Medicus Mundi Schweiz
Gesundheit für alle

MMS Bulletin #104
Gesundheitspersonal: die Krise überwinden

Health system strengthening requires greater investment

A call for greater Swiss Investment in Global Health!

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The new health initiatives have a tendency towards verticality; yet to succeed in their endeavour they depend upon the system as a whole. Therefore they also depend upon invest¬ment in health system strengthening made by others. The international health challenges which the Millennium Development Goals address cannot be tackled through the direct health sector con¬tributions of single development partners. Switzerland lags behind as far as its direct and indirect supportive measures to address global health challenges. Parliamentary efforts to change the course towards an appropriate (i.e. much greater) "Swiss investment" in international health seem not to be producing the hoped for results.

Let us begin with the good news! For some years now international health enjoys a higher position on the political agenda than ever before. The reasons for this are many, but include:

- "new" pandemics with a strong "disease of poverty" dimension (AIDS, SARS);
- "old" diseases and epidemics reaching level of major concerns (malaria) or presenting a new threat due to resistance (TB);
- major public health problems still seen to affect poor populations in developing countries disproportionably - such as sexual and reproductive health and maternal and child health;
- other potential threats of global concern, such as avian flu.

The increased visibility of international health brought with it a positive response at the highest political level. A first important signal was given in 2000 with the inclusion of these concerns in the Millennium Development Goals (MDGs): three of seven substantive MDGs are directly related to health. Secondly, a strong new political commitment has emerged, calling for serious scaling up of investments and technical assistance in this field (G8 and UN General Assembly, followed by others).

From intentions to acts

It is heartening to observe that declared intentions (MDGs and related expressed political will) have been followed by concrete steps: a real mobilisation of funds took place to support, for example, the Global Alliance for Immunisation (GAVI) and the Global Fund to fight AIDS, tuberculosis and malaria (GFATM). This positive move is of a magnitude not often seen in the history of development assistance (let us say the last 40-50 years). To take an example, the Global Fund, launched in January 2002, has already received contributions and pledges in excess of US$ 10 billion, has already committed close to US$ 6 billion for specific programmes and projects and disbursed 3.5 billion (March 2007 figures).

We have also seen new actors taking part in the debate as well as in the financial efforts and/or implementation. In particular we refer here to the major foundations and the private sector. In addition, Governments which had not contributed much to official development assistance (ODA) in the past, such as Italy or Spain, Russia or Saudi Arabia, have started investing relatively large sums in such programmes.

To respond to the scope of the problems and the amount of the funding required, completely new initiatives have been developed and received support by governments desirous to engage innovatively with the challenges and act "out of the box". The International Drug Purchase Facility (UNITAID) is a case in point. It aims at mobilising resources for the purchase of drugs and at structuring the drug market, by establishing reciprocal agreements between producers and buyers in the long term (1).

The UK led IFF initiative (the International Finance Facility and its avatars) is another one. It is a financing mechanism which aims at accelerating investments in health in particular to help meet the MDGs by 2015. It plans to disburse resources through existing multilateral and bilateral mechanisms (2).

These new initiatives have been conceived and implemented at a pace made only possible thanks to strong political support. They have already produced hundreds of millions of dollars.

Whether all these increased funding measures are really additional to planned levels of Official Development Assistance, as asked for by UNGASS-AIDS in June 2001, remains to be proven. In several instances, the evidence is that it is not. However, UNITAID, the RED® campaign of the Global Fund and the IFF definitely tap into other sources such as non taxpayers' money – both by borrowing on the financial markets and by extracting it from the citizen-cum-consumer's pocket!

Promoting a conducive environment and addressing side effects

With such major programmes in place, aiming at addressing MDGs in fighting specific diseases, it seems unavoidable to see vertical programmes at play. Here again, the theme has already been well covered elsewhere and we limit ourselves to recalling the problem.

Vertical programmes can only produce efficient and measurable results if at the very end of the chain, the patients and other intended targets are benefiting from the investments. To successfully implement an immunisation, a treatment or a prevention campaign, many actors play a critical role and certain structures and tools need to be in place: in particular health systems and adequate human resources. By “adequate”, we mean sufficient numbers of appropriately trained staff, deployed where they are needed and paid at a level sufficient for them to be able to accomplish their duties in a satisfactory manner.

Thus, in a nutshell, vertical programmes depend upon other elements for the success of their endeavour. There are other general conditions too, which this article will not address in detail: issues to do with access to services, human (and particularly women's) rights, the socioeconomic situation of countries, the patient’s ability to pay and transport facilities, to name just a few.

The possibility can also not be ruled out that vertical programmes may have perverse effects too – precisely because they are comparatively well funded. There are undoubtedly cases where staff have been attracted from existing structures for the immediate benefit of a vertical programme. Indeed, if such effects exacerbate the very problem in the health system which the vertical programme has been put in place to address, the net result is particularly ironic.

Health system strengthening has thus become one of the major "passages obligés" in the scaling up exercise being presently undertaken. This can largely be attributed to the Global Fund, the Bill and Melinda Gates Foundation, GAVI or UNITAID in many developing countries.

Remedies

Reacting positively to the above mentioned perverse effects, the Global Fund has already accepted that some of its funding be targeted at strengthening health systems in general – both for the benefit of its own programme as well as for the indirect gain of other health activities. These health system strengthening activities do not, however, cover all the needs deriving from the additional GFATM investments.

Furthermore, most development partners now recognise that while supporting the new vertical programmes, there is also a need to support the work of agencies such as the World Health Organisation and UNAIDS, precisely because of the role they too play in health system strengthening or other useful epidemiological monitoring. It is a source of concern that additional activities required from these organisations are not remunerated by the Global Fund but operate under a sort of unpaid mandate.

Fortunately some development partners, while contributing to the Global Fund, have taken into account that accompanying measures are also necessary and are making a substantial effort to pro¬vide assistance in this respect. The German GTZ has for instance developed a "Back-Up

Initiative" which offers assistance to several countries which would like to benefit fully from GFATM investments, whilst DFID (UK) is reorienting some of its programmes to contribute specifically to health system strengthening.

Beyond the Health Sector

As far as Human resources are concerned, health systems strengthening calls for further investments outside the health sector: Basic and secondary education, specialised training such as accounting and audit, organisational development capabilities and good gov¬ernance are other areas in need of strengthening. All these domains relate to human resources training and system devel¬opment. Health systems strengthening, itself a prerequisite to the success of the scaling up in health expenditure, calls for human devel¬opment at large.

In other words: while investing in the new health initiatives major donors would be well advised to invest in additional contributing fields as well. In doing so however, efforts should be made to avoid funding for health from being diverted, e.g. from the education sector. Similarly avoiding a "health only" approach is crucial, as it could lead to deadlocks if it is not accompanied by more general efforts to increase ODA and private resource investments in neighbouring sectors (3).

Overall it is up to all development partners to ensure the coherence of their policies across the board, i.e. that the position in the different governing bodies are harmonised (some countries, for instance, oppose any increase in the WHO budget, but support a series of new initiatives impacting heavily on health systems).

Obviously most OECD countries (the so-called donors) now have to pay the high price for not having invested sufficiently over the years in human development and in health in particular. This would also apply to the UN Funds and Programmes (with the exception of UNICEF and UNFPA, which have always orientated their activities towards such goals) and to Development Banks (particularly regional ones). As a consequence, the effort needed to scale up is now immense and costly.

Developing countries as well have their share of responsibilities. Many Governments have neglected the importance of quality investment in human resources and in health systems alike. One will recall however that both the Education and Health sectors were placed under heavy stress at the time of the structural adjustment programmes (SAP) imposed upon them by the Bretton Woods institutions, and that most of the human resources short¬comings were for some time a direct consequence of these rigid restrictions.

Nowadays, some developing countries, particularly those which have more difficulties to make sense of globalization or, say, which have less comparative advantages in this respect, are lagging behind in terms of human resources development. These are often the very same countries which are heavily affected by the diseases of poverty.

Health or Development: is this the question?

Does the above plea for investment in health become a plea for investment in development? The answer is both yes and no.

Yes, because measures in support of the surrounding human development will have a positive effect on health investments. No, because simply continuing with development as business as usual (as we will see with the case of Switzerland) is unlikely to produce expected measurable results in health. Scaling up in health requires massive additional funding in health proper.

The case of drugs for TB and AIDS serves as an example. Millions of people require such drugs and, in the case of HIV/AIDS, the need is for life-long treatment. The ARV drugs exist; individual should have access to the treatment they need. The bill is costly, but the development benefits outweigh them by far, as has been demon¬strated in several studies.

Multiple-drugs-resistant TB should be fought with all energy, as it is an important global public-health hazard. The cost of a treatment presently exceeds US$ 20,000. It is not something which "it would be nice to do" but something that we have little choice but to do, and to do it at once. Tens of thousands of treatments/year are necessary.

In conclusion: it is good that some industrialized countries are not willing to be satisfied with the present level of ODA and the present "business as usual" portfolio. It is good that many have drawn consequences and have reoriented their pledges and disbursements accordingly. Very often it has been the pressure from civil society that has brought Governments to face their interna¬tional responsibilities. Such Governments are in dialogue with their people about the real return value of such investments.

What about Switzerland?

Our country does not belong to the above mentioned group of countries. It has maintained its Official Development Assistance (ODA) at a relatively low level. The 0.7% of GDP target has never been accepted politically and remains, therefore, a remote objective. Also our country has never calibrated its investment share in global health to a sufficient level. Little has been done in recent years to correct this and presently the trend may be that things get even worse. With much less than 10% of its total ODA investments dedicated to health at large and a very modest share to basic education, Switzerland is definitely off-target and seems unable to scale up its inputs in health and human development.

The Swiss Agency for Development and Cooperation (SDC) currently focus their support in other important areas which also contribute to the attainment of some of the MDGs, such as work in governance, in human rights or in the promotion of the civil society. A lot of funding as well goes to humani¬tarian goals. Immediate human suffering gets attention. The fact that the health sector has never managed to receive the necessary attention is partly due to historical

factors which cannot be addressed here in detail and partly to the difficulty to change trends when ODA resources are not growing at a sufficient pace. Quasi-stagnation of ODA (4) does not help, as both the organisation and its staff tend to become defensive and are in favour of a status-quo. Information is available on the situation offering sufficiently convincing evidence that this state of affairs should be adjusted to changing needs.

However, a resetting of priorities in Switzerland remains illusive. Even efforts by Parliamentarians to change the state of affairs (for example the Amgwerd Motion calling for additional budgetary provisions to help adjust the Swiss contribution to the Global Fund closer to the level expected) have not yet produced the expected results. Though accepted by the two houses in 2005-2006, this motion has still not translated into the necessary budgetary decision.

By comparison, external assistance programmes such as DFID in the UK or GTZ in Germany are much better placed in terms of health investment. For DFID the share for health of their overall ODA is above 20%. Their investments in health are massive. And as an internal side effect (i.e. within the agency) such a sizable share offers a critical mass for making the voice of human development heard, ensuring that the institution invests more, and more appropriately, in education and pro-poor training with the expected benefits for the health domains.

These agencies can also deploy more staff to make field visits, keep themselves abreast of development and eventually contribute positively to strategies design and implementation including at the multilateral level.

Finally this critical mass helps to keep the appropriate attention on the part of politicians alive. In the UK, Tony Blair and Gordon Brown are fully aware of the challenges and have often come up with bold solutions. I sometimes wonder whether in Switzerland our Minister of Finance, as an example, has ever heard about global health issues, about the necessity to fight "Global public bads" and the need to invest massively in fighting the diseases of poverty. If he had (and the other Federal councillors with him) then our country would also be engaging in judicious and timely international health investments both to help people in poor countries and also to protect our own population. To do so now will avoid the accumulation of costly bills in the future. The recently adopted Foreign Health Policy guidelines mark a welcome departure point but are not yet supported by the necessary financial means. (5)

New quantitative objectives

The expected Swiss contribution in multilateral health financing should be a multiple of the current level. In terms of supporting WHO, UNAIDS and particularly the Global Fund, Switzerland still has a long way to go in sharing the burden. For the Global Fund, with an average of CHF 6 million/year over the last six years, Switzerland lags very much behind other countries. Its share, presently at less than 0.3% of the total contributions to the Fund, should be in the magni¬tude of CHF 50 million/year representing approximately 1.4%. The situation is better for UNAIDS (where our contribution represents approximately 1.9%, but calculated on

a smaller budget). As for WHO it is again not very favourable, with the Swiss share including the assessed contribution paid for by the BAG (6) representing 0.8% of the total contributions only.

Politics are based on perception however. It remains unclear how long the weak position of Switzerland in sharing the burden in international health financing can remain such in the face of hard facts and evidence.

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Notes

1. UNITAID / IDPF aims at (a) mobilizing resources for the purchase of drugs and other medical products (e.g. diagnostic kits) needed for the treatment of the three killer diseases of the developing world, with strong emphasis on HIV/AIDS and drug-resistant malaria and TB and (b) structuring the drug market, particularly that of ARVs, allowing for lower prices through better structured competitive mechanisms and by establishing reciprocal agreements between producers and buyers in the long term, while also ensuring the quality of drugs.

2. The International Finance Facility (IFF) is a financing mechanism which would provide up to an additional $50 billion a year in development assistance between now and 2015. It would leverage in additional money from the international capital markets by issuing bonds, based on legally-binding long-term donor commitments. The IFF would be responsible for repaying bondholders using future donor payment streams. Finally it would disburse resources through existing multilateral and bilateral mechanisms.

3. By private it is meant here mostly large Foundations and the like. One will note that the Bill & Melinda Gates Foundation seem to do it right from this perspective, as they invest both in health and education. It would be of interest to know whether supported programs in these two sectors are systematically working hands in hands in a mutually supportive manner in a given country.

4. In fact, ODA has not always been stagnating, but additional budgetary resources seem to be systematically absorbed, among others, by Molech contributions such as the one to the IDA of the World Bank.

5. www.bag.admin.ch/org/01044/03338/index.html?lang=en.

6. BAG : Bundesamt für Gesundheit / Federal Office of Public Health FOPH

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