

The above is a simplified outline of the breakdown of a project's costs into one-time, recurrent, direct and indirect categories on the basis of function. Asterisks denote information contained in the Sine-Saloum report. It is obvious from the small numbers of asterisks that little costing of this project was undertaken. The most serious and constant omission occurs on the far right hand side of the Table, i.e., the recurrent cost category. What asterisks do occur in that column are supplied by Mead Over in Appendix F of the Sine-Saloum Report. It is in this Appendix where M. Over disaggregates the regional budget into functional categories and discovers that such a disaggregation leads to a pessimistic view toward budgetary capabilities of project maintenance. Since many expenses are either already committed or are of a recurrent nature one cannot "rob Peter to pay Paul" as was first expected.

### Conclusion

Neither this paper nor the "parent paper", "The Costing of Primary Health Care", could provide any actual numbers. Both papers sought to provide the health planner and project evaluator with a conceptual framework that would lead to a logical ordering of priorities, considerations, and aspects of the cost estimates that should be considered, included, or questioned. I anticipate that many readers will be disappointed by the lack of numerical benchmarks in these two works. Because of this, I would like to devote the conclusion of this paper to an explanation of this "deficiency" and to safeguard the evaluator against such benchmark estimates.

What is primary health care? Although definitions can be given, there is no universal meaning to the term. Some of A.I.D.'s projects focus on comprehensive care and some on basic care. Obviously, here is the first divergence in cost. Basic health care is much more limited in scope, objective, and duration. Comprehensive care is none other than "the development concept in the guise of health care". To predict the costs of this type of health care would be to project the cost of the development process itself.

By the same token, it is impossible to calculate the costs of projects that have as their endpoint two divergent definitions of population. Some projects are pilot projects, some are national in scope, some are regional. The concept of "cost per individual" is not invariant to the endpoint of the project! Rather projects should be grouped by the range and scope of coverage and costs could be compared within those groups.

Must the project develop an infrastructure before it can begin to function, or can it draw upon the existing infrastructure? Does a Ministry of Health exist? Is there transportation to the target population? Do input markets exist for drugs, materials, personnel? Obviously, if such infrastructures do not exist, they must be first developed before the project can begin to provide primary health care. This brings up the next point.

Is the primary health care project to produce just health care, or is it to produce intermediate products? Will drugs, facilities, doctors, nurses, paramedics be produced by the project and then used within the project? OR will

the project buy these inputs directly? (If they are bought directly are they imported, produced at home, or donated?) If the inputs are to be produced within the project then all the concepts of cost and production must be applied to these goods also.

What does the population look like? Here those demanding health care must be considered, for this dictates the cost of health care. If the health care needs of the population are easily satiated, then the project may incur low costs. Over time, however, the needs of the population change. Population growth, demographics (especially emigration, and immigration), socioeconomic factors affecting the prevalence of disease will affect the type of care the health care unit is to provide. Thus the function of the project may remain the same and yet the cost of fulfilling that objective may change dramatically as the population changes. The astute evaluator should ask the project planner to "think through" this concept of evolving needs and the effect it will have on the project.

The above has sought to explain the differences that exist in health care projects. The evaluator/planner need not "rediscover the wheel" with each project however. Given the increased number of health care projects in recent years, many "like" projects can be found. It is anticipated that perhaps over time a catalogue of comparative studies could be compiled. "Like studies" would be alike on the basis of: providing similar care; duration; similar population; and comparable stages of national economic development. Within these groups evaluators can compare costs of coverage, success and failure, and learn from past budgetary mistakes.

The evaluator should develop a standard list of questions to ask of each project. Questions should fall in the category outlined in this paper and costs can be divided as they are in Table 2. In this way some systematic form of evaluation can be applied to all projects.

In short, there is no short cut to a detailed evaluation of each project. No "cut-off" numbers can be given and none should be applied. Evaluators must develop a logical framework for the evaluation of projects. The two papers that I have authored for A.I.D. have presented in varying detail this logical framework. In conclusion, I must add that there is no short-cut to the thinking process -- the use of "short cut" numbers can lead to a severe misuse of health care resources.