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Von Geld und Gesundheit

No health available at $7.50 per person per year

Macroeconomics of Health

Von Jeffrey D. Sachs

The horrific disease burden of the poorest countries - claiming millions of lives every year and billions of days of sickness - is a fundamental barrier to economic improvement of the world's poorest people.

Perhaps three million people, mostly children, die annually from diseases readily preventable by vaccination. Millions more die of diseases that are preventable by other means, or that are likely targets of new technologies in the next few years. Health is of course an end in itself, and humanity must not stand by as millions of people suffer unnecessary, often easily preventable deaths. But health is also an investment - in the economic well-being of people at the edge of survival. Without an improvement in public health in the poorest countries, all of the economic reform agenda, all of the potential benefits of a fast-growing world economy - are likely to bypass hundreds of millions of people, and leaving them and their children in utter impoverishment.

Poor health cripples poor societies in numerous ways. Most directly, the burdens of illness and death rob society of productive healthy workers. This is most starkly the case in the HIV/AIDS pandemic, which is robbing Africa of the millions of the societies' most productive members in the prime of their lives. But the burden works through less obvious channels as well. Children surviving multiple bouts of diarrhoeal disease, respiratory infection, helminthic infections, and malaria, may well suffer lifetime impairments in physical and cognitive capacities. They are more likely to drop out of school early after repeated absences. The lifetime burdens of illness and under-nutrition, we have learned, can start with nutrient deficiencies in-utero, so that pre-natal care is an investment in a lifetime of health and productivity of the yet unborn child.

Ironically, the evidence strongly suggests that the massive number of early deaths among children - especially from malaria, diarrhoeal disease, and respiratory infections - actually speeds population growth, rather than slows it, with all of the attendant complications for society. This occurs because in societies with high rates of infant and child deaths, parents compensate the risk of death by having large numbers of children. And because they want

insurance that at least one son will reach adulthood, they may have as many as six children when the expectation is that two will die. Insurance for the parents, though, translates into unmanageably fast population growth for the society, and low levels of school and health investments in each individual child.

When health is looked upon as an investment in the future of today's poorest people, we must stand shocked at the extent of the underinvestment that we are making. In the world's poorest countries, the national investments are a mirror of national impoverishment. When a country at $250 per capita makes an investment in public health of 3 percent of GDP, that translates into annual spending of just $7.50 per person per year. This compares with public health spending of $3,000 to $5,000 per person in the rich countries. Critics of foreign assistance sometimes mistakenly argue that the basic problem of health care in the poorest countries is mismanagement of health systems. I want to reject that view categorically: there is no way to manage an efficient health system at $7.50 per capita. And there is no way that the world's poorest societies, just barely surviving at current income levels, or perhaps not surviving, can manage much more than that out of their own resources. This is especially true when debt service payments to governments, the World Bank, and the International Monetary Fund, are draining more than the annual budgets for health care. Yes, by all means, countries like India and Nigeria which are spending around $3.00 in public funds per year in public health could do more themselves. And yes, by all means, countries should strive to maintain efficiency and honesty in health care delivery. But no, the poorest are the poor cannot be blamed for the disastrous state of public health. They simply lack the resources to do better.

And globalization is not making matters easier in this regard. Through Africa, highly mobile doctors are leaving their countries to work in Europe, the Middle East, and the United States. The market for skilled workers, including skilled workers in health, has become global. Poor countries, like it or not, will have to pay a competitive wage to their doctors if they expect to keep them in Kano, Nigeria, or Arusha, Tanzania, or Kerala State in India. The squeeze on skilled labor will therefore get worse, not better, unless we do something about it.

The rich countries will have to help square the circle through a massive effort of support at disease control. The numbers can not add up in any other way. But thank goodness, very modest efforts by the standards of the rich countries can make a manifold difference for the poorest of the poor. The rich countries today, are unimaginably rich even by standards of twenty ears ago. The U.S. average income is $30,000 per year, signifying a $10 trillion dollar economy. The capital gains in the U.S. stock markets in the past five years are an astounding $8 trillion. There are now 1 billion people in rich countries enjoying a standard of living unrivalled in world history. Make no mistake about it, however, despite thirty years of public pronouncements about disease control, despite an international pledge of "Health for All in the Year 2000" made a generation ago, the richcountry support of health for the poorest of the poor is at shockingly low levels. These levels are even below what you might imagine.

The Organization for Economic Cooperation and Development (OECD), in Paris, keeps careful records of all official development assistance (ODA) by the rich countries and by the international institutions on behalf of the poorest countries. The numbers are shocking. In the category of Basic Health, which includes provisions for infectious disease control and support for primary health clinics, the total grants in 1998 from all donors - both governments and international agencies - for all 619 million people in the least developed countries was $209 million, or around 30 cents per person in the poorest countries. Even this exaggerates the real aid, however, since $21 million of this was tied aid and $88 million was so-called technical assistance, paying experts in the rich countries rather than providing cash-support to the poor countries. In fact, only $78 million came in the form of untied cash support for the poorest countries, around 13 cents per person in the recipient countries, and around three ten-thousandths of one percent of the income of the rich countries... one or two minutes per year worth of rich-country income.
The level of support for HIV/AIDS is equally shocking, totaling a few tens of millions of dollars per year for the poorest countries, while the greatest pandemic in modern history, perhaps in world history, has unfolded before our eyes.

The work of the Commission on Macroeconomics and Health established by the WHO is devoted to understanding the areas of highest social return to new international investments in public health in the poorest countries, and to providing a serious estimates of the sums that will be needed as well as potential delivery mechanisms. That work will not be completed for one year, but we are far advanced in several aspects of the undertaking. We have identified major disease areas - including HIV/AIDS, malaria, TB, diarrhoeal disease, acute respiratory infection, helminthic infections, nutritional disorders, reproductive health -- as the likely targets of effective intervention, and have begun to prepare detailed cost estimates for providing the population with existing technologies of prevention and treatment, as well as cost estimates for new research priorities where new technologies are urgently needed. I can safely say, speaking personally and with preliminary data, that international support for disease control can and should reach $10 to $20 billion per year from the richest countries, still a mere $10 to $20 per person per year in the rich countries. This must be accompanied by comprehensive debt cancellation for the world's highly indebted poor countries. With debt cancellation and a greatly increased level of spending, millions of lives can be saved, untold suffering can be relieved, and economic development prospects of the world's poorest countries can be enormously enhanced. And even the sum of $10 to $20 billion per year would be less than one-tenth of one percent of the incomes of the rich countries.

Increased spending should be combined with new methods of health delivery - drawing on the new information technologies, the schools, and the communities - in innovative ways. So too, the world's scientific community and the leading pharmaceutical and biotechnology companies must be induced, often through novel means such as "guaranteed purchase funds for vaccines" to devote much more of their astounding scientific prowess to the urgent, life-and-death needs of the world's poorest peoples. The donors will also need a new form of cooperation, not simply more funding. They will need to pool resources, rather than segregate them in pet

projects. They will need to give up turf in a common battle against disease. They will need to turn to the independent scientific community for intensive, high-level, ongoing scrutiny, at every stage of the process. Independent panels of scientific experts should review disease control proposals coming from the international community, especially welcoming proposals coming from the affected countries themselves. These panels should emphasize scientific rigor, peer-review, and independence, to ensure the highest scientific standards in our new Massive Effort against disease. The World Health Organization has a unique role to play in this in convening this expertise, since WHO is the leader of global public health and the world's foremost bridge between the official donor community and the worlds of medical science and public health.
*Plenary presentation by Prof. Jeffrey D. Sachs, Director of the Centre for International Development, Harvard, USA, and Chairman of the Commission on Macroeconomics and Health, during the Massive Effort Advocacy Forum held in Winterthur, Switzerland from October 3-6 2000. The Commission on Macroeconomics and Health established by the World Health Organization earlier this year aims to bring together the worlds of international finance and public health.

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