(para 7.39)**

43. As part of the sub-sector contracts, the Committee recommends that the successful contractors be required to compile, maintain and distribute details of the aid programs in their sub-sector, who is running them and where the national sources of expertise are. AIDAB should be responsible for merging the sub-sector databases and promoting the combined database to public subscribers. **(para 7.46)**

44. The Committee recommends that the non confidential information in AIDAB's Lessons Learnt database be made available in printed and electronic form to public subscribers. **(para 7.50)**

45. AIDAB has expressed reservations about the cost of making its databases public and is unsure of the demand for the service. Accordingly, the Committee recommends that the databases be made available to subscribers in a pilot scheme to assess demand. The Committee believes that information in the databases should also be summarised in a printed format for wider distribution. **(para 7.51)**

46. The Committee recommends that the AGH, or one of its subcommittees, examines the potential of developing standards of compatibility for an international health database network. The network has the same potential as AIDAB's in-house databases to be made available at differential levels of access to public subscribers. **(para 7.55)**

Chapter 1

ESTABLISHMENT OF THE INQUIRY

INTRODUCTION

1.1 On 25 June 1992, the then Minister for Health, Housing and Community Services, the Hon Brian Howe MP, wrote to the then Chairman, Mr Harry Jenkins, MP referring an inquiry to the Committee. The specific terms of reference were for the Committee to inquire into and report to the Parliament on:

i) The composition and the direction of Australia's bilateral and multilateral health-related aid with a view to assessing the extent to which donor and recipient requirements are being met, and assessing whether commercial opportunities arising directly and indirectly from the aid program in the health area are being maximised; and

ii) Australia's participation in multilateral health-related organisations, particularly as they relate to the Asia/Pacific region with a view to recommending to the Government ways in which national interests might be pursued more effectively.

CONDUCT OF THE INQUIRY

1.2 The inquiry was advertised in the major metropolitan newspapers in July 1992. In addition, letters inviting submissions were sent to a number of individuals and organisations likely to have an interest in the inquiry.

1.3 The calling of the general election in 1993 and subsequent dissolution of Parliament made it necessary to seek ministerial approval to resume the inquiry after the election. This was given by the Minister for Health, the Hon Senator Graham Richardson on 11 June 1993. Interested parties and those who had already forwarded submissions were advised of the recommencement of the inquiry by the new Chairman of the Committee, Mr Allan Morris, MP.

1.4 The inquiry generated over 50 submissions and supplementary submissions from individuals, multilateral health related organisations, non government aid organisations, State and Commonwealth government bodies and associations representing academia & health professions. A list of all the submissions received by the Committee can be found at Appendix 1.

1.5 To assist its investigations, the Committee held public hearings in Adelaide, Brisbane, Melbourne, Sydney and four times in Canberra. A list of witnesses who appeared before the Committee can be found at Appendix 2.

1.6 The Committee was also briefed in September 1993 by Professor Richard Feachem, Dean of the London School of Hygiene & Tropical Medicine and Chairman of the Advisory Committee for the World Bank's World Development Report 1993: "Investing in Health".[1] Professor Feachem briefed the Committee on the World Bank report and provided an overseas perspective on Australia's international health programs.

PRELIMINARY OBSERVATIONS

1.7 Australia's overseas aid program has been the subject of detailed scrutiny in the last 20 years with a range of reviews into various aspects of the program and its administration. These have included four Parliamentary inquiries: one by the Parliament's Joint Committee of Public Accounts (1982) and three by the Joint Committee on Foreign Affairs, Defence and Trade in its various guises (1973, 1985, 1989).[2]

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1 World Bank, "World Development Report 1993: Investing in Health", Oxford University Press, 1993.

2 Joint Committee of Public Accounts, "Efficiency Audit - Administration of Bilateral Aid", Parliamentary Paper 315 of 1982; Joint Committee on Foreign Affairs, "Australia's Foreign Aid", Parliamentary Paper 3 of 1973; Joint Committee on Foreign Affairs and Defence, "The

1.8 In addressing Australia's international health programs, the Committee has remained conscious of the previous reviews which have influenced the composition of Australia's health related aid. These investigations, where appropriate, have been taken into account and not duplicated in this inquiry.

1.9 This, however, is the first Parliamentary investigation specifically into Australia's bilateral and multilateral health related aid programs and into Australia's participation in multilateral health related organisations, such as the World Health Organisation (WHO).

1.10 In December 1991, the Industry Commission published a report "Exports of Health Services" which examined the export of health services through the provision of health care to foreign patients in Australia.[3] Because the focus was on foreign patients coming to Australia, the report discussed the operation of Australia's health care system and health related immigration laws. However, the terms of reference of the Commission's inquiry did not require a review of health related aid programs or the off-shore use of Australian health services.

1.11 This inquiry has been conducted during a period of change and expansion of Australia's international health programs and their administration. Many of these changes have reflected the need to overhaul existing procedures, improve coordination and change policy directions as health becomes an increasingly significant component of Australia's overseas development assistance.

1.12 For example, the International and Audit Branch (hereafter known as the International Branch) of the Commonwealth Department of Health, Housing, Local Government & Community Services (DHHLGCS) has expanded to become more actively involved in the debate on Australia's contribution to multilateral health related organisations. DHHLGCS has a part time consultant posted to Geneva to ensure greater liaison with WHO and to raise Australia's profile within the Organisation.

Jackson Report on Australia's Overseas Aid Program", Parliamentary Paper 203 of 1985; Joint Committee on Foreign Affairs, Defence and Trade, "A Review of the Australian International Development Assistance Bureau and Australia's Overseas Aid Program", Parliamentary Paper 87 of 1989.

3 Industry Commission, "Exports of Health Services", Report No 16, 5 December 1991, AGPS.

1.13 Likewise, the Australian International Development Assistance Bureau (AIDAB) has expanded its Health & Population Section, established the in-house Coordinating Group on Health, introduced Health Impact Assessments to ensure that the positive health impacts of "non-health" projects are maximised, finalised its International Health Programs Policy Base and begun an officer exchange program with DHHLGCS.

1.14 August 1991 saw the establishment of the Advisory Group on International Health (AGH), drawing together representatives from DHHLGCS, AIDAB plus five health professionals. Representatives were appointed by the then Minister for Trade & Overseas Development and the then Minister for Health, Housing and Community Services.

1.15 AIDAB now enjoys closer links with the Australian Trade Commission (AUSTRADE) and, since October 1993, AIDAB has posted details of project tenders on AUSTRADE's International Project Intelligence Network (IPIN).

1.16 The Committee is aware of several reviews taking place as this inquiry is completed. The AGH is being evaluated and a Joint review of Multilateral Aid is being undertaken by AIDAB, the Departments of Foreign Affairs & Trade and Treasury. Funding for the Public Health Education and Research Program (PHERP) is being evaluated and this will have an impact on the international focus of public health programs run in several tertiary institutions. Internationally, WHO's Global Program on AIDS is also being reviewed. The findings of these reviews are likely to influence the administration and priorities of Australia's international health programs.

1.17 The Committee's inquiry forms part of this wide ranging revision of the policies and administration of international health programs and the Committee has made a number of recommendations to improve the efficiency and effectiveness of these policies.

1.18 Throughout the report, the Committee stresses the need for better communication between all participants in the formulation and delivery of health related aid programs. Better communication allows better coordination of programs and, hopefully, better cooperation between the participants. These attributes are the necessary precursors for an effective, high profile program which maximises benefits for aid receiving countries and Australia alike.

1.19 The report begins with a description of the historical influences that have shaped the administration of the Commonwealth's health related aid budget and its current priorities. Also examined is the size and scope of the health related aid budget and a brief overview of the main mechanisms of aid delivery. The Committee strongly reaffirms the importance of focusing aid on primary health programs within the Asia-Pacific region.

1.20 While conducting its investigations, the Committee heard concerns about AIDAB's lack of in-house health expertise and its emphasis on country programs at the expense of a sectoral approach. The Committee was also told that there should be greater communication between AIDAB and Australian health experts. The Committee has made a number of recommendations to encourage closer links between AIDAB and the health community and to maximise AIDAB's use of health expertise.

1.21 The report also examines Australia's participation in multilateral health related organisations. The Committee received conflicting advice on the effectiveness of funding and participation in the activities of multilateral agencies, most notably WHO and its specialist programs. The Committee believes that a number of strategies can be devised to improve the effectiveness and value of Australia's participation in multilateral organisations.

1.22 Both government and non government agencies have become far more aware of the commercial benefits potentially arising from international health programs. The Committee suggested several ways in which the business opportunities, arising directly or indirectly, can be further enhanced.

1.23 The report also considers ways to improve coordination and communication between AIDAB, DHHLGCS, AUSTRADE, and the myriad professional associations, multilateral organisations, educational institutions, hospitals, research organisations, companies, consultants, and non government organisations which are all involved in the delivery of health projects.

1.24 In its concluding Chapter, the Committee summarises the attributes of successful health related aid programs and discusses the development of a longer term, coherent strategy that focuses on Australia's strengths and maximises its contribution to overseas health development activities.

Chapter 2

HISTORICAL INFLUENCES ON THE HEALTH AID BUDGET

The nature of aid

2.1 Australia, as a middle ranking western power, has long recognised its obligations and responsibilities to the international community to assist in alleviating the problems of the developing world by providing humanitarian aid and sustainable development assistance.

2.2 It should be recognised, however, that the provision of this support also confers considerable financial, strategic and geo-political advantages to Australia. Development aid can contribute, however indirectly, to political and economic stability in the South Pacific and South East Asian region which is to Australia's benefit. By providing aid, Australia can develop close and friendly relations with aid receiving countries, often those closest to our shores, and bolster our image as a good international citizen. In addition, providing aid funds to combat health problems in our region, such as tuberculosis, malaria and HIV/AIDS, provides a local pool of expertise and benefits Australia's own health profile. The aid program also provides commercial benefits to Australian contractors and suppliers tendering for AIDAB contracts and introduces Australian enterprises to potential new markets in developing countries.

2.3 The dilemma for the aid program is to reconcile these objectives in a way which accommodates Australian self interests without distorting the primary goal of supporting social and economic development.

History of the official aid program

2.4 Australians have provided overseas development assistance, since early settlement times, through missionary activities and philanthropic societies. Australia's government funded aid program began later, however, with modest grants to Papua New Guinea (PNG) before World War II. In the decade after the war, aid to PNG was increased, and bilateral programs were introduced under the aegis of the Commonwealth's "Colombo Plan" for bilateral technical assistance. Australia also began contributing to multilateral organisations such as the World Bank and the United Nations Special Funds.

2.5 In 1959, the Commonwealth Cooperation in Education Scheme was established, which was used as the channel for Australian education aid to Commonwealth countries. In the 1960s, the geographic distribution of Australia's aid began to focus on the South West Pacific region and in 1964 the South Pacific Aid Program was established by Australia to provide technical assistance to countries and territories in the Pacific.

2.6 Before 1973, separate elements of the official aid program were managed by different Federal departments including: the Department of External Territories (responsible for PNG); the Department of Foreign Affairs (responsible for aid policy, bilateral programs, training programs and funding of some multilateral organisations, such as the United Nations); Treasury (responsible for aid to the international financial institutions); and the Department of Education, which was the training authority for government sponsored trainees.

2.7 In 1973, the Australian Development Assistance Agency (ADAA) was established as a statutory body to coordinate administration of all the bilateral and multilateral aid programs. In 1977, ADAA was formally abolished and the functions of ADAA were transferred to a Bureau within the Department of Foreign Affairs called the Australian Development Assistance Bureau (ADAB). It was subsequently renamed the Australian International Development Assistance Bureau (AIDAB) in August 1987.

2.8 AIDAB is now the Commonwealth government agency responsible for the administration of the official aid program. It falls within the portfolio of the Minister for Foreign Affairs and Trade, but is directly responsible to the Minister for Development Cooperation and Pacific Island Affairs (previously the Minister for Trade and Overseas Development).

2.9 In 1983-1984 a major review of Australia's aid program was completed in what became known as the "Jackson report".[1] The Jackson report noted that the wide variety of delivery forms reduced overall coordination of the aid program. One major recommendation of the report was that aid programs should be managed on a country rather than sectoral basis. While there should remain centralised policies for some areas, such as the funding of non government organisations and international development agencies, country strategies should be developed and country managers should have overall coordination of aid programs.[2] The key findings of the Jackson report were adopted and country programs remain the main mechanism for delivery of Australia's bilateral development cooperation.

Recent influences on the health component of the aid budget

2.10 The priorities and composition of Australia's health related aid programs have largely been shaped by the wider influences on Australia's overseas development assistance (ODA) programs. Australia has traditionally focused its aid efforts on the agricultural sector, which has reflected the requirements of developing countries and Australian expertise. The health sector, by comparison has received a lower priority. However, the reorganisation of AIDAB flowing from the Jackson report provided an opportunity to review all aid sectors, including health.

2.11 The Jackson report argued that, as well as using a country program strategy, Australia needed a greater sectoral focus to link developing country needs with Australian expertise.[3] As a result, in a Bureau reorganisation, the Appraisals, Evaluation and Sectoral Studies Branch was established to provide sectoral advice

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1 R.G Jackson et al, Report of the Committee to Review the Australian Overseas Aid Program, March 1984, AGPS.

2 R.G Jackson et al, op cit, Chapter 9.

3 ibid, p 59.

and policy for all country program managers. During 1986-87, the Branch conducted a sector review of the health needs of developing countries and of the relevant Australian health expertise.[4]

2.12 After discussion with interested parties, AIDAB adopted a health sector strategy in September 1987. The strategy had three main objectives:

a) increased visibility, through collating and distributing information on Australian expertise relevant to regional health needs, as well as information on existing and planned health aid activities;

b) increased focus, including a theme of WATCH (Women and Their Children's Health); and

c) improved programming to better incorporate health activities into Bureau programs in a systematic way.[5]

2.13 Follow up health sector studies were undertaken in PNG, China, the Philippines and Indonesia to match particular needs with Australian capabilities. Furthermore, a "Women, Health and Population Section" was established in AIDAB, which is now known as the Health and Population Section. A number of projects in the South-East Asian and South Pacific regions were begun and extra funding was provided for health related programs run by multilateral organisations, such as the World Health Organisation's Expanded Program on Immunisation. The new projects were collectively known as the Health Initiatives Program with $24 million allocated in the 1988-1989 budget.[6]

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4 See Hull, V, "The Health Sector in Australia's Aid Program", AIDAB Development Papers No 3, Canberra, 1987.

5 Hull, V, "Healthier, Wealthier, Wiser? AIDAB's Health Sector Strategy One Year Later", AIDAB Development Paper No 9, Canberra, 1988, p 1.

6 "Explanatory Notes 1988-89, Foreign Affairs and Trade Portfolio", Budget Related Paper No 8.8, Canberra, 1988, p 116. $6 million was also provided for population programs.

Health aid to Papua New Guinea

2.14 Papua New Guinea (PNG) has consistently been the largest recipient of Australian aid, mainly in the form of untied budgetary support.[7] In consultation with the PNG government, untied budgetary support is being phased out gradually and replaced with project funding. The new forms of Australian aid will be sector focused with health programs having a major priority.

2.15 Aid to PNG will become AIDAB's largest and most complex bilateral program and there is currently a major effort to identify and develop appropriate aid projects. As part of this effort, a large scale joint PNG/AIDAB Health Sector Review took place in May and June of 1993. The fact that the health sector has been given a high priority in the emerging PNG aid program will, by necessity, raise the profile of the Health and Population Section within AIDAB.

2.16 The effectiveness of AIDAB's design, implementation and evaluation of health related aid programs is discussed in Chapter 3.

International influences on the health aid budget

2.17 Australia's aid programs are primarily based on an evaluation of the needs of aid receiving countries and Australia's capacity to meet them. However, Australia is party to a number of international agreements which also provide broad direction for Australia's health related aid programs. Such agreements include the World Population Plan of Action (1974), the Alma-Ata Declaration on Primary Health Care (1978), the Nairobi Forward-Looking Strategies for Implementation for the Advancement of Women 1986-2000 (1985) and the World Declaration on the Survival, Protection and Development of Children (1990).

2.18 One report by an international agency that will influence Australia's health related aid budget is the World Bank's World Development Report of 1993 on global health priorities.[8] The report recommends, inter alia, that developing countries should spend less of their health budgets on expensive, specialised care in

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7 In 1969-70 74% of the aid budget went to PNG, 50% in 1982-83 and 24% in 1992-93.

8 World Bank, "World Development Report 1993: Investing in Health", Oxford University Press, 1993.

tertiary facilities and more on lower cost primary health care programs that do more to help the poor.

2.19 If the report influences World Bank lending criteria, then developing countries will have to spend greater proportions of their national budgets on health care, particularly on cost effective primary health care. As AIDAB indicated:

> "one of the things that the world development report has done, which probably could not have been done using WHO or other bodies, was, in a sense, tie in and create a nexus between the health ministries and the finance and treasuries... It is drawing this nexus and making the finance ministries sit up which is probably the most important thing that that report has done". (AIDAB: Transcript of evidence, p 907)

2.20 The composition of Australia's aid program will be affected by the new focus on the health of developing countries which will influence requests for health related aid.

2.21 The World Bank is also producing a separate report reviewing health achievements and priorities for its Pacific Island member countries. The draft report expresses concern at the expenditure on hospital based care and the corresponding lack of emphasis on primary curative and preventive services. The final conclusions of this report will also influence the aid programs of donor countries, which will have a major impact on Australia.

Other influences on the health aid budget

2.22 The priorities of Australia's health related aid budget reflect changing epidemiological trends and are influenced by a range of factors including the need to combat the resurgence of old diseases, such as malaria, and the spread of new ones, such as HIV/AIDS. For example, Australian funding for international HIV/AIDS programs has increased from $0.4 million in 1987-88 to over $5 million in 1992-93, thereby affecting the proportion of the budget available for other programs.

2.23 Of course, the major influence on the size and scope of health related aid activities is the size of the overall aid budget. As the Australian Council for Overseas Aid pointed out, health programs are particularly vulnerable to reductions in aid finance:

> "The crucial point is that health tends to be in the discretionary areas of the aid program. It tends to have small programs, which tend to be ad hoc and which tend to be through non government organisations. They are not the large infrastructure programs that go for four or five years, which are the ones that get the committed funds. So the level of funding available for aid is quite critical in terms of the level of funding that is then allocated to health". (ACFOA: Transcript of evidence, pp 539-40)

2.24 The relative priority that should be given to the health section of the aid budget is discussed in greater detail later in the Chapter.

WHAT IS HEALTH AID?

Primary Health Care

2.25 In 1977, members of the World Health Organisation (WHO) agreed that the main targets for WHO and member countries in the next thirty years should be "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life". (DHHLGCS: Submission, p 498). From this commitment, WHO developed its goal of "Health for All by the Year 2000". In 1978, WHO and the United Nations Children's Fund (UNICEF) sponsored an international conference in Alma-Ata at which it was agreed that the way to provide health for all by the year 2000 was through the provision of primary health care.

2.26 WHO defines health aid as assistance to improving primary health care. The WHO primary health care definition encompasses: health education, proper food supply and nutrition, maternal and child health, family planning, safe water and sanitation, immunisation against major childhood diseases, prevention of common

diseases and injuries, and the provision of essential drugs. A very similar definition has been adopted by the Development Assistance Committee of the OECD (Organisation of Economic Cooperation and Development) and is used by AIDAB.

2.27 Within the Australian aid budget, AIDAB distinguishes between "health" aid and "health related" aid. Health aid refers to core activities such as child health, nutrition, medical & dental services and public health programs. Population, water supply and sanitation programs are considered "health related" aid as they can have a significant impact on health. AIDAB has placed a complementary emphasis on programs directed to women and their children's health (WATCH).

2.28 A primary health care emphasis means that health aid should not be diverted to funding sophisticated tertiary facilities (such as hospitals and ambulances) which provide highly technical health services for a small cross section of the population. Rather, aid funds should be spent on cost effective, preventive health care such as nutrition and immunisation programs provided at the local level.

Too narrow a definition of health aid?

2.29 Several witnesses before the Committee have argued that definitions of health aid used in Australia that focus exclusively on primary health care are too narrow. As a result, the aid program cannot be used to support other worthwhile health related projects. For example, in its submission, the South Australian Economic Development Authority (SAEDA) (formerly the South Australian Department of Industry, Trade and Technology) commented that health projects should be more broadly defined to include provision of assistance in hospital administration, environmental health, nurse training and bio medical engineering. (SAEDA: Submission, p 50)

2.30 SAEDA also believed that Asian health requirements are now more sophisticated:

> "what we have tended to do in the past has been to focus our health aid into primary health care... Over a period that tends to give us a reputation of being experts in that area. In addition to those areas, which are important in their own right, countries like Thailand,

Malaysia and Indonesia are increasingly afflicted with the western diseases - cancer, coronaries and so forth. We are not using our AIDAB funds to promote our expertise in these areas". (SAEDA: Transcript of evidence, p 369)

2.31 This latter point was reinforced by the firm International Business Consultants (Australia), who warned that AIDAB aid policies, in Indonesia at least, "are still conceived with more attention paid to an impoverished past than to a now foreseeable prosperous future...". (ITC: Submission, p 402)

2.32 Arguments for AIDAB to adopt a wider definition of "health aid" are echoed in other evidence. Halsodel Consultants argued that:

"It is possible that "WATCH" is too limiting a theme. Excessive emphasis on so-called primary health care and community health services including maternal and child health, overlooks the need for preventive services to be backed up by curative services...". (Halsodel: Submission, p 122)

and the Chairman of the Australian Centre for Control of Iodine Deficiency Disorders (ACCIDD) noted:

"The way the system operates is that... there is... a bias towards primary health care. There is nothing wrong with that but if that bias operates to the exclusion of higher technology sophisticated health care, then it is wrong". (ACCIDD: Transcript of evidence, p 159)

2.33 The Committee, on the other hand, believes that the health related aid budget should remain closely focused on preventive primary health care projects. Calls to provide aid funding for more sophisticated forms of health care delivery will draw too many scarce resources away from the main focus on cost effective primary health care programs. According to the Nutrition Program from the University of Queensland:

"If we are genuinely looking for a pay-off in terms of the health of

people, we will put much more into primary health care than people are currently advocating". (Nutrition Program, University of Queensland: Transcript of evidence, pp 498-99)

2.34 From an international perspective, the World Summit on Children in 1990 stated that health aid should focus on primary health care. Similarly, the World Bank has commented that:

"The productivity of aid would increase substantially if donors were to direct more of their assistance to public health measures and essential clinical services, especially in low-income countries".[9]

2.35 There are a variety of ways in which primary health care development assistance can be delivered. For example, direct health aid can be provided in-country through nutrition and iodine programs and the provision of family planning services. Equally vital components of primary health care assistance can be provided indirectly, both in-country and from Australia. Examples of indirect primary health care are: fundamental medical research into a malaria vaccine; the training of indigenous public health and medical experts, both in Australia and in-country; assistance to develop sustainable health policies, such as rational drug use and HIV/AIDS programs; institutional strengthening, such as funding for the Fiji School of Medicine; and the development of basic public health infrastructures in developing countries, such as maintenance of cold chain facilities for vaccines and the construction of sewage treatment works.

2.36 It should be noted that health care is also provided indirectly through other sectors of Australia's aid program. In 1992-93, a further $80 million of aid was employed on health related programs through indirect channels such as Papua New Guinea budget support, development banks and other sector projects. Thus, agricultural sector aid, for example, can ultimately improve health outcomes by providing better nutrition. In another example of indirect health aid, the Department of Health, Housing, Local Government & Community Service provides free policy and research advice to regional countries to assist in the development of their own health programs, standards and regulatory systems.

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[9] World Bank, op cit, p 167.

2.37 AIDAB is now also recognising that health is of cross sector significance in "non-health" projects. Health Impact Assessment guidelines are currently being designed to ensure that the positive health impacts of non-health projects are maximised and any potential negative effects are minimised. The guidelines will focus on incorporating health concerns more explicitly into existing cross sector analyses (for example environmental policies) and on developing sector-specific "key concerns" in health for use by staff.[10]

THE SIZE OF THE HEALTH AID BUDGET

The total aid budget

2.38 The 1993-94 budget has allocated $1 402 million for overseas development aid (ODA), an increase in nominal terms of $17.4 million, but a decrease in real terms of one percent. This represents 0.35% of Australia's Gross National Product (GNP), which is a drop from the 0.36% aid/GNP ratio achieved during 1992-93.[11] The United Nations recommends that developed countries have an 0.7% aid/GNP ratio.

2.39 It is beyond the scope of this inquiry to comment on the overall size of the aid budget. However, while pointing out the overall budgetary restraints, the Minister for Development Co-operation and Pacific Islands Affairs, the Hon Gordon Bilney MP, has said that his objective is to increase aid to 0.4% of GNP "as soon as possible".[12]

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10 AIDAB, Programs Operations Guide, Vol 1, 1993, p 5:12

11 Aid/GNP is the measure used by the OECD to compare the level of foreign aid expenditure by developed countries.

12 The Hon G. Bilney, Minister for Development Cooperation and Pacific Island Affairs, Australia's Development Co-operation Program 1993-94, 1993, AGPS, p iii.

The health component of the aid budget

2.40 In 1992/93, AIDAB and DHHLGCS together spent approximately $37.4 million on direct health programs, which constitutes around 2.7% of the total aid budget. In addition, AIDAB spent $10.42 million on population programs, and $25.1 million on water supply and sanitation programs. In total, AIDAB and DHHLGCS spent $72.88 million, or 5.2% of overseas development aid on health and health related programs. A greater percentage of the budget is spent on health related aid if the support for development banks and UNICEF that goes on health related projects is taken into account. AIDAB argues that if this form of expenditure is included, then a total of 11% of the aid budget is spent on direct and indirect health and health related aid. Appendix 3 details a breakdown of the 1992/93 health related component of the ODA budget and projected expenditure for 1993/94.

2.41 These figures represent an improvement on the position in earlier years. For example, in 1991/92 direct health and health related aid comprised 2.84% of total ODA. (AIDAB: submission, p 286) AIDAB expects the upward trend to continue in 1993/94, in particular as budget support to PNG is replaced with program aid and there is expenditure of $30 million of a new four year $130 million population initiative.[13] See Chapter 8 for further comments on the population initiative.

2.42 Nonetheless, many witnesses told the Committee that AIDAB does not spend enough of its budget on health, or health related projects. For example, the Australian Centre for Control of Iodine Deficiency Disorders told the Committee:

> "health care has been the cinderella with AIDAB... Health care has receive a very low priority, and very poor funding, compared with most other areas of activity and interests of AIDAB". (ACCIDD: Transcript of evidence, p 149)

2.43 The Public Health Association commented:

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[13] Caution is required when making comparative statements about health aid levels as figures variously refer to health, health and population or health, population and water/sanitation expenditure under the umbrella term "health related" aid.

"the most important point to make is that both international health within [DHHLGCS] and the health section of AIDAB are incredibly poorly resourced and understaffed... That is also reflected in terms of the amount of money that is dedicated to international health in those two portfolios. They are pathetically poor compared to western European countries". (PHA: Transcript of evidence, p 98)

2.44 ACFOA, the peak NGO aid organisation, stated that:

"The crucial thing... is that we have to ensure that health gets a higher priority in country strategies... and in the overall objectives of the aid program". (ACFOA: Transcript of evidence, p 546)

2.45 From an international perspective, UNICEF observed that "health is not a big issue in the Australian aid program". (UNICEF: Transcript of evidence, p 120)

2.46 The World Bank in its development report for 1993 comments that "[i]t would be desirable for bilateral grant-funding agencies... to increase their assistance to health...", and furthermore, that the share of aid going to health should rise to the equivalent of 7% of total official development assistance "immediately" and should then "rise substantially over the next five years".[14] The figure of 7% includes expenditure for health and population activities, but not water supply and sanitation. In 1992/93 AIDAB allocated 3.45% of its budget to health and population programs.

2.47 AIDAB itself acknowledges that, historically, health aid has taken a low priority in the aid budget. In 1977 it noted that expenditure in the agriculture sector exceeded that in the health sector by a factor of eight and that only 7% of AIDAB sponsored students were in health fields while those studying agriculture outnumbered students in health by nearly 3:1.[15]

2.48 AIDAB believes, however, that health aid has now received greater

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[14] World Bank Report, op cit, p 166.

[15] AIDAB, "The Health Sector in Australia's Aid Program: Development Paper No 3", AGPS, 1987, p 4.

recognition in the aid budget and that this will continue, albeit gradually:

> "you are likely to see an increased emphasis on health coming through in our country program discussions... I do not think there is going to be a stampede towards health programs, because every dollar they spend on health is a dollar not spent on something else... you will see, over a considerable period of time, I would say, - not immediately - a growth in health care activities". (AIDAB: Transcript of evidence, p 907)

2.49 The Committee is conscious of the danger of special pleading when arguing for an increase in the health component of the aid budget. However, the almost universal complaints about the lack of health funding in the aid budget, coupled with international pressure for developing countries to increase the proportion of their aid budgets spent on health indicate to the Committee that more of Australia's aid budget should be spent on health.

2.50 Accordingly, the Committee recommends that the percentage of Australia's overseas development aid spent on health and population be increased to 7% of the budget by 1996/97, as recommended in the World Bank's World Development Report 1993. *This figure should not include funding for indirect* health program support, such as through the development banks. In recognition of the historically unusual nature of the PNG aid program, this figure should also discount the health component in the conversion of PNG budget support to program aid.

Chapter 3

OTHER MAJOR PARTICIPANTS IN HEALTH AID

THE ROLE OF THE DEPARTMENT OF HEALTH, HOUSING, LOCAL GOVERNMENT & COMMUNITY SERVICES

3.1 While AIDAB is primarily responsible for administration of the official aid program, the International Branch of the Department of Health, Housing, Local Government & Community Services also delivers some health aid.

3.2 On behalf of the Government, DHHLGCS fulfils Australia's international obligations by contributing assessed core funds to the general operations of the World Health Organisation and several specific WHO programs.[1] The Department manages Australia's participation in WHO management and in the activities of its associated agencies, such as the WHO Program on Substance Abuse and the WHO Global Program on AIDS. It also funds and sends representatives to attend one-off activities in support of WHO. For example, DHHLGCS has funded, or part funded, the 1990 Conference on AIDS in Asia & the Pacific, an International Workshop on the Control of Narcotic Drugs and Psychotropic Substances and the Western Pacific Regional Office Regional Training Course on Environmental Epidemiology.

3.3 DHHLGCS funds a part time consultant in Geneva who provides a direct link with WHO headquarters. In addition, the Department is also considering placement of another officer in Manila at WHO's regional office for the Western Pacific.

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1 In 1993, the contribution to WHO was $7.643 million and in 1992 the contribution to the International Agency for Research on Cancer was $1.017 million. In addition, DHHLGCS makes voluntary annual contributions of $100 000 to the International Program on Chemical Safety and $90 000 to the WHO's Regional Training Centre at the University of NSW.

3.4 In the last two years, DHHLGCS has become increasingly aware of the international commercial potential of the Department's core domestic services. The International Branch, once only responsible for administering Australia's contributions to WHO, is now also responsible for identifying and exploring "issues on the roles [DHHLGCS] can and should play in developing a coherent and co-ordinated strategy for the export of services" and for identifying and pursuing "opportunities under bilateral agreements on health cooperation with regional countries".[2] As the Assistant Secretary of the International Branch pointed out:

> "In 12 months we have gone quite a long way. Information and education are needed to actually get the rest of the department to adopt an international focus. We are certainly endeavouring to do that". (DHHLGCS: Transcript of evidence, p 48)

3.5 The Public Health Association supported this view, acknowledging that "the current group within the Department of Health is extremely active and committed". (PHA: Transcript of evidence, p 98)

Memoranda of Understanding

3.6 One strategy DHHLGCS is adopting to facilitate the export of its services is the use of Memoranda of Understanding (MOUs) between DHHLGCS and ministries of health in regional countries. The Department signed an MOU with Indonesia in November 1992, one with China in September 1993 and another with Thailand in October 1993.

3.7 The purpose of a Memorandum of Understanding is to provide an overall government to government framework for cooperation between DHHLGCS and overseas ministries of health. As DHHLGCS explained, MOUs are:

> "a facilitating mechanism which perhaps makes some governments feel a little more comfortable about a commercial relationship. They also

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[2] Program Performance Statements 1993-94, Health Housing, Local Government & Community Services Portfolio, Budget Related Paper 7.8A, p 454.

provide a framework under which greater cooperation can take place". (DHHLGCS: Transcript of evidence, p 755)

3.8 For example, the MOU with the Ministry of Health of Indonesia lists the exchange of information and legislation, the exchange of experts, cooperation between public health institutions/ organisations, training and education, and scientific research as areas of cooperation. The MOUs require 3 year plans of action to define specific cooperative activities between the MOU partners. While the International Branch will have a coordinating role, implementation of any joint project will be the responsibility of the particular program area within DHHLGCS.

3.9 The Committee has several concerns about MOUs. First, to be effective, they must receive sufficient funding and have some clear benefit. Fortunately, DHHLGCS is aware of this:

> "we are a bit nervous about having too many of these memoranda without being able to deliver on them... we need to make a success of two or three of them, at the most... and see how we go... We do not want to give the impression to our Asian neighbours that we sign pieces of paper and cannot deliver on them. That would be the worst possible thing". (DHHLGCS: Transcript of evidence, pp 753-54)

3.10 This point has not been lost on people outside the Department. One witness told the Committee, seven months after the signing of the first MOU, that MOUs were:

> "an example of how things are done at a high level, and it sounds good and everyone gets a good warm glow, but it does not seem to assist practical contacts at the bottom level... it is a classic example of how something is going on at high level in the Commonwealth department of health does not filter down to practical requests coming in, and it was certainly not publicised". (Department of Health Administration & Education, La Trobe University: Transcript of Evidence, p 199)

3.11 It is of some concern to note in that regard then, that DHHLGCS admitted:

"[DHHLGCS] have been very conscious that we cannot do very much until such time as we do have some resources, both human and financial. That process, as you well know, takes some time to work itself through at a time when resources are very short". (DHHLGCS: Transcript of evidence, p 755)

3.12 The use of health related MOUs is a recent development and the Committee appreciates that it will take time and resources for their potential benefit to be realised. **In the interim, however, the Committee recommends that no further negotiations for MOUs be entered into until an evaluation is made of the benefits and cost effectiveness of the existing MOUs. Once fully established, MOUs should be evaluated triennially.**

3.13 MOUs are significant agreements and should not be entered into lightly. Accordingly, the Committee recommends that further MOUs not be considered until core funding is pre-committed.

3.14 The second of the Committee's concerns relates to the need for the activities of the Department, under the aegis of the MOUs, to be closely coordinated with the activities of other government and non government organisations, particularly AIDAB and the Australian Trade Commission (AUSTRADE). DHHLGCS is aware of this need:

"it is important that we do not try to reinvent the wheel, we do not try to do AIDAB's job for it and we do not try to do Austrade's job for it but we work in close cooperation with both of those organisations... [DHHLGCS] certainly in the health field, AIDAB, certainly in the development assistance field, and Austrade in the trade field, hopefully [we] can all work together to make it a synergistic relationship". (DHHLGCS: Transcript of evidence, p 752)

3.15 The Committee is also aware that the non government consultancy business "International Trade Communications" (ITC), has recently been assigned the role of "intermediary in initiating, guiding and completing future health care related commercial arrangements between Australia and Indonesia" by the Indonesian Director General for Medical Care. (ITC: Transcript of evidence, p 473) It is unclear to the Committee, and apparently DHHLGCS, how the Indonesian MOU with the Ministry of Health, and the ITC arrangement will be coordinated.

3.16 In Chapter 6, the Committee expresses its concern at the current piecemeal approach to the delivery of health aid and development. With the increased involvement of DHHLGCS in international health related programs, the potential for uncoordinated activity is even greater. **The Committee wants to ensure a coordinated approach to the delivery of health aid and development and recommends that formalised coordination mechanisms for future MOUs be established between DHHLGCS, AIDAB, DFAT and AUSTRADE.**

3.17 Furthermore, the Committee recommends that DHHLGCS widely publicise, with involvement by AIDAB and AUSTRADE, programs considered for inclusion in MOU plans of action. This will encourage non government organisations to offer advice and enable some degree of coordination of their own programs with the plans of action.

The Public Health Education and Research Program

3.18 The Public Health Education and Research Program (PHERP) is a DHHLGCS program that funds nine tertiary institutions around Australia to provide public health postgraduate training. DHHLGCS is conducting a review of institutions receiving PHERP finance as current funding ceases at the end of 1994.

3.19 PHERP provides a small amount of core funding for the Centre for Clinical Epidemiology and Biostatistics at the University of Newcastle, the Tropical Health Program of the University of Queensland & the Queensland Institute of Medical Research. These centres have developed international education and research programs on the health of people in developing countries.

3.20 Both offer residential and distance learning public health courses tailored for health professionals and students from developing countries, in particular from the Asia-Pacific region. International students can be sponsored by their own countries and through scholarships from various sources including AIDAB, WHO and DHHLGCS. The centres have developed exchange and partnership arrangements with medical schools in neighbouring countries to encourage institutional strengthening, indigenous research and teaching capabilities. Staff at the centres are also involved in conducting public health related research and consultancies, often in the region.

3.21 The international activities of these centres play an important role in strengthening the health services of developing countries, many of which receive other forms of Australian health aid. Such training reduces the reliance of developing countries on aid donors and overseas expertise to develop primary health programs.

3.22 The World Bank supports this form of institutional strengthening in developing countries, commenting that aid productivity would increase substantially if it focused on capacity building and research.[3] AIDAB has also acknowledged that: "High priority should be given to training, including training of trainers, assistance in program management, program evaluation and research".[4] As the University of Newcastle noted:

> "surely, as our country's contribution to international health, we would actually get more value if we were training people from overseas who would work in their own countries... that whole concept... to train people so that they make changes in health in their own countries is of a much greater magnitude than anything that could be made from outside". (Centre for Clinical Epidemiology and Biostatistics, University of Newcastle: Transcript of evidence, p 168)

3.23 These activities also provide a commercial return for Australia by providing a cash inflow into the educational institutions and, in the long run, by encouraging the trainees to continue to use Australian expertise and develop professional links with Australia.

3.24 The international benefits associated with *PHERP* funding have been recognised only recently by DHHLGCS, as one of its officers acknowledged:

> "Systematic thinking about the role of international health in Australian public health, both in academic training and more broadly in the other public health programs... is really only something that we have taken up strongly over the past couple of years. I guess we are

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3 World Bank, op cit, p 167

4 AIDAB, The Health Sector in Australia's Aid Program: Development Papers No 3, AGPS 1987, p 3.

still on a bit of a learning curve about how to best integrate it all". (DHHLGCS: Transcript of evidence, p 744)

3.25 To provide these sort of international health facilities, Australian institutions need to maintain their own staff and research programs. The Public Health Association (PHA) highlighted:

"the importance of Australia sustaining its training and intellectual resources in this country. Any wind-down of funding, or any lack of commitment because of continued instability of the current programs will lead to the closure of Australia being seen as any resource at all internationally". (PHA: Transcript of evidence, pp 105-06)

3.26 In its own defence, the Queensland Tropical Health Program (THP) argues that Australia should "support the long term development of health services overseas and of complementary infrastructure in Australia". (THP: Submission, p 106) The THP further noted that:

"Australia's greatest resources... are the expertise of its professionals and the high regard in which it is held in developing countries. International health should... aim to develop and maintain such precious resources". (THP: Submission, p 118)

3.27 The Nutrition Program at the University of Queensland, which does not receive PHERP funding, agrees, pointing out that "Universities are our biggest resource but we are not using them". (Nutrition Program, University of Queensland: Transcript of evidence, p 505)

Special "international" PHERP funding

3.28 The Committee believes that the PHERP review provides an excellent opportunity for DHHLGCS to demonstrate its commitment to international health and recommends that specific PHERP funds be set aside to support Australian tertiary institutions running extensive international education and research programs. The programs should be focused specifically on the public health needs of countries in the Asia-Pacific region.

3.29 For institutions to develop comprehensive programs they need funding certainty, a point made by the THP:

> "Our colleagues working in Asian institutions... express surprise at the stop/start nature of Australian funding, [and] at the uncertainty surrounding institutional development... The Australian government must not only develop comprehensive policy, it must provide evidence of long term commitment". (THP: Submission, p 114)

3.30 The Committee therefore recommends that such "international PHERP" funding be guaranteed for a period of at least six years to allow proper long term planning and then on a triennial basis.

3.31 Special "international" PHERP funding should be provided in sufficient amounts to allow comprehensive programs to be developed. In the current period of economic restraint, this means that not all worthy programs will receive funding. As the Nutrition Program at the University of Queensland put it:

> "the Government has to start picking some winners. If it spreads the jam in the way that it has done in the past, we will all end up with so little money that we can do nothing significant with what we receive". (*Nutrition Program, University of Queensland: Transcript of evidence*, p 493)

3.32 The Program puts this down to a lack of Government will:

"people are not game enough to make the decisions that need to be made. In the absence of that sort of courage, people are saying, 'There are 10 institutions. Let's divide it by 10 and give them all a little bit'". (Nutrition Program, University of Queensland: Transcript of evidence, pp 505-6)

3.33 The Committee accordingly recommends that DHHLGCS prioritise claims by public health programs for "international PHERP" funding commensurate with the significance of the programs' teaching and research activities in the Asia-Pacific region.

PUBLIC HEALTH RESEARCH

3.34 The National Health and Medical Research Council (NHMRC) comes under the portfolio of the Minister for Health and receives secretariat support from DHHLGCS. NHMRC's function is to inquire into, advise and make recommendations on matters relating to: the improvement of health; the prevention of disease; health, medical and dental care; health and medical research; and related ethical issues. It also advises the Commonwealth on expenditure on health and medical research generally.

3.35 Primarily, NHMRC has a domestic focus. However, it does fund research institutes and individual researchers for projects which have direct relevance to regional developing countries. Since 1991, NHMRC has also funded training workshops on health research in six South Pacific countries and provided a small scholarship for the Fiji School of Medicine.

3.36 The Committee commends NHMRC for these initiatives, particularly since the World Bank has noted that "local research capacity in developing countries is woefully inadequate".[5]

3.37 Funding research into public health is important, both to assist primary health programs and to strengthen Australian institutions involved in providing public health programs. However, the Australian Centre for Control of Iodine

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5 World Bank, op cit, p 169.

Deficiency Disorders believes that there is not enough recognition of the preliminary research required for successful public health programs. The ACCIDD Chairman told the Committee:

> "I do not think that AIDAB encourages research... We were consistently in a position of having to justify the research, because it was not seen as direct clinical care or public health care - when... a lot of our clinical care in public health does depend upon research. If you do not do research, you really are very ineffective in what you do". (ACCIDD: Transcript of evidence, p 156)

3.38 A Public Health Association representative believes that further research money for public health research is required:

> "NHMRC has, at least in the past, consistently supported what it regarded to be priority projects in terms of scientific criteria rather than in terms of need. I think there is an argument for saying that a component of public health funding. Health funding which is far less than the total NHMRC package, ought to be for applied health research...". (PHA: Transcript of evidence, p 105)

3.39 The need to support such research has been recognised by AIDAB, which is currently undertaking a study of appropriate mechanisms to encourage international health research.

3.40 The Committee believes that both AIDAB and NHMRC have a role to play in funding Australian public health research with an international focus. The Committee acknowledges that there are limited funds available in either AIDAB or the NHMRC's budgets to divide between worthy programs. **However, the Committee recommends that NHMRC give consideration to funding: (a) further small research programs or scholarships in regional developing countries and (b) applied public health research programs.**

3.41 Furthermore, the Committee recommends that AIDAB give consideration to funding public health research programs or scholarships in developing countries in the Asia-Pacific region auspiced by public health institutions in Australia.

THE ROLE OF THE DEPARTMENT OF FOREIGN AFFAIRS AND TRADE

3.42 As mentioned earlier, AIDAB lies within the portfolio of the Department of Foreign Affairs and Trade (DFAT), which is responsible for representing the Australian government overseas.

Direct Aid Program

3.43 Each year, heads of overseas missions are provided with small sums to expend on local level projects in-country, under a scheme called the Direct Aid Program (DAP).[6] DAP was formerly known as the Head of Mission Discretionary Aid fund, and is not specifically designated for health related projects.

3.44 DFAT believes that there is little chance of a lack of coordination between AIDAB and DAP funding:

> "In those posts where we expend the largest amounts of discretionary assistance, there are AIDAB officers... Conceivably [there may be a lack of coordination] in smaller posts and, if so, it would not be a major duplication and the reporting back from the post should ease any possibility of duplication". (DFAT: Transcript of evidence, p 775)

3.45 DAP funding appears to provide a useful supplement to larger, more formal projects and should be continued, providing that DFAT ensures that the DAP projects conform with AIDAB aid policies and do not duplicate AIDAB projects.

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[6] The total budget for DAP in 1992-93 was $3.6 million.

DFAT liaison with AIDAB

3.46 While AIDAB has management autonomy within the Foreign Affairs and Trade portfolio, there need to be close links between DFAT and AIDAB to ensure that foreign policy, trade policy and aid policy with individual countries are coordinated.

3.47 The Committee is satisfied that there are adequate levels of coordination between AIDAB and DFAT. AIDAB has told the Committee that:

> "The working relationship between AIDAB and DFAT is extensive and effective and there is a range of formal and informal contacts". (AIDAB: Transcript of evidence, p 833)

3.48 A DFAT representative confirmed:

> "We engage in a constant dialogue with AIDAB on major program departures, new programs and increases in expenditure on existing programs. It is not a case - particularly because the organisations are within the one portfolio and ... AIDAB is part of DFAT - of one organisation overruling another. There is a very productive and close dialogue". (DFAT: Transcript of evidence, p 776)

3.49 While AIDAB and DFAT appear to have close links, there appears to be a greater potential for inconsistent or competing policy priorities between DFAT and DHHLGCS.

DFAT liaison with DHHLGCS

3.50 In the broader context of foreign and trade policy, international health is not a key issue for DFAT. However, within its portfolio responsibilities, DFAT has primary responsibility for electoral reform and budget issues in all United Nations agencies. DFAT's primary involvement in international health issues arises from these responsibilities as they relate, in particular, to WHO.

3.51 Thus, while DHHLGCS is responsible for directly representing Australian interests on health related matters in WHO, both the Department and DFAT make policy on matters of common interest, such as WHO's financial and electoral reform.

3.52 This overlapping responsibility led one DFAT officer to admit:

> "What has become apparent in the last couple of years is the importance of making that clear distinction as to who is responsible for what particular aspects are operating there and making sure that there is adequate and effective dialogue between the relevant players". (DFAT: Transcript of evidence, p 778)

3.53 One witness before the Committee, a former Commonwealth minister, believes that DFAT has overriding influence:

> "in the past... all the crunch decisions about Australia's actions in WHO and [the WHO Global Program on AIDS] have not been made in the Department of Health, they have been made in the department of foreign affairs". (Australian National Council on Aids: Transcript of evidence, p 561)

3.54 In this regard, several witnesses commented that Australia's voting decision at the May 1993 election for the Director General of WHO appeared inconsistent with achieving Australia's optimal health goals.

3.55 DFAT argued, however, that it has close links with DHHLGCS:

> "In the case of the World Health Organisation, our liaison with the Department of Health is particularly close; it certainly is never a question of our pursuing objectives in the area of reform which are contrary to the international objectives that the department of health is pursuing". (DFAT: Transcript of evidence, pp 779-80)

3.56 Close coordination between DFAT and DHHLGCS should ensure that Australia's foreign and international health policies remain consistent, particularly as DHHLGCS becomes more active internationally. In recognition of this, the two departments have undertaken an officer exchange in 1993, with:

> "the specific aim of improving and increasing the integration between what we do in international forums and domestic policy priorities". (DFAT: Transcript of evidence, p 777)

The Committee believes an officer exchange program between DFAT and the International Branch of DHHLGCS will contribute to greater coordination between the two departments. **Accordingly, the Committee recommends that the officer exchange initiated in 1993 between DFAT and the International Branch of DHHLGCS be continued as part of a regular program of such exchanges.**

3.57 Other forms of officer exchange programs are discussed in Chapters 4 and 5.

THE ROLE OF NON GOVERNMENT ORGANISATIONS

3.58 While Australia's official aid program is administered by AIDAB and DHHLGCS, non government organisations (NGOs) play an important role in Australia's health related aid programs. NGOs receive financial assistance from AIDAB through the AIDAB/NGO Cooperation Program, run AIDAB projects and have the opportunity to participate in country development strategies. AIDAB also provides funds on an as needed basis to Australian and International NGOs for refugee and disaster relief projects.

3.59 NGOs can also access health funds through AIDAB's International Seminar Support Scheme (ISSS), which provides support for conferences and meetings which have a development focus. This is supplemented through the Professional Associations International Development Scheme (PAIDS), which assists professional societies in Australia to strengthen the technical and administrative capacities of their counterparts in developing countries.

3.60 NGOs involved in providing international health programs are diverse and range from: university and professional associations, such as the International Development Program of Australian Universities & Colleges and the Royal Australasian College of Physicians; to volunteer organisations, such as the Australian Red Cross and the Australian Third World Health Group; to research centres, such as the Macfarlane Burnet Centre for Medical Research and the Tropical Health Program at the University of Queensland; and to special interest groups such as the Lions Save Sight Foundation and the HIV/AIDS & Development Program. A range of organisations and consultancies also act to facilitate health programs.

3.61 The quality of liaison between AIDAB and NGOs is discussed in greater detail in Chapter 7.

The advantages and disadvantages of using NGOs to deliver aid

3.62 AIDAB acknowledges the role of NGOs in the provision of basic health aid:

> "We believe that NGOs do have some capacities, some expertise and some skills which are a useful complement to the program as a whole. One place where they do have a comparative advantage is at the grassroots - at person-to-person interaction". (AIDAB: Transcript of evidence, p 30)

3.63 However, AIDAB warns that this "does not necessarily apply equally to all non-government organisations". (AIDAB: Transcript of evidence, p 30)

3.64 Others agree that NGOs can provide efficient aid delivery at the local level, with the Australian Council for Overseas Aid, the peak body for NGO overseas aid organisations, commenting that "Non-government organisations are best placed to deliver primary health care at the village level...". (ACFOA: Transcript of evidence, p 514) In a similar vein, another witness commented that "the non-government organisations can do more at basic country level than either consultants or AIDAB itself". (Hirshman: Transcript of evidence, p 129)

3.65 Concern was expressed, however, that not all NGOs are as effective at delivering aid as others and that their low cost approach may hide a lack of efficiency. For example, as the consultancy firm EPI-INFO Consultants pointed out:

> "non-government organisations tend to say that they only spend such a tiny amount of money on administration, and that is often where the problem lies in the sense that they do not have sufficient administrative support that they need in order to run a professional program". (EPI-INFO Consultants (Australia): Transcript of evidence, p 317)

Another witness believed that:

> "A lot of the NGOs are taking on people who have little or no experience in international health, which means that their first year is a long learning curve".(Centre for Health Advancement, Flinders Medical Centre: Transcript of evidence, p 334)

Further, EPI-INFO warned:

> "if the non-government organisations are still operating on a semi-amateur type of basis, which they possibly have been in the past, and they are now being provided with money from the Australian Government and, as you know, the aid budget is declining, more is going to non-government organisations, it seems to me that it is quite important that the Government and the people be assured that that money is being used in its most effective way."(EPI-INFO Consultants (Australia): Transcript of evidence, p 317)

3.66 AIDAB has a graded entry scheme for NGOs wishing to receive AIDAB funding under the AIDAB/NGO Co-operation Program (ANCP). The entry point is the Pool Fund Scheme which gives NGOs access to 1:1 (AIDAB: NGO) subsidies for individual projects with maximum entitlements decided annually. The second tier of the ANCP is the Individual Project Subsidy Scheme (IPSS) which NGOs can apply to join after two years in the Pool Funded Scheme. NGOs can receive subsidies for their aid projects on a 3:1 (AIDAB:NGO) ratio. After NGOs have

shown efficiency in managing a complex aid program they are eligible for 3:1 (AIDAB: NGO) funding as bulk payments in program allocations rather than on a project by project basis.[7]

3.67 The Committee is satisfied that these procedures for providing public monies to NGOs are prudent and ensure appropriate accountability.

[7] AIDAB, Program Operation Guide, Vol 3, 1993, Chapter 12.

Chapter 4

DELIVERY OF BILATERAL AID

COUNTRY STRATEGIES AND PROGRAMS

4.1 As outlined in the previous Chapter, AIDAB uses a country rather than sector based approach to bilateral aid delivery. The process of developing, implementing and reviewing official bilateral aid projects is codified in AIDAB's "Activity Management Cycle", which sets out the procedure for creating and managing a comprehensive development program for aid receiving countries.[1] Australia's development cooperation program with each country or region is set out in a country paper comprising two stand-alone parts: a "Cooperation Strategy", providing the overview and focus, and a "Cooperation Program" which details the planning, resource requirements, time schedules and formulation of the aid delivery projects.

4.2 The primary goal of country strategies is to clarify the recipient government's aid priorities and match these needs with Australia's aid objectives and capacity to assist. AIDAB may assist the aid receiving country identify its health priorities and will already have an idea of Australia's capacity to assist after having conducted "Capacity Studies". AIDAB conducts capacity studies to identify the strength of Australian expertise in different specialities. Recent health related capacity studies include the sub-sectors of malaria, HIV/AIDS, family planning and pharmaceutical goods and services.

4.3 The strategies are reviewed in a five year cycle, unless significant events occur in Australia or the recipient country to prompt an earlier review.

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[1] The activity management cycle is detailed in AIDAB's Programs Operations Guide: Development Cooperation Programming and AIDAB, Vol 1, March 1993, Chapter 3.

4.4 The development of country programs within AIDAB is the responsibility of country program managers. To develop and implement country programs, program managers need to draw on expertise within AIDAB, expertise in other government agencies, and expertise available in the wider community. In the case of the health sector, program managers tap the resources of AIDAB's Health and Population Section, the Department of Health Housing, Local Government and Community Services and the plethora of universities, research institutions, professional societies, single issue groups and individuals with international health knowledge.

4.5 The main task of country managers is to meet the specific development needs of the country they are responsible for. However, the managers also have to ensure that aid projects making up the country programs conform with AIDAB's policies on sectoral issues, such as health, human rights and the environment. In the case of health, this means the country program managers must take into account AIDAB's primary health care focus, the WATCH theme, and, where appropriate, the sub-sector policies on HIV/AIDS and reproductive health. As health impact assessment guidelines are finalised, they too will have to be incorporated into project design by country managers.

HEALTH SECTOR COORDINATION WITHIN AIDAB

The Health and Population Section

4.6 One of the responsibilities of the Program Development and Review Branch is coordination of AIDAB's individual country programs. Coordination of health sector projects is the responsibility of the Branch's Health and Population Section. The Section provides advice on health sector priorities to country program managers, ensures that there is a consistent approach to health activities across countries and facilitates consultation with outside organisations. The Health and Population Section, as with the other sections in the Program Development and Review Branch, also takes part in the planning stages of country strategies and programs.[2]

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[2] Other Sections in the Program Development and Review Branch include the Environment Section and the Women in Development Section.

The Coordinating Group on Health

4.7 The in-house Coordinating Group on Health (CGH) was formed in November 1992 to facilitate coordination and information exchange on health issues between the Health and Population Section, country program managers and the policy areas of AIDAB. Essentially, the CGH is "an information sharing group" which draws together people working on country desks to keep them abreast of health sector developments. (AIDAB: Transcript of evidence, p 679) It also ensures that the Health and Population Section is aware of the various health projects currently undertaken in different countries.

4.8 The CGH meets approximately once a month and is chaired by the Director of the Health and Population Section. A representative from DHHLGCS attends the meetings as an observer. To date, the main policy issues discussed by the Group have been HIV/AIDS, population policy and Health Impact Assessment procedures.

Coordination of health priorities

4.9 AIDAB believes that the Health and Population Section and the CGH ensure that health sector priorities are well coordinated within the basic country program framework, telling the Committee that: "There is quite a clear focus within AIDAB for population and health issues on a sectoral level". (AIDAB: Transcript of evidence, pp 670-71)

and that:

> "our coordination efforts in the health area are more extensive than they would be, say, in education or in agriculture or in many of the other areas that we deal with". (AIDAB: Transcript of evidence, p 709)

4.10 Outside groups are not as confident about the success of AIDAB's internal mechanisms to coordinate health sector activities. A number of witnesses expressed concern that, despite sectoral coordination, the country program emphasis ensures that AIDAB does not have a clear health focus. For example, the Centre for Clinical Epidemiology and Biostatistics at the University of Newcastle commented:

"There is no real health focus within AIDAB, and that makes it very difficult for us to communicate. When we talk to someone on the country desk they do not have health as their priority". (Centre for Clinical Epidemiology and Biostatistics, University of Newcastle: Transcript of evidence, p 169)

4.11 Similarly a witness from the University of Queensland stated that:

"By and large, it is true at the moment that the desks are too dominant in AIDAB. If you want anything to happen within AIDAB, you have to do it through the desks; you cannot do it through any of the other divisions. I think that is a real difficulty for AIDAB at the moment...". (Nutrition Program, University of Queensland: Transcript of evidence, pp 496-97)

4.12 A witness from the Faculty of Medicine at the University of Newcastle told the Committee:

"I worry about the organisation of AIDAB by country desk... While I can see that gives a wonderful perspective on that country... it means that you do not have coordination across...". (Faculty of Medicine, University of Newcastle: Transcript of evidence, p 608)

However, an exclusive sectoral focus is not the right answer either, as AIDAB warned:

"AIDAB had a policy of programming by sector prior to 1984 in the Jackson committee report. The general conclusion of all the committees of review which looked at that was that it was an unmitigated disaster. It was a disaster because we were not concentrating on the recipient governments' needs and priorities". (AIDAB: Transcript of evidence, pp 686-87)

4.13 The Committee believes the creation of the CGH was a step in the right direction towards establishing an appropriate balance between country and

health sector priorities within AIDAB. However, the comments from health experts outside AIDAB indicate that the right balance has not yet been struck. The Committee acknowledges that the potential of the CGH may not yet have been realised, given that it has been established recently and has discussed only limited issues. Nonetheless, the Committee believes that health sector coordination within AIDAB needs further strengthening.

4.14 Accordingly, the Committee recommends that the Coordinating Group on Health become the principal vehicle for health coordination within AIDAB with support from the Health and Population Section. The Group should meet once a week and liaise with country program managers on all major health sub-sectors.

4.15 The Committee also recommends that AIDAB extensively publicise the existence and functions of the Coordinating Group on Health through its normal channels of communication with non government organisations.

AIDAB'S ACCESS TO HEALTH EXPERTISE

4.16 To develop coherent health policies and programs, AIDAB requires both generalist in-house health advice and access to specialist experts in the wider community. The in-house health advice is provided by the Health and Population Section and the detailed advice is provided by specialists on various forms of contract.

Access to in-house health expertise

4.17 The ability of the Health and Population Section and, through it, the Coordinating Group on Health, to develop a consistent health policy for AIDAB and to ensure that it is reflected in country programs, depends, in part, on the level of health expertise within AIDAB.

4.18 The Committee and witnesses have been impressed with the expertise and dedication of the existing staff of the Health and Population Section. However, a number of witnesses are concerned that AIDAB still does not have enough internal health expertise to sufficiently influence AIDAB aid policy, country strategies or country programs. The Australian Council for Overseas Aid told the Committee:

"[AIDAB] does go outside for expertise, and I think that is appropriate. But what it has to win inside is the policy debate about conflicting priorities within the aid program. That is why it needs some strength". (ACFOA: Transcript of evidence, pp 548-59)

4.19 The Macfarlane Burnet Centre for Medical Research reinforced this comment:

"there has to be more expertise actually guiding the policy. In terms of AIDAB's capability to do that, it actually has to have more people with health expertise either contracted or working with it so that they can actually guide it in a way that is sensible". (Macfarlane Burnet Centre for Medical Research: Transcript of evidence, p 246)

4.20 The Faculty of Medicine at the University of Newcastle stated that:

"there should be some consideration given to bringing in one or two more people who have health professional backgrounds and experience on staff, as opposed to having them slightly at arm's length. You need people who are going to be around all the time. You do not just want people you can wheel out when you need them for particular consultancies". (Faculty of Medicine, University of Newcastle: Transcript of evidence, p 608)

4.21 The International Council for Control of Iodine Deficiency Disorders agreed that:

"[AIDAB] does not have a lot of professional staff... In the case of health, if you want to have a better level of performance from AIDAB, you need a little bit more professional staff there to do the job... if AIDAB is going to spend more it will have to recruit more professionals". (ICCIDD: Transcript of evidence, pp 394-95)

4.22 This evidence suggests that there is a threshold level of internal health expertise, below which AIDAB will be unable to generate its own health policy or

ensure that health policies receive appropriate management priority.

4.23 An international perspective on this argument was provided by Professor Feachem, of the London School of Hygiene and Tropical Medicine and Chairman of the Advisory Committee for the World Bank's 1993 world development report. Professor Feachem told the Committee that, without sufficient internal health expertise, AIDAB:

> "would be unable to develop a really coherent health sector policy or push it through or cause it to happen. It would be unable to have adequate dialogues with the department of health on the one hand and with the Australian technical, scientific and medical expertise that is out there around the country on the other. Certainly some [official aid bureaus] which have become significant players in international health have found that a strong team in the [aid bureau] has been essential, as has an investment in the local capacity outside government. So there is a need for a strong team of health sector generalists in the [aid bureau]". (Professor Feachem: Transcript of evidence, p 811)

4.24 *The Committee is aware that AIDAB has recently strengthened its* Health and Population Section by two staff; that AIDAB has appointed a health professional, responsible for coordinating health sector activities to the Sydney based Pacific Regional Team (PRT); and that AIDAB is currently negotiating for the secondment of two appropriately medically qualified personnel from DHHLGCS The Committee further acknowledges that AIDAB could not hope to employ enough health experts to provide specialist advice on all health issues in all countries. Nor should it, as AIDAB appropriately relies on contracted specialist advice for such detailed advice.

4.25 Nonetheless, the Committee believes that AIDAB needs further in house health expertise to provide high level policy influence and coordination within AIDAB. Accordingly, the Committee recommends that AIDAB strengthen and expand its Health and Population Section by employing further public health generalists. The people employed should have skills in epidemiology, a knowledge of health policy, health economics and experience of the health problems of developing countries.

4.26 The number employed will obviously depend on the availability of funds and limits on average staffing levels. However, the Committee believes that the necessary expertise could be employed, on long term contracts or through secondment from other organisations if necessary.

Access to DHHLGCS expertise

4.27 One obvious source of health expertise for AIDAB is DHHLGCS, particularly since DHHLGCS has expanded its international focus. AS DHHLGCS explained:

> "The contacts between AIDAB and [DHHLGCS] at a senior level and also at the working level are very strong... I would argue that those contacts were not there 12 to 18 months ago". (DHHLGCS: Transcript of evidence, p 761)

4.28 DHHLGCS saw the future potential of this cooperation:

> Let us take the example of... [the] report into health in Papua New Guinea. I would think that will open a very substantial range of areas for cooperation between AIDAB and [DHHLGCS]. The point is that we will make sure that that does happen now. It is starting...". (DHHLGCS: Transcript of evidence, p 762)

4.29 DHHLGCS has already been directly involved in the design of AIDAB's feasibility study for the Philippines National Drug Policy Project and the Reproductive Health Project Identification Mission in China and two of the agencies have a joint working group on HIV/AIDS. DHHLGCS and AIDAB also cooperate on decisions regarding the funding of multilateral organisations:

> "There is certainly very close cooperation and coordination on multilateral aid aspects... It is very much a question of the programs being WHO programs. The issue is whether the judgments to be made are health judgments or ODA judgments. I guess they are both. The

question is where the balance lies. AIDAB presently funds them and we contribute to the process of determining what sort of funds should go where". (DHHLGCS: Transcript of evidence, pp 763-64)

4.30 AIDAB and DHHLGCS have begun exchanging staff from program areas, in a process that can only bolster the health expertise of AIDAB and the international health expertise of DHHLGCS. The Committee recommends that further staff exchanges between AIDAB and DHHLGCS be continued and expanded where appropriate.

4.31 The Committee is encouraged by the attempts made by AIDAB and DHHLGCS to share expertise. DHHLGCS is a source of health advice that AIDAB should utilise whenever possible.

4.32 The role of the Advisory Group on Health, which should assist AIDAB-DHHLGCS communication, is discussed in Chapter 7.

Access to contracted expertise: contracts over $75 000

4.33 While the Health and Population Section provides AIDAB with its own in-house health advisory capacity, much of the project work is undertaken by outside contractors working under AIDAB guidance. AIDAB uses a wide range of health professionals from academic institutions, non government organisations and private consultancies to run projects and conduct pre and post project evaluations.[3]

4.34 Currently, contracts valued at more than $75 000 are advertised in the Purchasing and Disposals edition of the Commonwealth Gazette; the national press or specialist journals, where circumstances warrant: and, since October 1993, through the Australian Trade Commission's International Project Intelligence Network. Contracts of this size are typically for the implementation of aid projects.

4.35 In what is known as a "two step selection process", Technical Advisory Panels" (TAPs), which are made up of non-tendering health experts, are used to assess tender bids.

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[3] Full details of contracting procedures are detailed in AIDAB's Programs Operations Guide: Development Cooperation Programming and AIDAB, Vol 2, March 1993.

Access to contracted expertise: contracts under $75 000

4.36 AIDAB uses two methods to access professional advice and consultancies worth less than $75 000. Contracts of this size are typically for project design, feasibility and evaluation consultancies, rather than for full project implementation.[4]

4.37 The first method is through AIDAB's Small Consultancy Contract system. To fill these contracts, AIDAB draws a short list of potential consultants, usually three, drawn from the AIDAB "Consultants Register", corporate knowledge of available experts or from names provided by professional associations. Those on the short-list are then invited to tender for the contract.

4.38 The Consultant Register contains the curricula vitae of approximately 3 000 experts from the public and private sectors who have either worked on previous AIDAB contracts or who have registered their particulars with AIDAB. Of the 3 000 names on the register, approximately 300 are health experts.

4.39 The second method AIDAB uses to access professional advice and consultancies worth less than $75 000 is through "Period Contracts". Tenders for period contracts are called when AIDAB identifies an ongoing need for expertise that cannot be filled in-house. Consultant companies tender for period contracts with lists of health experts that they are prepared to make available for consultancies at short notice and at a pre-negotiated rate. The names of the health professionals nominated by the successful consultancy firm are put on AIDAB's period contract list. AIDAB draws on these health experts, through the consultancy firm, for small consultancies as required. The period contracts were set up as an easy way of getting expertise at short notice, without going through competitive tender, as AIDAB explained:

> "The period contracts and our contracting procedures allow us to tap into people we could not have in-house if we tried... We can tap into those people as we need them for three to four weeks". (AIDAB: Transcript of evidence, pp 665-66)

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[4] The $75 000 divide is an arbitrary figure determined by AIDAB.

4.40 Three health and two population period contracts have been awarded. In September 1993, there were a total of 81 people listed on health period contracts and 30 people on population contracts.

CRITICISMS OF COUNTRY PROGRAM IMPLEMENTATION

4.41 Three themes have emerged during discussions with witnesses about AIDAB's current program implementation methods. The first is that the current competitive bidding system for AIDAB contracts discourages vital cooperation between the limited number of international health experts in Australia. The second is that AIDAB funding is spread too thinly over many health sector projects and that funding should be focused on priority sub-sectors. The third is that aid projects have an overly long start up time.

Lack of cooperation between potential contractors

4.42 On the first point, several witnesses have been concerned that "open displays of competition between Australian institutions" are encouraged by AIDAB's tendering process and stated that this adversely affects the quality of project consultancies. (THP: Submission, p 114) As a consultancy firm explained:

> "Under this competitive scheme we will not get the best. We might think that we will get the best but it will exclude individuals who have a lot to offer. For the size of the problem, the amount of dollars needed and the few people who are involved, it would have been better to pull them all together and come up with another selection process for it. It pits these research organisations against each other". (WBM Oceanics Australia: Transcript of evidence, p 441)

The firm pointed out that:

> "A lot of the time [bidders] have the same level of experience or complementary experience. It would be better if they were working together rather than trying to knock each other out of the court". (WBM Oceanics Australia: Transcript of evidence, p 444)

4.43 This problem is not unique to Australia, as the Committee was advised by the Chairman of the Advisory Committee for the World Bank's 1993 world development report:

> "you cannot run good health sector projects like you can run roads projects... You cannot just put it out to tender, because you do not have the contractors around the country with the expertise to bid. There is not that industry operating. There may be for building hospitals, perhaps, but there is not for advising on malaria control or running a good primary health care system". (Professor Feachem: Transcript of evidence, p 812)

Lack of focus in the health sector

4.44 The second point raised was that AIDAB spreads its health related aid too thinly over too many projects. What AIDAB needs to do, argued several witnesses, is to concentrate funding on several key health sub-sectors. This criticism is not new or unique to the health sector. As far back as 1984, the Jackson report commented that the entire aid program was:

> spread over too many countries, with too many initiatives and activities implemented in too many different ways... Not enough has been done to identify and exploit Australia's relative strengths so that aid delivery can take full advantage of competitive Australian goods and services".[5]

4.45 The same point has been made by witnesses before this Committee. The Commonwealth Serum Laboratories stated that:

> "The major problems that we face with our aid program are a lack of focus and a lack of targeting in respect of what we want to do with our aid money". (CSL: Transcript of evidence, p 571)

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5 R.G. Jackson et al, op cit, p 5.

and further, that "With the relatively limited budget available and some 200 health-related programs... it is not surprising that we get very little value for money". (CSL: Transcript of evidence, p 583)

4.46 The Tropical Health Program argued that the "reason for Australia not establishing international leadership through its aid programme is that the programme itself is fragmented". (THP: Submission, p 110)

4.47 This point was echoed by the consultant firm EPI-INFO which believed that the "Australian effort is too fragmented and therefore minimises the national interest" and that "too many small agencies are involved in programs which lack a good profile". (EPI-INFO Consultants (Australia): Submission, p 397)

4.48 The Public Health Association (PHA), concurred, observing that:

> "It seems to PHA that in the area of health in particular, there may be value in identifying overall priorities for the region - such as polio immunisation - and then funding such an initiative for, say, 3 years". (PHA: Submission, p 426)

4.49 The disadvantage of focusing on priority health sub-sectors is that other worthy programs may not receive funding, as a senior AIDAB officer pointed out:

> "I personally find the idea of [AIDAB] concentrating on five diseases very helpful. I know, however, that immediately we did that, we would have outraged howls from all the specialists in the diseases who had not been chosen amongst the five... or from people who only need a small amount of additional funding from AIDAB". (AIDAB: Transcript of evidence, p 677)

4.50 Nonetheless, a balance can be struck in which the bulk of bilateral funding is provided to a half dozen health sub-sector priorities. Other projects will still be eligible for funding, but the health related aid program will clearly focus on Australia's major health strengths.

Project lead time

4.51 The third concern raised by witnesses was the length of time it takes between the conception and implementation of aid projects. One witness who has recently won an AIDAB consultancy contract provided an example:

> "We were told we have won it about two months ago, but there is still no contract sighed, and still no action. I have been told that these sort of delays are not uncommon". (Department of Health Administration & Education, La Trobe University: Transcript of evidence, p 191)

4.52 Another contract winner commented on the implications for their consulting team:

> "We made a very nice proposal which was submitted to AIDAB and was funded 12 months later... The staff that I worked with... to prepare that proposal and plan that implementation are now gone... So that is one problem that happens, I think, reasonably often in terms of proposals". (EPI-INFO: Transcript of evidence, p 319)

4.53 Long start up times not only affect the successful consultants but can also damage AIDAB's overseas reputation, as the firm Halsodel pointed out:

> "What is not adequately recognised... is the effect on the recipient country of proposals dropped or lengthily delayed. It is uncommon for progress reports to be given to the potential recipients about proposed projects in preparation including advice that an activity which has been investigated will not proceed at all". (Halsodel: Submission, p 124)

4.54 AIDAB acknowledged that there is a long lead time for projects, particularly more complex ones:

> "Even if we decide to do something now, given the need for design studies and so on, we would be unlikely to start doing that even within a year; and in many cases it does take longer than that. By the time

you have talked to the government concerned and so on it can take easily 18 months or two years to get new projects under way". (AIDAB: Transcript of evidence, p 24)

4.55 The Committee is fully aware that projects need to be properly planned and that this requires time to conduct feasibility studies and design the projects. It is also appreciated that AIDAB's tendering process must adhere to the Commonwealth purchasing principles of gaining value for money and maintaining open and effective competition. Furthermore, the pace of negotiations with the governments of aid receiving countries can be slow and out of AIDAB's hands.

4.56 This, however, does not mean that AIDAB cannot improve the efficiency of its own procedures. The Committee believes it will be possible to harness Australia's expertise more effectively, reduce project lead time and focus AIDAB's health priorities through modification of the existing period contract system.

Sub-sector period contracts

4.57 The Committee recommends that AIDAB engage in discussion with regional aid receiving governments, multilateral health organisations and interested parties in Australia to determine five or six major health priorities in developing countries in the Asia-Pacific region that could become the focus of AIDAB's health sector aid. The health areas, or "health sub-sectors", identified should take into account regional priorities and levels of Australian expertise. Possible sub-sectors could be malaria, diarrhoeal diseases, rational drug use, micro-nutrition, immunology and HIV/AIDS.

4.58 The Committee recommends that AIDAB then call for period contracts in each priority health sub-sector. The successful contracting groups would be drawn upon for all necessary project design and implementation consultancy work in each country where aid projects in that health sub-sector are undertaken. Project design and implementation should be treated separately from project evaluation which should be independently assessed.

4.59 As a consequence of these proposals, the Committee recommends that the period contract system in the health sector be extended to include contracts over $75 000, reorganised along sub-sector lines.

4.60 The consultancies should be decided under the existing "two step" tendering process for 5 year terms. A five year contract offers a balance between providing long term stability and competition. At the conclusion of the five year term, AIDAB would determine whether the sub sector period contract should be re-tendered or allowed to expire, depending on whether that sub-sector remained a major health priority.

4.61 The Committee recommends that, initially, these extended period contracts be confined to the health and population sectors. If, after evaluation, they prove successful they could be extended to include water and sanitation projects.

4.62 The Committee recommends that AIDAB continue to fund health projects not classed as sub-sector priorities, although as a secondary priority. The Committee believes that consultancies for such secondary projects can be tendered for under existing procedures.

4.63 AIDAB is currently reviewing its contracting arrangements and has indicated to the Committee that it is already exploring the possibility of reorganising period contracts on sub-sector lines:

> "Instead of a health period contract, we could have a subgroup of health in malaria, and we could have a subgroup of something else... Maybe we have got a mechanism there that is worth looking at". (AIDAB: Transcript of evidence, p 905)

4.64 The recommendations above take AIDAB's suggestion one step further and exploit the advantages that period contracts provide in offering speedy access to expertise. The Committee also believes that the modifications will satisfy AIDAB's contracting requirements, encourage cooperation in the health sector and improve the continuity of personnel on AIDAB projects.

4.65 Equally importantly, the Committee sees the recommendations as facilitating a higher national and international profile for AIDAB's health sector activities. The need for a higher, focused, health profile is discussed in greater detail in the final Chapter of this report.

AIDAB'S ACCESSIBILITY TO NGOs

4.66 As detailed above, AIDAB relies on the expertise of individuals and non government organisations to provide health expertise and run aid projects. Some of these NGOs, however, have commented on the difficulty of obtaining AIDAB information, which in turn affects their ability to assist AIDAB. The Centre for Clinical Epidemiology & Biostatistics at the University of Newcastle, runs extensive international health programs, but has been:

> "dismayed at the difficulty of providing input into Australia's international health programs. We find, with some notable exceptions, communications with AIDAB to be difficult and one sided". (Centre for Clinical Epidemiology & Biostatistics, University of Newcastle: Submission, p 101)

4.67 Without information, organisations may not be able to contribute to the aid program effectively, as the Australian Centre for the Control of Iodine Deficiency Disorders pointed out:

> "Information gathered by agencies, such as AIDAB and UNICEF, is generally difficult to obtain and certainly not widely known... Until information detailing recipient requirements is widely disseminated it is unlikely that Australian involvement in international health programs will increase". (ACCIDD: Submission, p 74)

4.68 The Australian Postgraduate Federation in Medicine, after contact with AIDAB, was left feeling that it:

> "simply could not get informed information out of [AIDAB] as to what

our role was, and what our relationship was with other organisations that may or may not have been doing similar things". (Australian Postgraduate Federation in Medicine: Transcript of evidence, p 281)

4.69 The Royal Australasian College of Physicians is also concerned that "it is often very hard to find out what funding is available through organisations like AIDAB". (RACP: Transcript of evidence, p 221)

4.70 On balance, NGOs also have a responsibility to become better informed if they wish to be involved in the aid program. AIDAB pointed out, that when period contracts were advertised:

"They were advertised nationally; they were advertised through the Public Health Association... we look at advertising in either national newspapers or through specialist journals... If people do not put in for tender, we cannot go beyond that". (AIDAB: Transcript of evidence, p 681)

4.71 Furthermore, all people registering expressions of interest in project tenders receive details of the projects and the names of all other people putting in expressions of interest, allowing them to build up private contact networks. In addition, AIDAB conducts a series of seminars in each State each year called "Access AIDAB", through AIDAB's Development Education and Public Information Scheme, that provide information on AIDAB's operations and funding mechanisms to interested NGOs. AIDAB's Program Operations Guide, which provides complete details on AIDAB's contract systems, program management methods and funding schemes, is also freely available to NGOs.[6]

4.72 DHHLGCS concedes that there is always going to be some difficulty for individuals trying to contact appropriate people in large organisations, simply because the organisations are geared to communicate with other organisations:

"the question of communication and getting one's ideas across to an organisation like AIDAB or an organisation like our own is always going to be a problem if it is individuals trying to do it rather than

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6 AIDAB, "Program Operations Guide", op cit, Vols 1-3, 1993.

peak organisations". (DHHLGCS: Transcript of evidence, p 758)

4.73 Several witnesses have suggested that AIDAB nominate a health contact officer to handle all inquiries from NGOs and the public. One witness gave an example from personal experience of the benefit of having a health contact officer:

> "instead of my having to spend half the day on the telephone finding out who the experts are, one could go through this point of contact whose job it would be to be facilitative and helpful and link people. He would have a database of names and addresses and he would know possible pots of gold and schemes like ISSS and whatever". (Department of Health Administration & Education, La Trobe University: Transcript of evidence, p 206)

4.74 As AUSTRADE pointed out:

> "The first thing is that departments have to nominate a person or a body within their organisation which has as its principal function the dissemination of information to other government agencies and the private sector'. (AUSTRADE: Transcript of evidence, p 730)

4.75 Given that AIDAB uses outside health professionals and organisations so extensively the need for easy communications seems essential.

4.76 Accordingly, the Committee recommends that AIDAB nominate a position in the Health and Population Section responsible for, among other duties, health liaison. A person filling this position would be expected to provide advice on: health priorities in aid receiving countries; health related aid projects and who is running them; publicly available information held on AIDAB's databases (see Chapter 7); and AIDAB's various funding mechanisms. The Health Liaison Officer would be responsible for ensuring that all questions were followed up and answered.

4.77 The telephone number associated with the position should be publicised and provided on all relevant AIDAB documents and reports.

4.78 **The Committee also recommends that AIDAB produce a document briefly describing AIDAB's role, its priorities in the health sector and the contact telephone number of the Health Liaison Officer. The document should initially be distributed to appropriate academic institutions, professional associations and aid groups and then provided on request.**

4.79 The Committee is very concerned about a case brought to its attention where a organisation conducting an aid project was not given access to the project evaluation report because the developing country did not allow AIDAB to release the findings. This caused unnecessary concern and uncertainty to the project organisers and their peers. **The Committee recommends that it be a condition of contracts entered into between AIDAB and developing countries that all assessment and evaluation reports will be made available publicly.**

Chapter 5

MULTILATERAL ORGANISATIONS

Australia's support for multilateral health related organisations

5.1 The distinction between the bilateral and multilateral components of Australia's aid program has become increasingly blurred. Multilateral channels are used to achieve Australia's bilateral aid objectives and "multi-bi" aid is provided to multilateral organisations to deliver Australian aid where direct bilateral links are either not possible or inappropriate. The distinction between the two forms of aid is even less clear where AIDAB uses semi-autonomous Australian branches of multilateral non-government networks, such as the Family Planning Federation of Australia, to provide bilateral aid.

5.2 Nonetheless, debate continues as to the proportion of Australia's aid program, if any, that should be allocated towards funding multilateral health related aid organisations. The debate is particularly acute in the health sector, where the largest health related multilateral organisation, the World Health Organisation is widely seen as inefficient.

5.3 Approximately one third of Australia's health related aid is distributed through multilateral organisations, including WHO and its special programs, the United Nations Children's Fund, the United Nations Population Fund and the International Council for the Control of Iodine Deficiency Disorders. Australia also contributes to the operations of the World Bank and the Asian Development Bank, which both fund, inter alia, health related projects.[1]

5.4 The WHO is the peak United Nations health organisation and has a budget of approximately US$1.5 billion, of which US$ 63 million was allocated to the

[1] See Appendix 3

Western Pacific Region in 1992-93. Approximately one third of the WHO budget goes to global programs, which also benefit the region. Contributions to WHO are almost equally divided between assessed contributions by member states and support provided from extra budgetary sources, in particular from voluntary contributions by nations to WHO Special Programs.

5.5 Given its role, WHO and its special programs receive the bulk of Australia's multilateral health related aid funds. Australia's assessed contribution to WHO in 1993 was A$7.64 million. Voluntary contributions by Australia to WHO special programs included A$750 000 to the WHO Tropical Diseases Research Program, A$780 000 to the WHO Global Program on AIDS and A$710 000 to the WHO Expanded Program on Immunisation. Australia's total contribution to WHO special programs in 1992-93 was $4.39 million, with another $1.04 million allocated to other multilateral programs.

Should Australia continue to support the multilaterals?

5.6 Support for WHO and its special programs is mixed because of perceptions that WHO squanders resources and is overly bureaucratic. As one critic argued:

> "Many of my colleagues have this vision that the World Health Organisation is purer than pure... but in my experience it has its full share of incompetence, bureaucracy, ineptitude and country politics". (Department of Health Administration and Education, La Trobe University: Transcript of evidence, pp 198-99)

5.7 The Doctor's Reform Society (WA) argued that this is a problem with all multilateral health organisations:

> "large multilateral organisations such as the World Bank, WHO and UNICEF which depend on Western experts and have large relatively unresponsive bureaucracies should have a low [funding] priority... They make plans but do very little". (Doctors Reform Society (WA): Submission, p 266)

5.8 Others believe that Australia's aid is more appropriately spent through bilateral projects that provide Australia with a higher profile: The Overseas Service Bureau (OSB) suggests:

> "More Australian health-related aid should be targeted to specific projects and programs and less in the form of budgetary support [to PNG]... and multilateral organisations. This creates more opportunities for Australian involvement, makes funded activities more accountable and enables closer identification of particular outcomes with Australian support". (OSB: Submission, p 457)

5.9 Even many of the WHO's supporters concede that the organisation has problems, as the Public Health Association (PHA) admitted:

> "There is a real problem in [WHO] as a whole because of the relationship of the director-general and, in some programs, excessive bureaucratisation. But I think any of us who have worked closely with the WHO are relatively strong supporters of the work that it does". (PHA: Transcript of evidence, p 91)

5.10 There is no doubt, however, that WHO does perform a vital, if inefficient, role in the international health arena. As the Tropical Health Program (THP) pointed out:

> "At the expert advisory level, WHO sets global standards. It is impossible to conceive of an organisation other than WHO doing that; the entire world looks to WHO". (THP: Transcript of evidence, p 458)

5.11 This opinion was shared by DHHLGCS, who believed that, [if] the World Health Organisation "did not exist globally, we would have to reinvent it. It is a valuable organisation". (DHHLGCS: Transcript of evidence, p 49)

5.12 A witness from the Walter & Eliza Hall Institute of Medical Research highlighted the importance of WHO's coordinating role:

"I would put the position very strongly that if we did not have the [WHO] and its special programs for tropical disease research, AIDS, diarrhoeal diseases and so on, we would have to invent a similar organisation. No matter how good the bilateral arrangements are, no matter how good [NGOs] are in their individual programs there needs to be that coordination and the ability to transfer what is learnt in one situation to another situation". (Walter & Eliza Hall Institute of Medical Research: Transcript of evidence, p 259)

5.13 In its defence, as a multilateral organisation, UNICEF pointed out that, while NGOs focus on project delivery, the multilaterals use a government level approach to effect health benefits in developing countries:

"[UNICEF] is an inter-government organisation. A lot of non-government organisations do not understand that. Our job is to strengthen the national capacity in the delivery of health programs... That does mean that obviously there will be a fair bit of bureaucracy involved". (UNICEF: Transcript of evidence, p 111)

5.14 AIDAB believes multilaterals, such as WHO, and organisations implementing bilateral aid projects have complementary roles:

"The World Health Organisation, through its special programs, provides a lot of technical advice and guidance. That is its strength. Its strength is not in program delivery. That is where the complementation comes, between the [bilateral] aid programs and the World Health Organisation...". (AIDAB: Transcript of evidence, pp 877-78)

5.15 Furthermore, not all multilateral organisations are alike. Some WHO special programs are effective and efficient, as the Royal Australasian College of Physicians (RACP) commented:

"there are strong and weak programs within [WHO], and some things WHO does very well...Its tropical diseases research program, which is very efficient, has got the lowest overheads rating of any UN organisation and they are good programs". (RACP: Transcript of

evidence, p 226)

5.16 This was also admitted by the Centre for Clinical Epidemiology & Biostatistics at the University of Newcastle:

> "Australia provides extra funds [to WHO] beyond the basic subscription... They also target funding to particular programs. Some of those are extremely effective programs". (Centre for Clinical Epidemiology & Biostatistics, University of Newcastle: Transcript of evidence, p 171)

Direct benefits for Australia

5.17 Australia benefits directly from WHO membership in a number of ways. Membership allows Australia to participate in the development of international health conventions and practices that provide a useful basis for Australian domestic health policies. WHO institutions also place WHO Fellows in Australian institutions and provide Australians with opportunities to tender for WHO consultancy contracts and undertake overseas public health activities, all of which strengthen Australian expertise and provide economic benefits. Membership also ensures that Australia is linked into international health networks, principally through the 37 Australian institutions designated as WHO Collaborating Centres.

GETTING BETTER VALUE FOR MONEY

Selectively supporting multilateral programs

5.18 As a relatively affluent country, Australia should continue to support multilateral health related organisations, particularly WHO, because such organisations continue to play an important role in combating international health problems.

5.19 What is equally clear, however, is that Australia needs to get better value for the financial contributions it makes. The Committee believes that this can

be achieved best through reforming WHO from within and by taking a more active role in its decision making process. This strategy has been accepted by DHHLGCS, which reports that it has:

> "made that effort in the last 12 months to be right there in the development of the program activities... We are attempting to play a larger role in the overall management of the region. I think things are changing and we are conscious that there is a need to change". (DHHLGCS: Transcript of evidence, p 37)

5.20 One striking point arising from information provided by witnesses is the variation in efficiency and effectiveness between the WHO special programs. It is beyond the powers of this Committee to make recommendations concerning the operations of WHO.

5.21 However, the Committee recommends that DHHLGCS and AIDAB lobby WHO, its Australian funded special programs and the Western Pacific regional administration to develop uniform administrative procedures. This should allow a comparative analysis to be made of the programs' cost effectiveness and hopefully promote greater coordination and resource sharing. With better and more open management and budgetary procedures, donor countries, like Australia, will have more confidence in the special programs individually and collectively, and be willing to fund them.

5.22 The Committee recommends that DHHLGCS and AIDAB should conduct a concurrent joint evaluation of WHO special programs supported by Australia. Funding priority should be given to those programs efficiently carrying out activity of direct relevance to developing countries in the Asia-Pacific region which complement Australia's bilateral aid programs.

5.23 The Committee sees the role of DHHLGCS' consultant in Geneva as important in providing the necessary feedback on WHO's special programs for such a review.

5.24 The need for a review has been acknowledged by DHHLGCS, which:

"is very concerned ... to undertake a review of the individual programs of [WHO] to see how we should best allocate money between those programs: which programs have the highest priority, which programs affect the largest number of persons... So we are concerned... to be involved in the reforms that are highlighted in some of the recent reviews of that organisation and to get much more accountability and effective operation in that". (DHHLGCS: Transcript of evidence, pp 34-35)

5.25 Furthermore, DHHLGCS should lobby WHO to ensure that sufficient WHO funds are diverted to the Asia-Pacific region. As DHHLGCS pointed out:

"There is always a discussion on where the WHO's funding goes... The swing of resources, and the focus, is constantly changing, depending upon political circumstances... In our own region we have a responsibility to make sure that the proportion of resources that goes to our own region is reasonable and addresses the major health issues in the region. We can only do that as a member state working as part of the regional organisation and as part of the global organisation".(DHHLGCS: Transcript of evidence, pp 51-52)

The Joint Review of Multilateral Aid

5.26 AIDAB, in conjunction with the Departments of Treasury and Foreign Affairs and Trade (DFAT) is currently undertaking a review of all multilateral programs funded through the aid budget, as part of the ongoing Program Evaluation Plan of the Foreign Affairs and Trade portfolio.

5.27 The review, expected to be published in 1994, will include an overview evaluation of Australia's aid contributions to international health organisations, including WHO's special programs, the UN Population Fund and the International Planned Parenthood Federation.

Improving liaison with multilateral organisations

5.28 For Australia to gain maximum benefit from WHO membership it needs to be able to effectively lobby WHO headquarters in Geneva and the WHO regional office for the Western Pacific in Manila. This point was made by the Macfarlane Burnet Centre for Medical Research:

> "Actually knowing what is going on and being an active contributor is where we can use the money and we can use our influence to guide programs in the right directions... but we have to know what is going on...". (Macfarlane Burnet Centre for Medical Research: Transcript of evidence, p 245)

5.29 As already mentioned, DHHLGCS funds a part time consultant in Geneva and is considering placement of another officer in Manila. The Public Health Association believes that Australia has already increased its influence by having a representative in Geneva:

> "If Australia is to take its international role seriously, it is extremely important that is has some method of collecting information and intelligence... [In 1993, Australia] was able to be very active at the World Health Assembly [of the WHO]. Its profile had increased enormously, and partly that was because we have somebody there... Australia's role at the World Health Assembly and in WHO in a more general sense certainly has increased over the last couple of years...". (PHA: Transcript of evidence, p 89-90)

5.30 Similarly, on a regional level, DHHLGCS believes:

> "If we wish to have influence on WHO, then I would suggest that we do need to have somebody probably closer to the source of decision making in Manila". (DHHLGCS: Transcript of evidence, p 38)

5.31 The employment of a part time officer in Geneva is a cost effective method of increasing Australia's influence in the WHO, as well as a way of obtaining

information on WHO policies. The placement of an Australian representative in Manila , possibly based at the Australian Embassy, should reap equal benefits. **The Committee, therefore, recommends that DHHLGCS fund a position in Manila to liaise with WHO's regional headquarters and other health related agencies.**

Utilising Australian expertise in multilateral organisations

5.32 There are a number of Australian health experts employed directly by health related multilateral organisations, particularly WHO and its special programs. These people are employed as WHO officers, rather than as Australian representatives, but such placements indirectly demonstrate Australia's levels of expertise and improve our health profile internationally. As the Public Health Association described:

> "Technically Australia is involved through appointments within programs in the Manila office and in other regional offices in the WHO region and within programs and departments or sections within WHO in Geneva. Australians there play an incredibly high profile. We are over-represented compared to most other countries, including countries which are much more generous donors. Australia is highly regarded for its technical expertise". (PHA: Transcript of evidence, p 90)

5.33 DHHLGCS agrees that:

> "In the western Pacific region of the World Health Organisation, Australians are so over-represented now as to be supernumerary in some positions. We have done very well in getting Australians into key representative jobs...". (DHHLGCS: Transcript of evidence, pp 52-53)

5.34 These experts clearly represent a pool of knowledge and experience that should be tapped on return to Australia. However, it does not appear that the benefits of this expertise is fully realised, as the PHA explained:

> "It seems quite extraordinary that many of our own Australians working in the WHO have very little contact with the embassy or with

anybody else in Australia. They do not represent Australia... they are clearly working for the WHO. But it seems they are a source of expertise and information that we have just simply neglected to gather". (PHA: Transcript of evidence, p 92)

5.35 DHHLGCS debriefs its own officers returning from overseas but there is no mechanism in place for the Department to contact other Australians returning from international conferences, contracts or employment. Contact with returning nationals is ad hoc and usually relies on the person involved initiating contact with DHHLGCS and offering information.

5.36 The Committee believes that opportunities provided by the available expertise are not being taken advantage of and that DHHLGCS should become more *pro-active and seek out nationals returning from employment with multilateral* health related organisations.

5.37 Accordingly, the Committee recommends that DHHLGCS compile a list of Australians working in multilateral health related organisations. The list should be compiled in conjunction with AIDAB. DHHLGCS should attempt to contact the nationals on their return to Australia to request a debriefing from DHHLGCS or, if appropriate, AIDAB. The nature and detail of the debriefings should remain flexible and left to the discretion of the returning national.

5.38 Obviously it will be even more difficult for DHHLGCS to contact Australian health experts returning from international conferences and short term consultancies. **However, the Committee recommends that DHHLGCS nominate a liaison position in the International Branch that can be used as a contact point for health professionals returning from overseas wishing to provide information to the Department. The existence of this position and contact details should be promoted to, amongst others, professional associations, appropriate tertiary and research institutions, NGOs and Australian WHO Collaborating Centres.**

International trainee programs

5.39 While Australia should utilise the experience gained by its trained health professionals working overseas, it should also take advantage of the ideal training opportunities offered by multilateral organisations, including several WHO

special programs, UNICEF, the UN Development Program (UNDP) and the UN High Commissioner for Refugees (UNHCR). Most are run along similar lines to UNICEF's Junior Professional Officers Scheme whereby countries sponsor trainees to work on UNICEF field projects. The sponsorships provide a cheap resource for the multilaterals and experience for the trainees. Countries using the Program gain a high profile for relatively little outlay as well as a steady supply of experienced and trained personnel with international networks of colleagues. As the Tropical Health Program noted:

> "Other countries are much more generous in terms of providing opportunities for their citizens to go as interns to WHO programs to work, for example, for a year. It is quite interesting not only to watch what happens with those interns in terms of their own careers but also in the way a particular intern will influence what is happening within a program... the example has been the role of the Nordic states in influencing tropical disease research, not only because the head of that program is from Norway but also because of the number of interns who provide effectively free labour at a relatively junior point in their own careers". (THP: Transcript of evidence, pp 459-60)

5.40 When PNG was an Australian colony, public health professionals had the opportunity to gain far greater experience of the health issues facing developing countries than is now possible through short term consultancies. As the Centre for Health Advancement at Flinders University pointed out:

> "the problem in Australia is that many... came out of the New Guinea experience and that has now gone and the expertise is ageing. As a nation we need to maintain an expertise in international health for home reasons, as well as for our ability to work more effectively in areas of international health". (Centre for Health Advancement, Flinders Medical Centre: Transcript of evidence, pp 336-37)

5.41 AIDAB has funded several people to work on secondment with UNDP and UNHCR in the past and is currently funding one person in each of the UNDP, the United Nations Population Fund, the World Food Program and the UN Drug & Control Program. AIDAB also receives requests from WHO Special programs for Australian trainees (called "Assistant Professional Officers") to work in the region,

which AIDAB cannot offer to fill because of budgetary restraints.

5.42 The Committee believes such schemes in the health sector could be better utilised by Australia. **The Committee accordingly recommends that DHHLGCS investigate the possibility of funding a scholarship for public health postgraduates to be seconded to appropriate health related multilateral organisations on a one or two year basis. The Committee believes DHHLGCS should be responsible for funding trainees in health sector activities, while AIDAB retain responsibility for trainees in other sectors.**

5.43 Secondments to multilateral health organisations would benefit DHHLGCS staff, and the Committee recommends that consideration be given to dedicating a proportion of the funds currently provided to WHO to sponsor appropriate DHHLGCS staff to WHO on a one or two year basis.

Chapter 6

THE COMMERCIAL POTENTIAL OF AID

6.1 The provision of overseas aid can provide political, strategic and economic returns to Australia, in addition to development benefits to recipient countries. As the Minister for Development Co-operation and Pacific Island Affairs explained:

> "the development cooperation program generates substantial benefits for Australia. Aid is an integral part of the Government's foreign and trade policy. It has a unique capacity to promote closer engagement between Australia and our neighbours in the fast growing Asia-Pacific region. By encouraging more prosperous and open societies with a greater appreciation of Australia, our aid has increased regional stability and opened considerable export opportunities for Australia".[1]

6.2 Economic pressures in Australia have led to increasing efforts to identify and exploit the commercial gains that can be made from the aid program, in part, to help offset aid expenditure. Within Australia, the aid budget funds consultancies, research grants, training places and product development & procurement opportunities for Australian firms. Furthermore, through its focus on the Asia-Pacific area, the aid budget reinforces the wider strategy of developing closer trade and investment links within the region. Importantly, the aid program is seen as providing export opportunities for Australian companies wishing to enter regional markets. The challenge for aid programmers, particularly those in the health sector, is to ensure that the indirect, secondary economic and strategic benefits do not overshadow the primary objective of providing direct aid.

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[1] The Hon G. Bilney, Minister for Development Cooperation and Pacific Island Affairs, "Australia's Development Co-operation Program 1993-94", AGPS, 1993, p iii.

BILATERAL HEALTH AID: RETURNS TO AUSTRALIA

6.3 AIDAB estimates that 87% of the value of its aid program is made up of goods and services sourced from Australia.[2] In the health sector, the major return from the aid budget is Australian consultancies to develop, implement and evaluate aid projects.

The use of Australian consultants

6.4 AIDAB makes extensive use of Australian consultants in the development and implementation of its aid projects. For example, in 1992-93 AIDAB has developed three feasibility studies for bilateral health projects in Vietnam and, in the process, contracted 25 Australian consultants. AIDAB predicts that a further 35-40 Australian consultants will be contracted to AIDAB as the projects progress. AIDAB acknowledges that it seeks "to maximise the use of Australian goods and services through the aid program" as an important priority. (AIDAB: Transcript of evidence, p 5)

6.5 While AIDAB's contracting system provides income for Australian health experts, a balance must be struck to ensure that the primary beneficiaries of the aid budget remain those in developing countries rather than Australian contractors:

> "There tend to be initial visits to see if the project is possible, then there is a prefeasibility study and a feasibility study. This is followed by an implementation visit and right at the end there will be one or two evaluation visits... it seems... a very substantial proportion of the aid money gets recycled through professional organisations or into Australian consultant's personal funds". (Faculty of Medicine, University of Newcastle: Transcript of evidence, p 601)

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2 AIDAB lists its principal contracts and contractors, DIFF/EFIC projects and food aid purchases in the booklet "Business Participation in AIDAB's bilateral Aid Programs", 1983, included in AIDAB's "Business Kit" which outlines the role Australian and New Zealand businesses can play in the aid program.

6.6 In a similar vein, the Australian Federation of AIDS Organisations (AFAO) warned that:

> "we need to make sure that we do not subordinate humanitarian, public health and broader socioeconomic considerations to retaining profits in Australia... This is already generating some level of hostility and some cynicism in the international context about so-called highly paid Australian consultants". (AFAO: Transcript of evidence, p 528)

6.7 The Committee is sensitive to the fact that AIDAB receives criticism for not using enough Australian resources on one hand, and for using too many on the other. AIDAB practice is to link Australian consultants with counterpart staff in developing countries in order to facilitate the transfer of skills to local staff. In addition, where local consultants are available, they are used in tandem with Australian consultants.[3] **The Committee recommends that as a general policy, AIDAB identifies and uses appropriate local consultants in developing countries, wherever possible.**

The encouragement of trade

6.8 A number of donor countries are increasingly manipulating their aid programs to promote the export of their products and services. Several witnesses drew attention to the Japanese aid program in this regard, citing an example, whereby:

> "Japan [had] put an awful lot of aid into the health care sector... I went to the vaccine production department which had been set up with Japanese equipment. It was fiendishly designed to take Japanese ampoules only. Japan had locked them into the supply of consumables from Japan forever. That is a bit over the top and I would not like to see our aid so specifically directed to trade but we seem to go to the other extreme. We are not making use of the opportunities and our contacts whatsoever". (Department of Health Administration and Education, La Trobe University: Transcript of evidence, p 204)

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3 See AIDAB, Programs Operation Guide, Vol 1, 3.28 & Vol 2, chapter 4B, pp 8-9.

6.9 A number of other witnesses have argued this latter point, including the Australian Centre for Control of Iodine Deficiency Disorders, which stated:

> "We have got to respond to the needs of developing countries in our region... and it must be humanitarian based. But we have got to be more pragmatic. There are enormous commercial opportunities, and we are just ignoring them.... we have to be a lot smarter in terms of how this country can capitalise on some of those advantages". (ACCIDD: Transcript of evidence, pp 151-52)

6.10 This view was reinforced by the WHO Collaborating Centre for Influenza in CSL:

> "You would have to look very hard at the health component of our aid program before you found many examples which you could say were benefiting Australia in the short term or in the long term other than in a very general kind of sense". (WHO Collaborating Centre for Influenza, CSL: Transcript of evidence, p 572)

6.11 The South Australian Economic Development Authority believes that AIDAB should be helping Australian companies meet the demands for more sophisticated forms of health care in the more developed regional economies. SAEDA argued that it is important that:

> "AIDAB recognise the changing trends in Asian health care and move to be at the forefront of new requirements... the emerging needs of the region will provide greater opportunities for Australia to enhance its reputation as a deliverer of high quality technology services... It is our contention that Australia, through AIDAB, should be promoting its expertise in these important emerging areas of health care". (SAEDA: Submission, p 51)

6.12 The health sector of the aid program does not lend itself as readily to commercial exploitation as other sectors such as engineering and water & sanitation. This is because primary health care, by its very nature, relies on people intensive,

low technology equipment being provided to countries with the least capacity to become involved in high value health trade. As the Chairman of the Advisory Committee for the World Bank's World Development Report, pointed out:

> "Trade implies turnkey hospital projects. It implies high-tech equipment, selling your latest scanner or whatever the example might be. Those are exactly the kinds of international assistance that [the World Bank] report recommends against. The recommendations here are about the primary and district level services. The trade implications for aid in that area are limited. (Professor Feachem: Transcript of evidence, p 800)

Furthermore:

> "You are exporting intellectual resources, certainly, and you may be exporting some very simple medical equipment. You may be exporting vehicles, and you are certainly exporting training, but you are not exporting large hospitals or fancy and expensive equipment". (Professor Feachem: Transcript of evidence, p 800)

6.13 AIDAB has acknowledged that "the health area generally does not lend itself to the same degree of commercial spin-off that you might have in other areas...". (AIDAB: Transcript of evidence, p 929)

6.14 A distinction, that is not always clear cut, needs to be made between the export of Australia's health services as commercial ventures as opposed to being components of the aid program. The Committee fully supports ventures by public and private enterprises to export health services, expertise and equipment on a commercial basis. However, the focus of AIDAB's health sector programs should remain on primary health care, where commercial opportunities are necessarily limited. If the health sector is to receive government subsidies and assistance to export, it should not be through the aid budget. As the Chairman of the Advisory Committee for the World Bank's 1993 world development report explained, the World Bank:

"is asking donors to put trade aside as a major consideration in health sector aid and to consider investing in human resources and human capital...". (Professor Feachem: Transcript of evidence, p 800)

6.15 Nonetheless, there are sub-sectors of a primary health care focused aid program that do have a trade potential. This potential should be enhanced, as the Department of Health Administration & Education at La Trobe University told the Committee:

"it is a matter of identifying whether there are some strategic areas in health which certainly not only fulfil the goal of humanitarian aid but which might fulfil the goal of commercial opportunities as well". (Department of Health Administration & Education, La Trobe University: Transcript of evidence, p 204)

6.16 Appropriate sub-sectors of the health program with particular trade potential include vaccine development and pharmaceuticals. Water & sanitation projects in the health related sector also offer potentially high trade spin-offs.

Longer term benefits

6.17 The health sector is able to provide less tangible, longer term trade benefits for Australia, once links between the aid donor and receiving countries have been established. The WHO Collaborating Centre for Influenza believes that:

6.18 Once a familiarity is gained with the way in which people do things - the equipment that is provided, the resources that are available - that becomes the natural preference for the health care workers and the politicians in the country. Then there is an evolution which occurs, often over a period of a decade, when those are translated into commercial relationships which are of benefit to the original donor and often, ultimately end up in joint venture in the country". (WHO Collaborating Centre for Influenza, CSL: Transcript of evidence, p 572)

6.19 A similar point was made by the Tropical Health Program:

"International health development is definitely of commercial advantage to Australia. But again, Australia should be prepared to take a long term view and accept that its greatest resources are its professional expertise and the high regard in which it is held in neighbouring countries". (THP: Submission, p 106)

6.20 The Public Health Association notes:

"people who have been trained in Australia or involved in an Australian funded project show a lot of goodwill towards receiving further Australian expertise and products or sending their people to Australia for training. They are the sorts of benefits that are hard to quantify but do occur... this is what happens when we provide good, receptive aid in these countries, especially at the primary health care level". (PHA: Transcript of evidence, p 95)

6.21 The Committee accepts that the commercial benefits arising from Australia's bilateral health related programs are less demonstrable in the short term. In fact, if the health sector of the aid program is providing high trade returns, it is probably a signal that the aid program is not directed at the primary health care level. Goodwill generated by health aid can reap commercial benefit, even if not immediately or during the life of a project. That does not mean, however, that the Australian health sector cannot gain immediate commercial rewards from any overseas aid programs. Of far greater trade potential than the AIDAB aid budget, are the virtually untapped commercial opportunities arising from the activities of multilateral health related organisations, such as WHO and UNICEF, and the various multilateral development banks.

Research grants

6.22 Australian institutions, such as universities and hospitals, have already been successful in attracting WHO funds to conduct research training and regional consultancies. For example, Australian centres involved in vaccine development received approximately $300 000 in WHO grants in 1991-92, and in the same year, Australian researchers received $824 000 in grants under WHO's Human Reproduction Program. (WHO Special Program for Research & Training in Tropical Diseases: Submission, pp 27-48.) Between 1977 and 1991, Australian researchers also received approximately $5 million from the WHO/UNDP/World Bank Special Program for Research and Training in Tropical Diseases (TDR).

6.23 Australian educational institutions also benefit from training fellowships offered by international organisations. For example, in 1991-92 Australian educational institutions received over 200 students on WHO fellowships, including 14 funded by the TDR.[4]

6.24 WHO has a Regional Training Centre at the School of Medical Education at the University of NSW, which was established in 1973 by a tripartite agreement between WHO, the Commonwealth Government and the University. WHO uses the Centre for student placements and as a source for consultants and technical advisers.

International tenders

6.25 Australian consultancy and supply firms can also take advantage of overseas and international aid contracts. The contractual requirements of multilateral organisations lead them to tender internationally for consultancies and equipment worth billions of dollars each year. For example, in 1992, UNICEF placed purchase orders worldwide with a total value of US$310 million. This compares with WHO orders of US$100 million and the UN Population Fund, with

[4] The Australian aid program also supports bilateral assistance for approximately 1 400 students to undertake postgraduate health courses in Australia each year.

orders of US$30 million. The UN affiliated organisations all use competitive tendering procedures which means Australian firms and organisations have the opportunity to bid for contracts.

6.26 The multilaterals advertise their international tenders in Australia through the commercial journal "Tenders-Australia", by direct contact with existing suppliers and by advising the Australian Trade Commission. A procurement study by AIDAB calculated that for calendar year 1990, UNICEF, UNFPA and WHO together, procured $3 million worth of goods from Australian companies. Despite these figures, UNICEF told the Committee that:

> "participation by Australian companies in UNICEF's global tendering process remains disappointingly low, although the potential to lift procurement figures in Australia is significant, especially with the current Australian dollar exchange rate...". (UNICEF: Submission, p 83)

6.27 Australian educational institutions also appear to be missing out on multilateral funding for student training. The Nutrition Program at the University of Queensland believes that:

> "These training funds are considerable and, at the moment, Australia would seem to be missing significant commercial opportunities". (Nutrition Program, University of Queensland: Submission, p 147)

6.28 The International Development Program of Australian Universities and Colleges also commented on the wasted commercial potential:

> "the expertise gained by Australians working in international programs largely funded by the Australian aid program should see Australia participating more in these programs which are put out for international competitive bidding... The contracting process of the World Bank or the Asian Development Bank are based on rates and supply formulae, which means that institutions can cover all of their costs and earn margins and fees". (IDP: Transcript of evidence, p 85)

and that:

> "Australia should be able to do more. America, Britain and Europe are winning more of these international projects than Australia is". (IDP: Transcript of evidence, p 86)

6.29 What is of particular concern is that the same problem was identified by the Joint Committee on Foreign Affairs, Defence and Trade in 1989. The Joint Committee commented that "Australia's procurement record in respect of multilateral assistance continues to be disappointing".[5]

6.30 One witness believes that the problem is that Australian health professionals, when overseas, become aware of pending contracts, but do not know how to communicate this on returning to Australia:

> "the aim of that exercise is to try and see if we can get a mechanism so that contacts being made by people like myself travelling around the region in response to requests by WHO or whatever can find their way back to Australian companies that may be able to tender for a particular contract... But it is not yet working... We have in theory an international divisions at the Commonwealth department of health, we have Austrade and we have AIDAB. They all say they are interested in commercial opportunities and pursuing these things but in my experience the links are not there". (Department of Health Administration & Education, La Trobe University: Transcript of evidence, p 202)

6.31 AIDAB, AUSTRADE and the Department of Foreign Affairs and Trade are now all endeavouring to provide Australian companies with advice on multilateral contracts.

6.32 AIDAB has recently placed an officer at the Australian mission to the UN in New York and one of his tasks, in cooperation with AUSTRADE's

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5 Joint Committee on Foreign Affairs, Defence and Trade, A Review of the Australian International Development Assistance Bureau and Australia's Overseas Aid Program, Parliamentary Paper 87 of 1989, p 123.

Washington office, is to forward to AIDAB details of pending UN tenders.[6] In addition, AIDAB conveys information about UN procurement methods in its "Business Kit".

6.33 DFAT is also concerned to assist Australian companies win international tenders:

> "our ambassador in Geneva also has among her highest priorities the enhancement of Australian procurement opportunities from the agencies there, of which WHO is the largest". (DFAT: Transcript of evidence, p 785)

6.34 DFAT's Business Affairs Unit, restructured in late 1993 to provide greater trade advice, has an officer responsible for liaison with AIDAB on the trade aspects of the aid program and for advising AIDAB on pending UN tenders.

6.35 AUSTRADE records tenders from AIDAB, the World Bank, the Asian Development Bank and a number of UN agencies on its International Projects Intelligence Network database, to which Australian companies can subscribe. AUSTRADE is also hoping to have Japanese aid funded contracts included on IPIN and has already helped one Australian firm win a Japanese aid contract in the Philippines.

6.36 While this recent activity by AIDAB, AUSTRADE and DFAT is encouraging, the information presented to the Committee suggests that procurement performance by Australian organisations remains poor. UNICEF has advised that "once Australian companies become successful in the international competitive tendering process, they tend to remain successful". (UNICEF: Submission, p 83) This suggests that Australian firms are not tendering for contracts because they do not understand the tendering requirements nor realise the potential of UN organisations as a source of contracts.

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[6] Through the World Bank Australian Consultants' Trust Fund, established in 1988, AIDAB supplies funds for the World Bank to pay the fees, travel and subsistence expenses of Australian consultants for short term assignments in support of the Bank's lending operations. The purpose of this fund is to encourage the World Bank to use Australian consultants.

6.37 AUSTRADE has already funded UN procurement officers to tour Australia. AIDAB, AUSTRADE, DFAT and the United Nations Association of Australia all distribute literature on the UN contract system. Nonetheless, the message needs to be reinforced, particularly because of the high potential returns to Australia. **Accordingly, the Committee recommends that AUSTRADE, with advice from AIDAB, DFAT and DHHLGCS, develops an ongoing public awareness program to inform Australian consultants, potential exporters of services and equipment suppliers, in the health sector at least, of the benefits to be gained from the international tendering process. AUSTRADE and DHHLGCS should be responsible for targeting the information to organisations in the health sector.**

6.38 The Committee also recommends that AUSTRADE includes all tenders issued by WHO, its special programs and UNICEF on the IPIN database. Providing advice on tenders is the first step in encouraging Australian suppliers and health experts to place bids for international tenders. Ultimately, however, it is up to private companies to exploit these opportunities, as the South Australian Economic Development Authority (SAEDA) observed:

> "The UNICEF people put on a seminar here last year... it was well attended. Once again you come back to this matter of leading a horse to water. We can support seminars and we can put information in front of suppliers but we cannot make them sign a contract". (SAEDA: Transcript of evidence, p 375)

DIFF projects

6.39 Most donor countries provide financial assistance called "mixed credits" through their aid budgets to firms in their country bidding internationally for projects that meet development criteria in aid receiving countries. In effect, finance from the aid budget is provided as a subsidy to companies bidding for appropriate contracts so that their bids can become internationally competitive.

6.40 Australia's mixed credit scheme is called the Development Import Finance Facility (DIFF), which combines development grant funds with export credits provided through the Export Finance and Insurance Corporation (EFIC). Requests for DIFF funding must show that the development contract being bid for is consistent with AIDAB's aid objectives in the recipient country. DIFF funding

also will only be provided if there is evidence that bidders from other countries are using mixed credit finance schemes.[7]

6.41 If approved, DIFF grants are normally equal to 35% of the total Australian content of a project. A growing proportion of the total aid budget is being absorbed by funding for DIFF subsidies. In 1987-88, $30 million of the aid budget was allocated to DIFF finance and by 1992-93 this had risen to $120 million (8.7%).[8]

6.42 Mixed credit schemes benefit the recipient country because they can receive contract bids at artificially low prices. This, however, may encourage countries to increase their debt exposure. Furthermore, critics argue that such use of aid funds subsidises inefficient producers and that Australia can not offer the levels of subsidy that larger donors can offer. Mixed credit schemes are also claimed to divert aid from low income to middle income countries and to be of more benefit to Australian business, in this case, than to the poor of the developing world.

6.43 There have been no DIFF funded projects in 1992-93 in the health or population sectors, although $5 million of DIFF funding has been used for water supply and sanitation projects. The low use of DIFF funding in the health sector reflects the fact that primary health care projects are often inappropriate for this form of finance.

6.44 The Committee believes that DIFF funding is of limited value in the health and population sectors and recommends that AIDAB not increase budget allocations for DIFF at the expense of health and population sector funding.

COORDINATION

6.45 AIDAB, AUSTRADE, DFAT and DHHLGCS are all involved in identifying and promoting the export potential of domestic and international health aid programs. AUSTRADE and DHHLGCS are also involved in identifying and promoting the export of Australian health expertise and equipment on a purely commercial basis. The distinction between these two forms of health export can

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7 AIDAB, "DIFF: Explanatory Brochure", 1992, p 1.

8 The 1993-94 aid budget also allocated $120 million for DIFF funding.

become blurred, particularly since the same organisations can be involved in exporting the same services and equipment on a fee for service basis and through the aid program.

6.46 AIDAB seems to be successfully developing close links with AUSTRADE, as the AUSTRADE officer responsible for liaison with AIDAB explained:

> "AIDAB... has changed radically. I find AIDAB to be an organisation undergoing change and becoming much more interested in talking to [AUSTRADE] and trying to find out what capabilities Australian industry has in particular areas and trying to tie the trade effort in with the aid effort... Very close cooperation is developing". (AUSTRADE: Transcript of evidence, p 719)

6.47 AIDAB agrees, seeing "a very good dialogue with Austrade at the desk level" in a relationship that is "maturing more and more as the personalities in AIDAB and Austrade also become more familiar with each other". (AIDAB: Transcript of evidence, p 929)

6.48 On a practical level, this coordination has led to AUSTRADE briefing and debriefing the PNG Health Sector Review Team, with AUSTRADE reporting that Australian companies have been developing links with PNG and "looking at the aid effort as a cooperative and mutual part of their commercial development". (AUSTRADE: Transcript of evidence, p 719)

6.49 The Committee welcomes enhanced levels of cooperation between AIDAB, AUSTRADE and DFAT. However, DHHLGCS is also becoming increasingly involved in the export of health services, both on a commercial basis, and through the aid budget. **The Committee recommends that DHHLGCS be brought into the formal liaison network with AIDAB, AUSTRADE and DFAT to ensure greater coordination and increased opportunities overall.**

Chapter 7

COORDINATION

The necessity for coordination

7.1 AIDAB remains the major Australian organisation providing health related aid. However, as the preceding chapters have indicated, AUSTRADE, DHHLGCS, DFAT and a wide range of semi-government and private research and educational institutions, consultants, professional associations, philanthropic societies, community organisations, multilateral organisations, aid agencies, manufacturers, hospitals, single issue groups and individuals run their own aid projects or assist directly, or indirectly, in the development, delivery and evaluation of AIDAB's health programs.

7.2 The variety of organisations and individuals involved, coupled with the large number of projects, often small and geographically dispersed, means that the health related aid program needs to be well coordinated if it is to remain coherent and effective.

7.3 Good coordination requires clear direction, good communication links and regular contact between those involved. However, evidence before the Committee suggests that the necessary links between AIDAB, DHHLGCS and the Australian international health community are not adequate. According to one witness:

> "we lack effective mechanisms for linking up the various parties. It is often left to enthusiastic individuals, many of whom are not aware of the system...". (Department of Health Administration & Education: Transcript of evidence, p 189)

7.4 The International Development Program of Australian Universities & Colleges warned of the:

> "almost burgeoning of international activities, and we are not able to keep track of it... If health cooperation is to grow, we believe that something should happen to pool knowledge and pool the record of who is doing what". (IDP: Transcript of evidence, pp 80-81)

7.5 The Public Health Association further stated that:

> "there is also an argument for greater Australian commitment towards coordination of Australian efforts in general in order to ensure the best possible use of Australian expertise". (PHA: Transcript of evidence, p 93)

7.6 The lack of pooled knowledge can have embarrassing implications for Australian health experts when overseas, as one witness explained:

> "Time and again I am in contact with colleagues from our countries in our region and I hear about some activity that we are doing in the region that we were never informed about... It is both an embarrassment to us and of concern that we are not providing the best that we can in these areas". (National Centre in HIV Epidemiology and Clinical Research: Transcript of evidence, pp 526-27)

7.7 This point was also made by Ashford Hospital in South Australia, which observed that:

> "one of the problems is the perception that certainly Malaysia and Thailand have that we are very uncoordinated. And we are... It is quite embarrassing". (Ashford Community Hospital: Transcript of evidence, p 308)

7.8 The Australian National Council on AIDS believes that the lack of coordination is because the various organisations wish to protect their "turf". The Council believes Australia is:

> "bedevilled by this territorial approach not only from AIDAB and the Department of Health and the Department of Foreign Affairs but all sorts of people - the thing has been far too territorial...". (ANCA: Transcript of evidence, pp 564-65)

7.9 There has been growing recognition that there needs to be greater coordination of the health sector of the aid program if it is to increase as a proportion of the overall aid budget. Several initiatives have already been undertaken, involving AIDAB, DHHLGCS and NGOs to create the necessary closer links.

Mechanisms for coordination

7.10 AIDAB and DHHLGCS have both gone to considerable lengths to improve their cooperation and share expertise and, according to DHHLGCS, have "worked extremely hard over the last 12 months to ensure that that relationship is a much more productive one". (DHHLGCS: Transcript of evidence, p 46) There are now regular meetings between senior staff, and DHHLGCS has observer status on AIDAB's recently established in-house Coordinating Group on Health. DHHLGCS believes the improvement in liaison arising from these initiatives has been significant. AIDAB agrees, noting its "extensive and varied levels of contact" with DHHLGCS in a relationship that is "a good close and effective one in terms of making sure that we all know that the other is doing". (AIDAB: Transcript of evidence, p 7)

7.11 While close communication between AIDAB and DHHLGCS is important and can be achieved relatively easily, the most critical and difficult liaison to achieve, is between AIDAB, DHHLGCS and NGOs. Many saw the creation of the Ministerial Advisory Group on International Health in August 1991 as the appropriate mechanism to ensure such communication.

THE ADVISORY GROUP ON INTERNATIONAL HEALTH

7.12 The Advisory Group on International Health was established at the request of the then Minister for Trade and Overseas Development, the Hon N Blewett MP and the then Minister for Health, Housing & Community Services, the Hon Brian Howe MP. The purpose of the AGH was to advise the ministers on strategies to enhance Australia's contribution to international health issues and programs. It continues to advise the ministers' successors.

The objectives of the AGH are to:

i) "help ensure the best possible quality product in the international health-related aspects of Australia's development cooperation program; and

ii) help ensure the best possible coordination of Australian inputs into other international health issues and relevant programs funded or administered by sources other than the Australian Government". (AGH: Submission, p 388)

7.13 The AGH's full terms of reference are listed at Appendix 4.

7.14 The AGH consists of representatives from AIDAB and DHHLGCS, plus five health professionals experienced in international health programs who are appointed by the Ministers for a two year term. The AGH has met 6 times between August 1991 and November 1993 and secretariat support is provided by AIDAB.

The role of the AGH

7.15 The AGH has had a number of achievements during its operation, including the refinement of the Health Impact Assessment procedures, and providing support for new budget measures, such as funding for the WHO Tobacco or Health Program. Some AGH members believe, that the AGH's major achievement has been to improve liaison between AIDAB and DHHLGCS. As one member commented:

"what we have succeeded in doing as a group has been to encourage

> collaboration between [DHHLGCS] and AIDAB that was absent but which was part of the impetus for the establishment of the [AGH] in the first place". (PHA: Transcript of evidence, p 97)

7.16 However, the AGH seems to have been fundamentally flawed because its role has been unclear, both to those within the AGH and to the wider health community. As one AGH member admitted, the "aims and objectives of the group were fairly unclear at the outset". (PHA: Transcript of evidence, p 97)

7.17 One public health expert commented that some of the AGH members were:

> "a little bit doubtful about the impact and what it is actually achieving. They are wondering whether this was just a token appointment to appease or whether it was really meant to be an effective advisory panel". (Third World Health Group: Transcript of evidence, p 140)

Even DHHLGCS said that:

> "nobody really has come to grips with what that AGH is meant to do. Is it a decision making thing; is it using [DHHLGCS] to seek out the whole network of people who do jobs for WHO that nobody knows about, or who does jobs in the country on important issues like malaria and so on who could be used overseas?". (DHHLGCS: Transcript of evidence, p 759)

7.18 In addition, it appears that the public health community has had unrealised expectations of the AGH's potential to link the government agencies with the wider health sector. Some of the criticisms have arisen because many expected the AGH to be a forum to represent the health sector and wider international health issues, rather than just a group to advise the Ministers. This has inevitably led to charges that the AGH is unrepresentative and ineffective. The point has been conceded by DHHLGCS, which pointed out that the role of the AGH in practice:

> "really came down to an exchange of what AIDAB was doing and what

[DHHLGCS] was doing. There was an interesting debate on some of these issues, but it was never given the mandate - maybe ministers do not want it to have the mandate- of saying how we should best focus our health aid, who should be doing it and who are the experts". (DHHLGCS: Transcript of evidence, p 759)

7.19 Written into the AGH's terms of reference is the requirement that it run for two years initially and that "its continuation thereafter to be subject to review by the Ministers". (AGH: Submission, p 388) The review is being undertaken jointly by DHHLGCS and AIDAB, in consultation with the other AGH members, and will be completed in late 1993.

Reform of the AGH

7.20 The Committee does not want pre-empt the review's conclusions, but believes that there is a continuing requirement for a group with a coordinating and broad policy advisory role, with membership representing AIDAB, DHHLGCS and the health sector. This point was made by the Australian Council for Overseas Aid (ACFOA):

"[The AGH] has not worked effectively, that is true; but the principle of having [DHHLGCS] and AIDAB seeking a broad range of advice from people in areas of science, the community and from those with a general interest in the health field and looking at coordination mechanisms is an important one". (ACFOA: Transcript of evidence, p 549)

7.21 The HIV/AIDS & Development Program also believes Australia still needs a formal mechanism to bring the community sector into the strategic decision making process:

"we rely pretty much on informal mechanisms and the goodwill of the individual officers at program level and the institutional support that is given to our non-government networking. But there is still an absence of a regular commitment that the community sector will have a formal input into strategic planning and policy development at a senior level...". (HIV/AIDS & Development Program: Transcript of

evidence, p 517)

7.22 Accordingly, the Committee recommends that the Advisory Group on International Health continues, albeit with a more clearly defined role and with greater representation from the health sector.

7.23 The Committee recommends that the major role of the AGH be to provide strategic policy advice on international health to AIDAB and DHHLGCS. In this role, the AGH could provide advice on: how to maximise the effectiveness of Australia's contributions to multilateral health related organisations; the health sector priorities that should be pursued on a regional and country basis; the distribution of international research funding to public health institutions and; standards for health database compatibility. These roles should be clearly defined and performance indicators set.

7.24 In Chapter 4, the Committee argues that AIDAB funding is spread too thinly over many health sector projects and that funding should be focused on priority sub-sectors. The Committee believes the AGH would be an ideal vehicle to steer debate on this issue.

7.25 There are several things the Committee believes the AGH should not be. First, it should not have the role of providing detailed specialist advice, which is a task that is more properly done using DHHLGCS and AIDAB's in-house expertise or external consultants. The AGH derives its main benefits from its generalist rather than specialist skills.

7.26 While it will indirectly represent the health sector through its membership, the AGH should not be a forum for consultation between the health sector and the two government agencies. Consultation is best carried out between public health experts and officials from the International Branch of DHHLGCS and the Health and Population Section of AIDAB directly.

7.27 Finally, the AGH should not be seen as the principal vehicle for inter-departmental consultation. While the need for this communication may have been a consideration in the original justification for the AGH, the relationship between AIDAB and DHHLGCS has developed sufficiently for coordination to occur independently of the AGH. While it will continue to offer a "neutral" and important

venue for inter-departmental communication, the AGH should now more fully utilise its external health sector experts in discussing strategic policy issues.

7.28 If the AGH is going to become more active in providing advice on the overall direction of health sector programs it will need to meet more often and have a more sophisticated structure. **The Committee recommends that the AGH meets four times a year, and makes use of sub-committees able to hold inter-sessional meetings where necessary.**

7.29 The Committee further recommends that AGH's membership be expanded by an additional two or three Ministerial appointees from the health community, with one of the additional appointees having direct experience in the commercial aspects of the health related aid program. Where necessary, the AGH should co-opt experts.

7.30 The Committee recommends that the AGH provides an outline of its function and proposed areas of activity to be distributed to health sector organisations and institutions. This action should avoid the misunderstandings that have arisen in the health community about the current role of the AGH.

The Advisory Council on Aid Policy

7.31 Another ministerial advisory forum for consultation between the Minister for Development Cooperation and Pacific Island Affairs and the Australian aid community, called the Advisory Council on Aid Policy, met for the first time in July 1993. The Council is designed to provide a means for bringing together the diverse range of views on development, development assistance and the aid program on a regular (twice yearly, unless additional meetings are requested by the Minister), structured basis in discussion with the Minister. The Advisory Council is chaired by the Minister, in contrast to the AGH which does not have ministerial representation.

7.32 The health sector focus of the Advisory Council and its influence on the AGH remain to be seen. Obviously, it is important that they do not duplicate each other's work. The risk of this is small, however, given that AIDAB and the Minister for Development Cooperation and Pacific Island Affairs have an interest in both.

COORDINATION WITH NGOs

7.33 While the AGH and the Advisory Council provide a degree of access for the health sector to AIDAB and DHHLGCS, they do not provide a substitute for regular liaison. AIDAB has gone to some lengths to refine the AIDAB - NGO consultative process through: regular meetings with the executive of the Australian Council for Overseas Aid; an annual AIDAB-NGO meeting each September; joint project appraisal panels; and a range of ad hoc meetings to facilitate NGO policy/program involvement in specific country programs. However, within the health sector, a number of the public health community question whether these mechanisms are bringing AIDAB into contact with all the appropriate health sector experts, resulting in a reduction in the quality of aid programs. In one instance, the Faculty of Medicine at the University of Newcastle argued that:

> "AIDAB for example is not always aware of the medical and scientific expertise that is around and therefore occasionally things go astray... there is quite an urgent need to bridge that gap, whether by a network, document or whatever". (Faculty of Medicine, University of Newcastle: Transcript of evidence, p 600)

7.34 The Australian Centre for Control of Iodine Deficiency Disorders made a similar point:

> "Most Australian health care institutions - hospitals, medical schools and research institutes - have little or no knowledge of the content of, and mechanisms for, delivery of international health programs... To our knowledge there is no formal process whereby this information is... distributed to institutions or health care groups... It would appear not unreasonable to conclude therefore, that the potential to exploit Australian expertise and resources remains largely untapped". (ACCIDD: Submission, pp 73-74)

7.35 AIDAB, argues, on the other hand, that it provides adequate opportunities for health experts to come forward through the contract system:

> "it is fair to say that [AIDAB] makes a very extensive effort to try to

attract people to work on aid program activities by the way that we seek assistance through the consultant community". (AIDAB: Transcript of evidence, p 669)

and that:

"Many in the medical community might wish to see it as a closed market and say, 'Why did you not seek me? I am an expert in areas X, Y or Z'... That person has to come forward and demonstrate that expertise, and the selection process is then undertaken". (AIDAB: Transcript of evidence, p 669)

7.36 There is obviously a disagreement about the extent to which AIDAB should go to seek out health expertise in the community. It is acknowledged that the international health sector is decentralised and multifaceted, without a peak organisation and that this makes communication difficult. As a result, **the Committee recommends that AIDAB pursue a more sophisticated, multi-tiered approach to interacting with the health sector than through the purely commercial links in the contract process.** There are encouraging signs that the need for this is recognised by AIDAB, as one of its senior officers indicated:

"One of the 'mistakes' AIDAB may have made over time is that we have tended to possibly treat the health community very much as we would any other private sector interest... My guess is... that those sort of outreach activities are not particularly attractive to the health professional community. They do not see themselves, possibly, in that strong private sector role. I think that what we are talking of here is in a way broadening that outreach activity so that it is not so directly contractually based and has a broader professional association type of arrangement around it rather than a very narrow contractual basis, which is the way often deal with other suppliers of goods and service". (AIDAB: Transcript of evidence, pp 908-09)

7.37 One way of broadening the relationship between AIDAB and the Australian health sector is through AIDAB's involvement and sponsorship of workshops and conferences in the international health area. AIDAB has recently

sponsored a workshop on the World Bank Development Report on International Health in August 1993 and also the International Conference on Population and Development in November 1993. DHHLGCS already sponsors seminars and consensus conferences on a regular basis on issues across its portfolio responsibilities. In the international health sector, DHHLGCS has most recently supported the Public Health Association's "Workshop on International Health" held in February 1992.

7.38 Such workshops can be supported for relatively small cost and provide an effective means of pooling knowledge and expertise and facilitating the development of formal and informal networks. AIDAB's involvement in this form of outreach has received support from the health sector, with one witness, believing that the forums sponsored by AIDAB have "opened up the way for what I call the more mature forms of interaction over time". (IDP: Transcript of evidence, p 75) A spokesman for the Third World Health Group commented that:

> "I can see a lot of advantage in people coming together as much as possible. I think AIDAB has learnt to cooperate better lately than in the past". (Third World Health Group: Transcript of evidence, p 135)

7.39 The Committee recommends that AIDAB continue sponsorship and participation in professional conferences in conjunction with DHHLGCS. At such conferences, the documents outlining AIDAB's health activities and involvement with Australian health community should be provided, along with information on the role of the Health and Population Section, the Health Liaison Officer and the Advisory Group on Health.

7.40 The development of health sub-sector priorities with longer term contractors, an expanded role for the AGH; the development of professional as well as commercial links and the creation of the position of Health Liaison Officer will all encourage a closer relationship between AIDAB and the health community in Australia.

7.41 One example where close and successful cooperation between AIDAB, DHHLGCS and NGOs has occurred is in the HIV/AIDS area, through the establishment of the HIV/AIDS and Development Program. The Program is a joint project by the Australian Federation of AIDS Organisations, the peak organisation

representing the HIV/AIDS community, and the Australian Council for Overseas Aid, the peak organisation representing NGOs, and is jointly funded by AIDAB and DHHLGCS. The success of the Program, is at least partly attributable to the coordination and strength of the domestic HIV/AIDS NGO networks which are willing to play an international role. The Program network may not be an appropriate model for all health sub-sectors, but provides an example of the benefits that can arise from close liaison between AIDAB, DHHLGCS and NGOs.

DATABASES

7.42 Coordination of the health related aid program requires, as its corner stone, a comprehensive flow of information, not only between AIDAB and DHHLGCS, but between these agencies and the health sector and also within the health sector. Witnesses have commented that to achieve this information network requires a common database providing information on who is involved in international health programs and what the developing country requirements are. As the International Development Program of Australian Universities and Colleges recommended:

> "Consideration should be given to the establishment of a register or database of currently active international programs that involve Australian organisations including professional medical associations, hospitals and universities as well as national agencies like IDP. This register should be used to distribute up to date information on such programs so as to promote understanding and to reduce the dangers of duplication". (IDP: Submission, p 474)

7.43 A witness from La Trobe University's Department of Health Administration & Education believes that even a simple database could assist improve coordination of Australia's international health programs:

> "There is still a need, I believe, for this to be more formally coordinated. Even a very simple thing I was mentioning of a database of names and addresses of key people in overseas ministries of health and non-government organisations that are interested in this area needs to be kept so that Australian resources, newsletters and

Australian Prescribers could at least be sent there. It sounds very simple but there is no mechanism currently for doing that very simple thing." (Department of Public Health & Education, La Trobe University: Transcript of evidence, p 202)

7.44 Others, however, have questioned the necessity for a database, with the Macfarlane Burnet Centre for Medical Research commenting that "the field is fairly small and most people in Australia know other people in the field". (Macfarlane Burnet Centre for Medical Research: Transcript of evidence, p 251)

7.45 A problem with creating and maintaining databases is that they can become time consuming and expensive, as the International Development Program of Australian Universities and Colleges warned:

"The danger is that these things become so expensive. By the time you have set up a secretariat for this body and arranged regular meetings and publications, newsletters et cetera, you could be facing quite a substantial annual budget". (IDP: Transcript of evidence, p 82)

7.46 The Committee does not think that a single national database on all activities and individuals active across the international health sector is achievable; primarily because of the cost of keeping such a database up to date. Instead, the Committee advocates information networks be developed around the five or six sub-sector priorities recommended by the Committee in paragraph 4.57. **As part of the sub-sector contracts, the Committee recommends that the successful contractors be required to compile, maintain and distribute details of the aid programs in their sub-sector, who is running them and where the national sources of expertise are. AIDAB should be responsible for merging the sub-sector databases and promoting the combined database to public subscribers.**

7.47 If the merged databases prove cost effective to maintain and there is demand for them, consideration should be given by AIDAB to creating databases for the non priority health sub-sectors and including them on the merged database. AIDAB would be able to use this database to complement and ultimately replace the health sector entries in the Consultants Register.

Utilising existing databases

7.48 AIDAB maintains a number of in-house databases, two of which contain information of potential interest to the wider health sector. These are the "Consultants Register" and "Lessons Learnt" database. Currently these are designed for internal use by AIDAB officers as management tools, but with appropriate modifications could be made available to public subscribers.

7.49 As was described in Chapter 4, the Consultants Register contains the curricula vitae of experts who have either worked on previous AIDAB contracts or who have registered their particulars with AIDAB. Of the 3 000 names on the register, approximately 300 are in the health sector. The Committee believes that the curricula vitae of the health experts could be made available to outside subscribers. Access to this database would allow subscribers to quickly identify experts with specific skills. The Committee does not believe there are insurmountable privacy obstacles in making the curricula vitae available and future registrations could be made on the understanding that the information would be made available to AIDAB's subscribers.

7.50 The second database is the Lessons Learnt database. All AIDAB projects have mid term and final evaluation reviews, out of which are extracted a list of the mistakes and successes of the projects. This data is then synthesised and put on the database. Project teams are required to consult the database before project design to ensure that past mistakes are not repeated and successful approaches, either by country or sector, are capitalised on. **The Committee recommends that the non confidential information in AIDAB's Lessons Learnt database be made available in printed and electronic form to public subscribers.**

7.51 AIDAB has expressed reservations about the cost of making its databases public and is unsure of the demand for the service. Accordingly, the Committee recommends that the databases be made available to subscribers in a pilot scheme to assess demand. The Committee believes that information in the databases should also be summarised in a printed format for wider distribution.

7.52 There are a number of private databases containing information on international health programs and associated experts, including those held by the *Public Health Association of Australia* and the *International Development Program* of Australian Universities and Colleges. As IDP commented:

"We have a database. If we need advice on who has expertise in a particular country, or who has worked for WHO before, we use our database and access fairly promptly Australia-wide people with expertise in particular specialisations." (IDP: Transcript of evidence, pp 76-77)

7.53 The Committee believes that the most effective way of utilising the information held by the various agencies is the development of compatibility standards that allow an easy interchange of information between databases. Thus, a communication network between the various decentralised databases would bring together information which currently exists but is not in a form which is immediately accessible.

7.54 In this way, for example, AIDAB could identify and contact health professionals who have expertise required by AIDAB but who may not have come forward and placed themselves on the Consultants Register. Equally, other subscribers could use the network to quickly identify experts or AIDAB projects underway in particular health sub-sectors. Adequate safeguards would need to be established to protect commercial-in-confidence and privacy concerns.

7.55 The Committee believes that the AGH is the most appropriate body to initiate and coordinate a review of the development of database compatibility between the various parties providing international health programs. **Accordingly, the Committee recommends that the AGH, or one of its subcommittees, examines the potential of developing standards of compatibility for an international health database network. The network has the same potential as AIDAB's in-house databases to be made available at differential levels of access to public subscribers.**

7.56 It may possible, ultimately, for an "international health network" to be linked in with existing networks such as the Australian Academic Research Network.

Chapter 8

A NATIONAL STRATEGY

A long term approach

8.1 One important principle of aid funding is that it is most effective when funded on a secure, long term basis. Long term expenditure commitment provides stability, which assists developing countries to strengthen their own support structures and assists Australian individuals and institutions to build up and maintain necessary professional skills.

8.2 The Committee is concerned at a Government decision in October 1993 to freeze expenditure of all non committed funds in the population program, pending an independent inquiry into the relationship between rapid population growth and economic development. Such short term action destroys Australia's reputation for providing justified and well planned aid programs and, in this case, flies in the face of internationally recognised policy directions. The decision also creates a potential precedent for other aid programs which could also be disrupted at short notice.

8.3 These views were reinforced by the Chairman of the Advisory Committee for the World Bank's World Development Report 1993 who, commenting on the relationship between rapid population growth and development, told the Committee that:

> "No sensible person would claim that reductions of rates of population growth is a panacea for the problems of developing countries. However there is a considerable, though not total, consensus among development economists and demographers that rapid population growth makes it more difficult to achieve development goals. In particular, moderation of population growth allows

greater expenditure per head on schooling and health".[1]

The Chairman of the Advisory Committee further added that:

> "I must stress that family planning is a key, and cost effective, component of maternal and child health and its vigorous promotion is justified on that ground alone. Smaller and better spaced families are much more healthy... In addition, the eradication of illegal abortion would reduce the number of maternal deaths per year by about 30 per cent".[2]

8.4 The Committee believes it is vital that institutions and individuals in both developing countries and Australia have confidence in the quality and intellectual foundations of the aid program, free from ad hoc decision making.

A strategic focus

8.5 A recurring theme throughout this inquiry has been that, while Australia provides a credible overseas health related aid program, it has the potential to be more effective.

8.6 Many witnesses have given qualified praise to AIDAB for its efforts. According to one witness:

> "These people from the WHO are saying that we are up there with the best... the perception which I have received when I have been out of the country is that AIDAB is well-meaning, but it lags way behind agencies such as Danida, which is the Danish organisation... and CIDA, which is the Swedish organisation. These agencies are swifter in response and perhaps a little less hidebound". (Faculty of Medicine, University of Newcastle: Transcript of evidence, p 606)

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1 Private correspondence from Professor Feachem, Chairman of the Advisory Committee for the World Bank's World Development Report 1993, 23 November 1993.

2 ibid.

8.7 The National Centre in HIV Epidemiology and Clinical Research agreed:

> "In terms of what we can do, we need to get a bit more bang for our buck. The prominence of our programs is not recognised internationally. No-one really takes seriously or knows what is going on with the AIDAB bilateral programs in our region. This is in enormous contrast to the other bilateral programs... I think that that is a great pity". (National Centre in HIV Epidemiology and Clinical Research: Transcript of evidence, p 560)

8.8 Australia's involvement in particular programs has also come in for praise. The Australian Federation of AIDS Organisations told the Committee:

> "In the Pacific, Southern Asia and South Africa there are fantastic examples of Australian funded delivery of programs and AIDS specific projects, as well as academic collaboration in the health sector. Despite problems of coordination, these are building a very good reputation for Australia in these areas. Things are looking very good in spite of our problems...". (AFAO: Transcript of evidence, p 568)

8.9 However, witnesses have argued that the full potential of Australia's health related aid program has not been realised because of its lack of focus and direction. This need for focus and direction are becoming more acute as the proportion of the aid budget spent on health related programs increases. As the Australian Centre for the Control of Iodine Deficiency Diseases explained:

> "We need a plan. We need information on what people are doing, but we need some plan as to how to more effectively use our resources internationally". (ACCIDD: Transcript of evidence, p 152)

8.10 The Committee believes that a fully effective health related aid program requires: giving priority to developing countries in the Asia-Pacific region; clear identification of the health related needs of developing countries, which AIDAB already provides: a sub-sectoral focus; and better coordination between the providers

of health aid. As the Chairman of the Advisory Committee for the World Bank's 1993 world development report, pointed out:

> "I think there is a strong and very plausible argument for Australia's health sector aid to be largely concentrated in your region: Asia and the Pacific... Equally, I can see many arguments in favour of focusing not only on the region but on a carefully selected list of topics within the region... Australia could really make a difference in the region. Australia could provide intellectual leadership and could combine its relatively small amounts of actual cash with the substantial amounts of brainpower, policy guidance, training and interaction with those governments". (Professor Feachem: Transcript of evidence, pp 801-02)

8.11 The aid sector in general has already recognised the need to concentrate aid projects in the Asia-Pacific region, if only because, the Australian aid budget is too small to have much impact further afield.

8.12 However, Australia still needs to identify, and give greater support to its key areas of international health expertise. By using the AGH to lead debate, donor countries, AIDAB and the health community should be able to determine five or six major health priorities in regional developing countries, where Australia has particular expertise. By providing priority support for these sub-sectors, Australia will be able to adequately develop the highest levels of expertise and institutional support. This in turn will allow Australia to provide comprehensive and integrated aid programs in the health sectors of greatest regional relevance.

8.13 Australia will also consolidate its reputation in the international health community by having clearly highlighted areas of expertise. Australia's reputation will be further enhanced through a complementary and more selectively active role in multilateral health related organisations, such as the WHO special programs.

8.14 A constant theme running through the inquiry has been the need for better coordination and communication between the various government, semi government and non government organisations. Only when such coordination has been achieved will the benefits and cost effectiveness of the health related aid program be maximised. The Committee has been encouraged by recent measures taken so far, but has identified further initiatives to better link those involved. An area of potential concern for the future will be to ensure that the commercially

orientated activities of AIDAB, AUSTRADE, DFAT and DHHLGCS in the international health area remain integrated.

8.15 A frequent criticism by health professionals has been the difficulty of communicating with AIDAB on other than the purely contractual and commercial basis. However, the creation of a health liaison officer within AIDAB, a more active Health and Population Section, subscriber access to AIDAB databases and AIDAB's greater involvement in professional seminars, all recommended by the Committee, should encourage better communication in the future.

8.16 The primary responsibility for providing a focused, cost effective health related aid program lies with AIDAB. The Bureau needs the corporate will to drive the health related aid program, making sure it meets donor needs, coordinating the Australian involvement, and ensuring the projects fully utilise Australian expertise. To date, AIDAB has not placed a high priority on the health sector, although this is now changing. By adopting its recommendations, the Committee believes that AIDAB will be better placed to identify and meet clearly defined health sector aid priorities in a cost effective manner. The result should be high quality programs meeting the needs of developing countries and Australia alike.

Allan Morris MP
Chairman

3 December 1993

APPENDIX 1

LIST OF SUBMISSIONS

Individuals

Mr T Barnes
Dr Y A Cader
Dr J McKay
Ms B Snell

Organisations

Australian International Development Assistance Bureau (AIDAB)
Australian Federation of AIDS Organisations Inc. (AFAO)
Australian Medical and Services Export Group
Australian National Council on AIDS (ANCA)
Australian National University, National Centre for Epidemiology and Population Health
Australian Postgraduate Federation in Medicine
Australian Red Cross Society
Australian Third World Health Group
Commonwealth Department of Health, Housing and Community Services
CSL Limited
Doctors' Reform Society, Western Australian Branch
EPI-INFO Consultants (Australia)
Family Planning Federation of Australia, Inc
Flinders University of South Australia
Halsodel
HIV/AIDS & Development Program
IBM Australia
Institute of Clinical Pathology and Medical Research (Westmead Hospital)
International Trade Communications
International Development Program of Australian Universities and Colleges Ltd
International Council for Control of Iodine Deficiency Disorders (ICCIDD)
La Trobe University, Lincoln School of Health Sciences
La Trobe University, School of Education
Lions Save Sight Foundation
Macfarlane Burnet Centre for Medical Research
Northern Territory Department of Health and Community Services
Overseas Service Bureau
Public Health Association of Australia
Royal Australasian College of Physicians
Saramane Pty Ltd
South Australian Department of Industry, Trade and Technology

United Nations Children's Fund (UNICEF)
University of Newcastle, Centre for Clinical Epidemiology and Biostatistics
University of Queensland, Nutrition Program
University of Queensland, Tropical Health Program
Walter & Eliza Hall Institute of Medical Research
World Health Organisation, Division of Diarrhoeal and Acute Respiratory Control
World Health Organisation, Development and Research Training in Human Reproduction
World Health Organisation, Expanded Program on Immunisation
World Health Organisation, United Nations Development Program, World Bank, Special Program for Research and Training in Tropical Diseases

APPENDIX 2

DETAILS OF PUBLIC HEARINGS AND WITNESSES

CANBERRA - 21 JUNE 1993

Australian International Development Assistance Bureau

- Mr Michael Casson, Assistant Director General, International Organisations and Public Affairs Branch
- Mr Laurence Engel, Assistant Director General, Papua New Guinea Branch
- Dr Valerie Hull, Director, Health and Population Section
- Mr Charles Terrell, Deputy Director General, Asia, Africa and Community Programs Division
- Dr Helen Ware, Assistant Director General, Program Development and Review Branch

Department of Health, Housing, Local Government and Community Services

- Dr Anthony Adams, Chief Medical Adviser
- Mr Brian Candler, Assistant Secretary, Health Services
- Mr John Okely, Assistant Secretary, International and Audit Branch
- Mr Ian Wingett, Assistant Secretary, Secretariat Branch, Health Advancement Division

Family Planning Australia

- Ms Dianne Proctor, Executive Director

International Development Program of Australian Universities and Colleges

- Dr Elton Brash, Director, Projects Division
- Mrs Prue Watters, Manager–PNG, Pacific and China Territory

Public Health Association of Australia

- Ms Margaret Conley, Executive Director
- Professor Lenore Manderson, Member and Convener, International Health Special Interest Group
- Dr Maxine Whittaker, Convener, Policy and Member, International Health Special Interest Group

SYDNEY - 22 JUNE 1993

Australian Third World Health Group

- Dr John Hirshman, Executive Member

University of Newcastle

- Professor Annette Dobson, Director,
  Centre for Clinical Epidemiology and Biostatistics
- Professor Richard Heller, Professor of Community Medicine and
  Deputy Director, Centre for Clinical Epidemiology and Biostatistics

Australian Centre for Control of Iodine Deficiency Disorders,

- Professor Creswell Eastman, Director, Institute of Clinical Pathology and
  Medical Research, and Chairman, Westmead Hospital

United Nations Children's Fund

- Ms Dorothy Wilson, Program Funding and Liaison Officer,
  United Nations Children's Fund

MELBOURNE - 28 JUNE 1993

Australian Postgraduate Federation in Medicine,

- Mr David Thompson, Project Director,
  Foreign Medical Graduates Project
- Professor Napier Thomson, Vice-President and
  Chairman, Victorian Medical Postgraduate Foundation

La Trobe University

- Dr Kenneth Harvey, Senior Lecturer, Department of Health
  Administration and Education

Macfarlane Burnet Centre for Medical Research,

- Dr Tamara Aboagye-Kwarteng, Research Fellow, Epidemiology and
  International Health Program
- Dr Alan Moodie, Head, International Health Program
- Dr Tilman Ruff, Physician, International Health Program

Overseas Service Bureau

- Mr Peter Britton, Manager, Program Development and Training Unit

Royal Australasian College of Physicians

- Dr Graham Brown, Secretary, Asia-Pacific Committee
- Professor Richard Larkins, Chairman, Asia-Pacific Committee

Saramane Pty Ltd

- Dr William Briggs, Chief Executive

Walter and Eliza Hall Institute of Medical Research

- Dr Robin Anders, Director, Malaria Laboratory

ADELAIDE - 29 JUNE 1993

Ashford Community Hospital

- Mr Geoffrey Sam, Chief Executive Officer

EPI-INFO Consultants (Australia)

- Mrs Helen Mackley, Principal

Flinders Medical Centre

- Professor Anthony Radford, Professor of Primary Health Care, Centre for Health Advancement

International Council for Control of Iodine Deficiency Disorders

- Dr Basil Hetzel, Executive Director

South Australian Economic Development Authority

- Dr Leon Gianneschi, General Manager, International Business
- Mr Keith Hope, Senior Project Officer

BRISBANE - 7 JULY 1993

International Trade Communications

- Mr David Cahalan, Managing Director, Day Surgeries Australia
- Mr Peter Wentzki, Principal

University of Queensland, Tropical Health Program

- Professor Lenore Manderson, Professor of Tropical Health
- Dr Donald McManus, Research Coordinator
- Professor Ian Riley, Director

University of Queensland, Nutrition Program

- Professor Peter Heywood, Director

WBM Oceanics Australia

- Mr Peter Ebsworth, Associate, Biology Group, WBM Oceanics Australia

CANBERRA - 4 AUGUST 1993

Australian Council for Overseas Aid

- Mr Russell Rollason, Executive Director

Australian Federation of AIDS Organisations

- Mr Lindsay Daines, International Program Manager
- Mr Kenneth Davis, Convenor of International Working Group

Australian National Council on AIDS

- Dr Don Grimes, Chairperson

Commonwealth Serum Laboratories Limited

- Professor Ian Gust, Director, R&D Division,
  and Director, WHO Collaborating Centre for Influenza

Department of Health, Housing, Local Government and Community Services

- Professor Peter McDonald, Chairman, Commonwealth AIDS Research Grants Committee, AIDS and Communicable Disease Branch

HIV/AIDS and Development Program
- Mr Timothy Mackay, Coordinator

National Centre in HIV Epidemiology and Clinical Research
- Associate Professor David Cooper, Director
- Associate Professor John Kaldor, Deputy Director

University of Newcastle

- Professor Anthony Smith, Professor of Clinical Pharmacology, Faculty of Medicine

CANBERRA - 13 AUGUST 1993

Australian International Development Assistance Bureau

- Mr Peter Hodge, Director, United Nations and International Programs Section
- Mr Rod Irwin, Acting Deputy Director-General, Pacific and InternationalPrograms Division
- Mr Trevor Kanaley, Deputy Director-General, Corporate Development and Support Division
- Mr Nicholas Notarpietro, Acting Director, Health and Population Section
- *Mrs Margaret Regnault, Director, Indochina Section*
- Dr Helen Ware, Assistant Director General, Program Development and Review

Australian Trade Commission

- Mr Ronald Jackson, Manager, Aid/Trade Division
- Mr Christopher Lang, Manager, Government Relations Division
- Mr John McCaffrey, Manager, Health and Scientific Business Development Unit

Department of Foreign Affairs and Trade

- Mr Kevin Boreham, Assistant Secretary, International Organisations Branch
- Mr Andrew Todd, Director, United Nations Social Section
- Dr Helen Ware, Assistant Director-General, Program Development and Review, AIDAB

Department of Health, Housing, Local Government and Community Services

- Dr Anthony Adams, Chief Medical Adviser
- Dr John Loy, First Assistant Secretary, Health Advancement Division
- *Mr Michael Mossop, Director, Grants and Projects Section,* Health Services Branch
- Mr John Okely, Assistant Secretary, International and Audit Branch

CANBERRA - 1 SEPTEMBER 1993

London School of Hygiene and Tropical Medicine

- Professor Richard Feachem, Dean, London School of Hygiene & Tropical Medicine and Chairman, Advisory Committee for the World Bank's World Development Report 1993

CANBERRA - 6 SEPTEMBER 1993

Australian International Development Assistance Bureau

- Mr Michael Casson, Assistant Director-General, International Organisations and Public Affairs Branch
- Mr Michael Commins, Assistant Director-General, South Pacific and Training Branch
- Mr Peter Hodge, Director, United Nations and International Programs
- Mr Trevor Kanaley, Acting Director-General
- Mr Colin Lonergan, Director, Health and Population
- Mr Andrew McNee, Health and Population
- Dr Ross Sutton, Health Adviser, Pacific Regional Team
- Mr Peter Versegi, Country Program Manager, Social Development Section, Papua New Guinea Branch

DIRECT HEALTH RELATED AID EXPENDITURE
$A MILLION
(1993-94 FIGURES ARE ESTIMATES)

	Health		Population		Water/Sanitation		Total	
PROGRAM ELEMENT	1992-93	1993-94	1992-93	1993-94	1992-93	1993-94	1992-93	1993-94
Country Programs								
Projects	23.0	16.75	6.90	19.65	18.5	23.48	48.4	59.88
Global Programs								
UN Population Fund			2.0	3.3			2.0	3.3
Int'l Health Programs	4.5	4.8	1.5	3.8			6.0	8.6
NGOs (CDC)[1]	2.1	0.7			1.6	1.0	3.7	1.7
ISSS[2]	0.16	0.07	0.02				0.18	0.07
DIFF[3]					5.0	9.8	5.0	9.8
WHO[4]	7.6	6.86					7.6	6.86
TOTAL	**37.36**	**29.18**	**10.42**	**26.75**[5]	**25.1**	**34.28**	**72.88**	**90.21**
% OF ODA	2.7%	2.1%	0.75%	1.9%	1.8%	2.4%	5.2%	6.4%

(Source: AIDAB)

The 1993-94 figures for Health and Water Supply & Sanitation sub-sectors do not include further projects likely to be approved and funded in the financial year.

[1]Non Government Organisations (Committee for Development Cooperation).
[2]International Seminar Support Scheme.
[3]Development Import Finance Facility.
[4]Funded through the Department of Health, Housing, Local Government & Community Services.
[5]The final expenditure for population programs will depend on the outcome of the independent review into the links between population and development (see Chapter 8). It is possible that expenditure could increase to the total of $30 million as announced by Minister Bilney.

APPENDIX 4

TERMS OF REFERENCE

The Ministers responsible for Health and for Overseas Development have established an Advisory Group on International Health (AGH) to advise them on strategies to enhance Australia's contribution to international health issues and programs in developing countries. The Group is established for two years in the first instance, its continuation thereafter to be subject to review by the Ministers.

2. The objectives of the AGH are to:

   - help ensure the best possible quality product in the international health-related aspects of Australia's development cooperation program; and

   - help ensure the best possible coordination of Australian inputs into other international health issues and relevant programs funded or administered by sources other than the Australian Government.

3. The AGH will advise the Australian Ministers responsible for Health and Overseas Development on strategies to deal with international health issues in development cooperation with developing countries. Such advice will cover, at a strategic level, the priorities and ways in which Australia can respond including, in particular

   (a) health development in the principal regions of Australia's development cooperation program;

   (b) health policy and programming issues arising in the World Health Organisation (WHO) and the World Health Assembly (WHA);

   (c) options for programming mechanisms for Australia's health-related development cooperation;

   (d) options for improving Australia's commercial opportunities in the health sector of Australia's development cooperation program.

4. The underlying rationale of the Advisory Group's discussions and advice will be the objective of helping social development in developing countries.

5. The Advisory Group shall consist of five officials and five experts from the Australian health professions who are experienced in health cooperation with developing countries. The officials will comprise the Chairperson of the Group, normally the Deputy Director General of the Community, Commercial and International Programs Division in the Australian International Development Assistance Bureau (AIDAB). Two other officials will be drawn from AIDAB and from the Department of Health, Housing and Community Services.

The experts from the health professions will be nominated by the Ministers. Experts on the Group may be replaced by alternates also nominated by the Ministers. AIDAB will be responsible for administrative arrangements.

6. The Advisory Group will meet at least once a year preferably twice: before the annual Session of the World Health Assembly and following the annual announcement of Australia's aid budget.