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INVESTING IN HEALTH

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Paper prepared by WHO for the
UN Conference on Financing for Development
Mexico, March 2002

Department of Health and Development
World Health Organization

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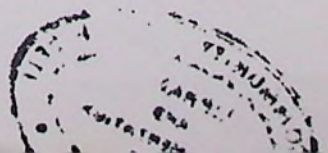


Executive Summary

- The Financing for Development Conference (FFD) provides a crucial opportunity to strengthen the international commitment to achieving the Millennium Development Goals (MDGs), to mobilize support for more resources for development, and to agree on strategies for the effective, efficient and transparent use of those resources.

- Evidence and experience from health can help to achieve these goals: many of the issues to be discussed at FFD have already had some application in the health sector.

The case for investing in health

- New evidence from the Commission on Macroeconomics and Health (CMH) suggests that improving the health and longevity of the poor is not only an outcome of economic development, but also a ***means*** of achieving it. Thus improving the health of the poor should be a central concern of the FFD.

- Good health contributes to economic development by: lowering the fertility rate; improving educational performance; increasing labour productivity; and improving macroeconomic stability.

- As good health is linked to economic growth, so ill-health and disease undermine economic development and create poverty. Disease can result in lost earnings and impoverishing health-care costs, depleting assets and possibly leading to debt. High rates of infant and child mortality are associated with high fertility, as parents compensate for the expected loss of children by having large families, perpetuating inter-generational poverty. A high disease burden creates a high turnover in the workforce, affecting workers' productivity, and lowering the competitiveness and profitability of enterprises, as well as the resources available for investment.

- A high proportion of the disease burden in low-income countries can be attributed to a small number of diseases and conditions, mainly communicable diseases and nutritional deficiencies. These conditions can be prevented or treated, but in most cases efforts to do so are not reaching the poor.

- Lack of resources is not the only reason for this failure, but it is a significant and inescapable part of the problem. A minimally adequate set of interventions and the infrastructure needed to deliver them costs in the order of $30-40 per capita. However, actual levels of spending are far lower – on average $23 per capita in low-income countries and $11 per capita in the least developed countries.

- Enormous economic benefits would result from bridging this gap in resources. The CMH estimates that **increased investment in health by donors and recipient countries of $66 billion a year (above current spending) by 2015 will generate at least $360 billion a year, a six-fold return.** About half of this would come from direct economic benefits – people will live longer, have more days of good health, and be able to earn more. The other half would result from indirect economic benefits from greater productivity. This, in turn, would "help to break the poverty trap that has blocked economic growth in high-mortality, low-income countries".

Part Two of the main text comments on several important issues for action identified in FFD background documents, from the perspective of health.

MOBILIZING DOMESTIC FINANCIAL RESOURCES FOR DEVELOPMENT

- Research into domestic financing of the health sector gives some insight into the feasibility of the FFD goal of mobilizing greater domestic resources across all sectors. The evidence suggests that some increases in government spending are possible, and some efficiency savings can be made. However, the poorest countries, home to 1.8 billion people, **cannot provide basic health services without external financing.**

MOBILIZING PRIVATE SECTOR RESOURCES

- The health sector can offer important lessons on how public-private partnerships (PPPs) work in practice. The Global Alliance for Vaccines and Immunization (GAVI) and the newly-established Global Fund to Fight AIDS, Tuberculosis and Malaria have both attracted significant private donations, and the private sector is involved in their management.

- However, PPPs are not always easy to manage and sustain. They require careful agreement on shared objectives – and rigorous monitoring to ensure they remain on track.

INTERNATIONAL TRADE AS AN ENGINE FOR GROWTH

- Although trade is essential for economic growth, it has important effects on health and social protection, some of which may undermine growth and poverty reduction. For example, the removal of import tariffs and export taxes is reducing tax revenue in many low-income countries which already have a critically weak tax base. This can force cuts in government spending.

- Two specific trade issues are of particular interest to health: access to essential medicines and trade in services. Essential drugs and medicines must be affordable if poor countries are to meet their urgent health needs. Differential pricing – particularly for those medicines under patent – is one way of improving affordability.

- The pharmaceutical industry is being encouraged to lower the prices of essential drugs to affordable levels in low-income countries and in some cases companies have agreed to do so. When drugs essential to a country's health needs are not made available at affordable prices, poor countries should be supported to implement and use the compulsory licensing and parallel imports provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).

- The current intellectual property regime, and financial incentives for the public and private sectors, need to be geared to stimulate research and development into diseases which predominantly affect poor countries.

- The growing trade in services also has implications for health. Relatively few countries are well-positioned to turn the gains from health services trade into health benefits for the majority of people. In some developing countries, trade in health services is increasing the "brain-drain" of health professionals, while foreign competition in health service markets is worsening equity in financing and reducing access to care for the poor. Each country needs to assess these issues carefully when developing national health and trade policy and its negotiating stance in the General Agreement on Trade in Services (GATS) talks.

Increasing international cooperation for development

- Health provides an illustration – and justification – of why a massive scaling-up of resources for development is required. Recent estimates suggest that ***additional*** Official Development Assistance (ODA) of $27 billion a year will be needed by 2007, and $38 billion a year by 2015, to provide essential health interventions in low-income countries and greater investment in research and development.

- If additional resources are to be effective, the ways in which ODA is delivered must improve. Efficient and transparent transfer of resources, a focus on poverty alleviation, and enhanced country ownership must be the guiding principles for donors and recipients. Experience from health can provide some insight into how to achieve these goals; for example, health has successfully encouraged donors to use pooling mechanisms in their provision of funds for health.

Sustainable debt financing and debt relief

- Important questions remain about the impact of debt relief on poverty reduction. Current research suggests that resources released by debt initiatives will fall far short of the amounts required to meet basic health needs.

- There is also an urgent need for more transparent monitoring of the use of resources released by the Heavily Indebted Poor Countries (HIPC) initiative. It cannot be assumed that all health spending (or all "social sector" spending) is pro-poor – the particular needs of the poor must be identified, and programmes designed to meet them. Close monitoring of resources released by HIPC is required to ensure that poverty reduction is prioritized.

Conclusion

The "wisdom" of the past 20 years – that health is a luxury that developing countries can afford only at a certain economic level – has been turned on its head. Health can no longer be characterized as a matter of "services" and "safety nets" which do not contribute to poverty reduction.

In WHO's view, the FFD conference must reflect the growing consensus that balanced and integrated social and economic investments are needed to achieve poverty reduction. This would be in line with previous international development conferences, which have recognized that proper investments in a country's human capital are a powerful engine for economic growth.

Social objectives (including health) need to be placed at the centre of policy-making, rather than be seen as by-products of improvements in overall economic performance. Such an approach has been adopted and accepted by the international community and now needs to be put into practice.

Introduction

The Millennium Development Goals (MDGs) have mobilized the development community around a set of important – and achievable – targets. There is now unprecedented consensus that the MDGs provide guidance, and new impetus, to reduce poverty and promote sustainable growth.

However, there is also a growing understanding that the MDGs will not be achieved without changes in policy and a steep increase in resources for development. Good policy means a better balance between pro-poor economic growth and social investment as mutually supportive strategies. Much greater mobilization of financing from all sources – donor nations, the private sector, and developing countries – is also critical.

The Financing for Development Conference (FFD) provides a crucial opportunity to strengthen the international commitment to achieving the MDGs, to mobilize support for more resources, and to agree strategies for the effective, efficient and transparent use of those resources.

Evidence and experience from health can help achieve these aims. First, health is now high on the international political and developmental agenda – reflected in the fact that three of the MDGs relate to health. This is in part due to the efforts of civil society, national governments and international organizations, and in part to public anxieties about the effects of communicable diseases, especially HIV/AIDS.

Second, there is a new financial realism in the health sector about what it costs to improve the health of the poor. There has been a welcome shift, from what can be done with the resources available to what needs to be done and how it can be financed. At the moment there is a massive gap in resources.

Third, it is increasingly recognized that improved health outcomes are central to the success of economic and social policies, and that good health and protection against disease cannot be achieved by the health sector alone. Many other sectors, including rural development, water supply and sanitation, and education have an impact on health status. This has led to a more strategic, broad-based approach to improving health outcomes which provides important lessons for overall development policy.

In summary, and as this document seeks to demonstrate, there is evidence and experience from health to show what needs to be done to arrive at better, more effective resourcing for development.

PART ONE: THE CASE FOR INVESTING IN HEALTH

Many debates on development define social sectors as "non-productive" and under-value their potential contribution to development. This section presents recent evidence which suggests that health spending is an investment that will not only have social benefits (a better quality of life for the poor), but also direct economic returns.

The aim is not to suggest that health should be prioritized over other areas – indeed, health is determined by a range of other sectors, all of which require adequate financing if health outcomes are to improve (*see box: Determinants of Health, page 8*). Rather, it is to show why increased financing for development is needed, and to provide some guidance on how increased resources should be spent.

INVESTING IN HEALTH FOR POVERTY REDUCTION: THE EVIDENCE

Improving the health and longevity of the poor is an end in itself, a fundamental goal of economic development. But improved health is also a means to achieve development goals – not only equity and social justice, as has been long recognized – but also economic development. Evidence linking health to poverty reduction and long-term economic growth has recently been presented by the Commission on Macroeconomics and Health (CMH).[1] The main findings are summarized below.

THE EFFECTS OF GOOD HEALTH

Countries with better health (and education) are significantly more successful in achieving sustained growth than those with poor levels of health. Using infant mortality rate (IMR) as a proxy for health status, CMH found that of the poorest countries (per capita income of less than US$750 per year) those with an IMR of 50-100 per 1000 live births had an annual average growth of 3.7 per cent per year, compared with only 0.1 per cent in countries with an IMR greater than 150.

CMH also found that each 10 per cent improvement in life expectancy is associated with an increase in economic growth of at least 0.3 to 0.4 per cent a year, controlling for variables. Thus **health status explains an important part of the difference in economic growth rates, even after controlling for standard macroeconomic variables.**

Good health contributes to economic development in a number of ways:

- Demographic changes — improvements in health lead to lower rates of mortality and fertility and a reduced dependency ratio. This allows for greater investment in the health and education of each child.

- Higher educational attainment — healthy children are better able to learn and have better attendance rates. When they grow up, better educated children produce more, earn more, and save more.

- Higher labour productivity — healthier workers are physically and mentally more productive, earn higher wages, and miss fewer days of work than those who are chronically ill. As well as contributing to growth directly, this strengthens incentives for investment.

International commitment to investment in health

There is a growing political momentum for tackling the health needs of the poor. The eight Millennium Development Goals (MDGs), three of which concern health, are the most important example of this commitment. The MDGs commit countries to halving poverty by 2015. Specifically, they call for a two-thirds reduction in child mortality, a three-quarters reduction in maternal deaths, and a halt to the spread of HIV/AIDS, malaria and tuberculosis.

UN conference resolutions have also recognized the importance of health. The Copenhagen Plus Five conference (1995) gave specific recognition "to the role of health policies as an instrument for poverty eradication", and the Third UN Conference on Least Developed Countries (2001) organized a plenary debate on the role of health in enhancing productive capacities. The most recent example of political commitment to health comes from the World Trade Organization (WTO) Ministerial Conference in Doha in November 2001. Health, in particular the access of poor people to essential medicines, was at the centre of discussions. The conference declared that WTO member countries should be able to interpret trade agreements in such a way as to protect public health and promote access to medicines for all.

The effects of disease

As good health is linked to economic growth, so ill-health and disease undermine economic development and create poverty.

For the individual, disease can result in lost earnings and impoverishing health-care costs, depleting assets and possibly leading to debt. Over the long term, future earnings may be lost owing to morbidity and disability (cognitive and physical), and as a result of education missed because of illness in childhood.[2]

For the family, illness in a parent or carer can lead to the illness, or even death, of a previously healthy child as family income and ability to care decrease. The child may be forced to drop out of school, either to help with household work or because school fees are no longer affordable, perpetuating inter-generational poverty. When the family breadwinner falls ill, the results can be particularly catastrophic.

For society, a high disease burden creates a high turnover in the workforce, affecting workers' productivity, and lowering the competitiveness and profitability of enterprises and the resources available for investment. A high national burden of disease can weaken government finances as tax revenues fall and the need for health-related expenditures rises. In sub-Saharan Africa high malaria prevalence has been estimated to reduce economic growth by 1.3 per cent a year. The World Bank has estimated that with an average HIV-prevalence rate of 8.6 per cent in 1999, Africa's income per capita growth rate of 0.4 per cent in 1990-1997 was three times lower than it would have been otherwise – about 1.1 per cent per year. For countries with very high HIV-prevalence rates, the economic cost is even more devastating. "In the case of a typical sub-Saharan country with a prevalence rate of 20 per cent, the rate of growth of GDP would have been 2.6 percentage points less each year." [3]

Addressing the disease burden

A high proportion of the disease burden in low-income countries can be attributed to a small number of diseases and conditions. These include HIV/AIDS, malaria, TB, childhood infectious diseases, maternal and peri-natal conditions, tobacco-related illnesses and micronutrient deficiencies. All these conditions can be prevented or treated, but in most cases efforts to do so are not reaching those who need them most: the poor.

Lack of resources

Lack of resources is not the only reason for this failure, but it is a significant and inescapable part of the problem. Various estimates concur that to finance a minimally adequate set of interventions and the infrastructure needed to deliver them costs in the order of $30-40 per capita.[1] Few countries' health systems perform well – by any measure – if they spend less than this amount.

However, actual levels of spending are far lower – on average $23 per capita in low-income countries and $11 per capita in the least developed countries. CMH's work suggests that increased investment in health, along with a greater focus on those health problems that disproportionately affect the poor and the health systems needed to deliver interventions, could **save eight million lives a year by 2010.**

The economic benefits of this investment would be enormous. The CMH estimates that increased investment in health by donors and recipient countries of $66 billion a year (above current spending) by 2015-2020 will generate at least $360 billion a year, a six-fold return. About half of this would come from direct economic benefits – people will live longer, have more days of good health, and be able to earn more. The other half would be the result of indirect economic benefits from greater productivity. This, in turn, would help to break the poverty trap that has blocked economic growth in high-mortality, low-income countries.

It is important to point out that CMH's recommendations are limited to health-system interventions in low-income countries. Other sectors are also critical to creating and maintaining health (*see box below*). It is essential, therefore, to consider health within a comprehensive and multi-sectoral framework for development and poverty reduction.

Determinants of health – the need for a broad perspective

Health status, particularly the health of the poor, depends on a wide array of inputs in addition to the provision of health services. Familiar examples of sectors that influence health include education, food security, water and sanitation, labour, and environment. For example, a strong contributor to reduced child mortality is the literacy of mothers: data from 13 African countries between 1975 and 1985 showed that a 10 per cent increase in female literacy rates yielded a 10 per cent reduction in child mortality.

Also significant are economic, trade and fiscal policies which are key determinants of household incomes, nutrition, living and working conditions, and government revenues available for health and related services.

To improve health outcomes, health policy must encompass more than simply financing and delivering basic health services. A focused and comprehensive approach is especially important to protect and improve the health of the poor, who are more likely to suffer deficits in income, education, and nutrition, and more likely to be exposed to dangerous housing and working environments. Actions both within and beyond the health sector are required.

Despite increased international commitment to health (*see box page 7*), growing evidence on the importance of health to poverty reduction is not being translated into action. Many of the poorest countries will fail to meet the MDGs. An estimated 73 countries will not meet the infant mortality goal, and 66 will fail to reach the child mortality target. The shortfalls in health improvement which these figures reflect are, in turn, likely to affect achievement of other MDGs. If the trend is to be reversed, commitments to a balanced development agenda, and to greater and more efficient levels of development assistance, must be realized. Specific ways in which the FFD conference can contribute to this goal are discussed in Part Two.

PART TWO: THE FFD AGENDA – LESSONS FROM HEALTH

This section comments on the principal issues for action identified in FFD background documents, from the perspective of health.

1. MOBILIZING DOMESTIC FINANCIAL RESOURCES FOR DEVELOPMENT

Examining the feasibility of mobilizing greater domestic resources in the health sector provides some insight into how the goal might be achieved across sectors.

Countries with a Gross National Product (GNP) of less than $500 per capita cannot spend more than 4 per cent of GNP on health, taking other demands on public revenues into account. In fact, none currently meet this target. But even if they did, a massive gap in resources would remain: in the richest of these countries, spending 4 per cent of GNP on health would mobilize just $20 per capita, yet $30-$40 per capita is the *minimum* in public resources needed to finance a health system that can provide adequately for the poor. Thus for the 1.8 billion people living in the poorest countries, external financing is essential to ensure the provision of basic health services.

In most cases, public resources could be better allocated within the health sector. Many government health budgets do not sufficiently target the poor, nor spend enough on preventing and treating the diseases and conditions of the poor.

But setting priorities with such low levels of spending can defeat the best-intentioned managers, facing vocal and competing claims for scarce resources. Many health workers receive very low wages, and are paid irregularly. In some countries, they are themselves among the poor. This means that they may turn to other income-generating activities, leaving less time for health management. Even so, the CMH concludes: "[more efficient allocation of resources] is likely to result in savings of no more than 20 per cent of existing spending. Only donor assistance can close the financing gap for low-income countries."

SOLIDARITY IN HEALTH FINANCING

The ways in which domestic finances are mobilized need careful attention. FFD background documents mention the importance of micro-finance to economic performance and of pension schemes to social protection. A similar pooling of funds for health affords protection from the high cost of unexpected health-care expenses.

At present, however, health financing in most developing countries relies predominantly on out-of-pocket payments by individuals at the time of treatment. This system may deny basic care to the poorest members of society. Even middle-income families are vulnerable to impoverishment if one of their members has to pay for expensive health care, or a family breadwinner can no longer work as a result of sickness or disability.

A further problem with health systems that rely too heavily on out-of-pocket payments is that they leave public goods, such as disease surveillance, preventive programmes and control of epidemics, severely under-funded.

WHO believes that social insurance or tax-based systems lead to greater fairness in financing. Developing countries should be encouraged to expand pre-payment schemes to include as much of the population as possible, so as to spread financial risk for health care across rich and poor, healthy and sick alike.

Among the poorest countries, where it will be hard to raise sufficient resources through prepayment and risk-pooling, and where little infrastructure or capacity exist to administer such pools, tax-based systems supplemented by external assistance may be the best solution in the short run.

Summary points

- Even with greater mobilization and more efficient allocation of domestic resources, crucial gaps in the financing of health will remain which can be bridged only with a large increase in external assistance.
- Like micro-credit and pension schemes (both mentioned in FFD documents), pre-payment health insurance can help to raise domestic resources and increase efficiency in domestic health spending.

2. Mobilizing private sector resources

Foreign direct investment (FDI) is a much greater source of finance for developing countries as a whole than aid, or official development assistance (ODA). According to the Organization for Economic Cooperation and Development (OECD), total ODA to developing countries amounted to $65.5 billion[5] in 2000; FDI to aid-receiving countries was $120 billion in the same year.[6]

However, FDI flows are falling – and predicted to fall further as the economic slowdown in industrial countries continues. In addition, FDI is concentrated in richer developing countries: in 1995, Africa received just 5 per cent of FDI to non-OECD countries.[7] The cost of FDI is also very high in foreign exchange terms, especially for low-income countries: the average rate of return on FDI in sub-Saharan Africa has been estimated by the World Bank at 24-30 per cent a year.

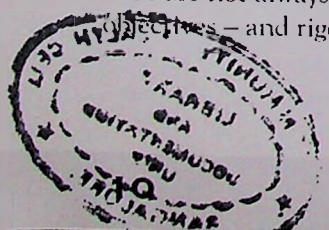
Foreign direct investment in health services may be particularly problematic (*see page 12*). As yet, however, information and analysis about the effects of FDI in health services are insufficient for a rigorous assessment.

Public-private partnerships

Public-private partnerships (PPPs) are regarded as an important mechanism of channelling private resources to development priorities. The health sector can offer important lessons on how PPPs work in practice. For example, the Global Alliance for Vaccines and Immunization (GAVI) and the newly-established Global Fund to Fight AIDS, Tuberculosis and Malaria have both attracted significant private donations, and members of the private sector serve on their boards. Some long-standing PPPs involve drug-donation programmes for neglected diseases, such as leprosy, trachoma, lymphatic filariasis and onchocerciasis.

PPPs have been identified as a means of raising resources for the development of new drugs and vaccines. Various initiatives, such as Medicines for Malaria and the Global Alliance for TB Drug Development have been set up to pursue this goal. Yet the bulk of health research and development (R&D) remains focused on the needs of rich countries: it has been estimated that 95 per cent of health R&D is focused on five per cent of the world's health problems.[8] The smaller the threat a disease poses to developed countries, the fewer resources it attracts – for example, there is very little R&D (and virtually no commercial R&D) into such diseases as African sleeping sickness, which are overwhelmingly or exclusively concentrated in poor countries.[9] PPPs have helped to redress this balance slightly, but cannot be considered a solution to the problem.

PPPs are not always easy to manage and sustain. They require careful agreement on shared objectives – and rigorous monitoring to ensure they remain on track.



Summary points

- At present the poorest countries attract very little FDI, and it may be too expensive to provide an important source of finance.
- Some experience from the health sector shows that private resources can be mobilized for development, particularly through public-private partnerships; however, the limitations of PPPs need to be recognized: they are not a solution to the most complex development problems.

3. International trade as an engine of growth

Liberalizing international trade and reviewing the impact of international trade agreements is a prominent part of the FFD agenda. Two sets of trade issues are of particular concern to health: access to essential medicines, and the trade in services.

Before turning to these specific issues, three general points will be made on the impact of trade on health. First, increasing levels of trade and greater flows of people across borders are thought to be increasing the rate of transmission of infectious diseases.

Second, the removal of import tariffs and export taxes (coupled with the lowering of corporate taxes to attract investment capital), is reducing tax revenue in many low-income countries which already have critically weak tax bases. In Cameroon, Guinea and Madagascar, for example, tax revenues are between 8 and 13 per cent of Gross Domestic Product (GDP), and **trade taxes account for between two-fifths and four-fifths of all tax receipts.** Even in India, tax revenues are only 8.4 per cent of GDP, and trade taxes amount to well over one-quarter of the total.[30] A reduced income from taxes can force cuts in government spending.

Third, the increasing marketing of rich-country products and lifestyles in developed-country markets is undercutting traditional cultural patterns, for example those relating to diet and drug use. Consumption of tobacco, alcohol and high-fat foods is on the rise in many poor countries.

The key point is that while trade is essential to economic growth, it has important effects on health and social protection, some of which may inadvertently undermine growth and poverty reduction. Thus the risks and consequences of trade liberalization need to be rigorously assessed in social as well as in economic terms.

Access to essential medicines

The debate on access to essential medicines is often characterized as a stark choice: either intellectual property rights or access to drugs. This is an over-simplification – both are necessary. However, they should not be equated: the ultimate objective is to ensure that people have access to the medical technologies that they need. Providing incentives for the development of such technologies is a means to that end.

Access to drugs is a function of many interdependent factors: sound health systems, rational use, adequate financing – as well as affordable prices. Even if drugs are made available at minimum or no cost, there is no guarantee that they will reach those who need them most.

Even so, there is a growing consensus that certain drugs and medicines must be affordable if poor countries are to meet their urgent health needs. Differential pricing – particularly for those medicines under patent – is one important way of improving affordability. This means that medicines are sold at low cost in poor countries, while rich countries pay market value (i.e. that the price a country is charged is in line with or proportional to its ability to pay).

Licensing of pharmaceutical products to high-quality local producers ("compulsory licensing") is another method of ensuring access to drugs. Currently, the TRIPS agreement does not cover companies' pricing practices, but it does contain safeguards – reaffirmed at the World Trade Organization ministerial conference in Doha in November 2001 (*see box below*) – which allow compulsory licensing, provided this is primarily for the domestic market rather than for export, and parallel imports of drugs still under patent.

The pharmaceutical industry is being encouraged to lower prices of essential, patented drugs to affordable levels in low-income countries and in some cases companies have agreed to do so. In other cases, however, price differentiation compounds the problem as higher prices are charged in poor countries than in rich ones. When drugs essential to a country's health needs are not made available at affordable prices, poor countries should be supported to implement and use the compulsory licensing and parallel imports provisions of the TRIPS agreement.

FFD background documents also mention the need for "incentives to innovate". As discussed above, the intellectual property regime and patent system provide incentives for research into the diseases of the rich, but they are not stimulating research into the diseases which predominantly affect poor countries – because poor-country governments are not able to subsidize R&D, and because there is no significant market for products once developed.

Other types of incentives are needed. Various options, including a pre-commitment to buy effective vaccines and medicines, once developed, and much greater public funding of R&D, have been suggested. Yet at present there is no consensus on how to tackle this issue, and thus no action. An urgent debate is needed among donors, poor countries, the pharmaceutical industry and multilateral institutions to reach agreement on the best way forward.

"We agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all."

– Declaration on the TRIPS Agreement and Public Health, World Trade Organization Ministerial, Doha, November 2001

General Agreement on Trade in Services (GATS)

International trade in health services is growing.[11] Large numbers of health professionals are migrating to other countries, usually in search of higher wages. There have also been notable increases in foreign investment by hospitals and health insurance companies in search of new markets. WTO negotiations launched in early 2000 to further liberalize trade in services under the General Agreement on Trade in Services (GATS) could further accelerate the growth of health services trade.

Where countries have excess capacity in health services – for example, where more medical professionals are trained than are needed to provide effective health services to the local population – exports of health services may provide a valuable (though generally modest) contribution to foreign exchange earnings.

Relatively few developing countries are in this position. Indeed, many low-income countries are experiencing a "brain-drain" of health professionals, which compounds existing shortages of health personnel and costs governments millions of dollars in training.

Equally, experience in middle-income countries suggests that foreign competition in health service markets tends to worsen equity in financing and reduce access to care for the poor. For-profit, private, foreign-invested hospitals tend to target lucrative markets, and, by offering more attractive employment conditions, can exacerbate staff shortages in public facilities, on which the poor rely. Most developing countries lack the capacity to develop or enforce regulations that can reduce these risks.

There are very few empirical studies about the health system or economic effects of trade in health services. Nor are there reliable studies about the health system effects of national or international trade policies, such as GATS commitments. Research and improved data collection systems are urgently needed to fill this gap in information and provide guidance to trade negotiators. Ministries of health, together with their counterparts in ministries of trade, need to consider the implications of opening up health service markets.

Summary points

- The impact of trade liberalization on all sectors of development, and its direct and indirect effects on health, need to be carefully monitored and evaluated. Lessons learnt should be used to inform trade policy.
- Future trade agreements need to be based on a thorough analysis of their potential effects on poverty and health. Meanwhile, existing safeguards to protect poor countries and poor households should be invoked when voluntary agreements (e.g., on differential pricing) fail.
- The gains from trade in health services must be weighed against the risks to public health objectives, such as equitable access to care and fair financing. Trade liberalization heightens the need for effective regulatory frameworks. Each country needs to assess these issues carefully when developing national health and trade policy and its negotiating stance in the GATS talks.

4. Increasing international cooperation for development

Current development assistance from all sources, for all purposes, totals around $65.5 billion per year. There is recognition that this figure is far below what is needed. In health alone, recent estimates suggest that *additional* ODA of $27 billion per year will be needed by 2007, and $38 billion per year by 2015, to provide essential interventions in low-income countries and greater investment in R&D into diseases predominantly affecting the poor.[12]

Some have expressed disquiet at the size of these numbers. Yet, if rich countries were to provide 0.7 per cent of GNP as aid, as they have committed to do, then current ODA levels would almost triple. Others are concerned about absorptive capacity in poor countries. This is a legitimate concern – more effective use of development funds, including health funds, is a priority in most developing countries. But this should not divert attention from the critical need for much greater levels of resources. The bottom line is that, for governments of low-income countries who want to improve the health of their populations, lack of external finance should not be the limiting factor.

Finally, it is important to stress that in quantifying the needs for investment in health, WHO is not advocating a diversion of resources from other sectors. As discussed in Part One, better health depends on good policies and practices across line ministries and other stakeholders – including education, water supply and sanitation, employment, and agriculture. Rather, WHO's purpose is to provide an illustration – and justification – of why such massive scaling-up of resources is required.

More efficient delivery of ODA

Leveraging additional aid funds is only half the answer. New institutional mechanisms and behaviours are also required to: (1) reduce the transaction costs of ODA, and increase the speed of transfer; (2) ensure fairness and transparency in the allocation of resources; (3) ensure consistency in ODA policy: poverty focus and the achievement of the MDGs must be at the centre; and (4) promote country ownership and responsiveness to country needs.

Critical to the success of these objectives will be a willingness on the part of donors to support nationally-led development processes and to provide funding for the overall budget rather than for individual projects. Pooling mechanisms not only help to ensure country leadership, but are also needed to generate much larger amounts of ODA. Sector-Wide Approaches (SWAps) and Poverty Reduction Strategy Papers (PRSPs) are the two instruments increasingly used to achieve these goals.

Health has been at the forefront of developing SWAps. A review of five countries with health SWAps found that the process had helped to: improve analysis of barriers to health service use; achieve greater coherence between the health budget and the overall government expenditure framework; and establish common procedures among donors for planning, disbursement, accounting, audit and review, thus reducing the transaction costs of meeting individual donor needs and increasing coherence in the health programme.[13]

The review also identified some important problems with the implementation of SWAps, including limited participation by government and civil society, under-developed monitoring systems, and failure to engage other sectors (such as education) which affect health. The key point for the FFD conference is that **the health sector is already encouraging donors to use pooling mechanisms, and can thus offer important lessons and experience that will help to ensure success in other sectors.**

Global public goods

The fight against disease requires investments in Global Public Goods (GPGs) – investments which need to be made in all or most countries to be fully effective, but which individual governments have insufficient incentive to provide because much of the benefit extends beyond their own populations. Examples of GPGs in health include better systems for communicable disease surveillance and response and, importantly, R&D into medical technologies for diseases of global scope. In most cases, these are communicable diseases predominantly affecting poor countries.

It is important that the GPG debate moves beyond economic theory – where it is currently entangled – and begins to look at practical mechanisms for selecting, providing and financing GPGs which will provide the greatest benefit for the poor. WHO believes that R&D into the diseases predominantly affecting low-income countries should be a priority.

In defining R&D priorities, it is important to take into consideration not only the burden of a disease (i.e. the numbers of people and countries affected), but also the current level of research and investment it attracts. HIV/AIDS, for example, has a high global burden but already attracts significant investment (although mainly into strains affecting rich countries). In contrast, malaria kills 1-2 million people each year but attracts very little R&D.

To ensure that their needs and priorities are reflected, developing countries should be encouraged to take a more active role in the debate on GPGs. Equally, while developed countries continue to dominate GPG discussions, it is important that funding for GPGs remains separate from other forms of ODA. Otherwise, there is a risk that the use of aid resources will be skewed away from the needs of recipient countries, and towards uses which also benefit donors.

SUMMARY POINTS

- Current levels of ODA are far below what is needed for development. In health alone, an additional $27 billion per year is required by 2007 and $38 billion by 2015.
- If additional resources are to be effective, the ways in which ODA is delivered must improve. Efficient and transparent transfer of resources, a focus on poverty alleviation, and enhanced country ownership must be the guiding principles for donors and recipients. Experience from health can provide some insight into how these goals might be achieved.
- Research and development into diseases which predominantly affect poor countries should be an urgent priority in the provision of Global Public Goods.

5. SUSTAINABLE DEBT FINANCING AND EXTERNAL DEBT RELIEF

Debt relief is seen as a key strategy to reduce poverty, in FFD discussions and elsewhere. But it is too early to tell whether it actually does so, because little data is available about: the overall amounts released by debt service reductions; the way that those resources are used; and the capacity of debt reduction to promote economic growth and development.

A recent study suggests that current levels of debt relief will fall far short of what is required to meet essential human development needs. The study calculates the cost of providing basic needs in 21 countries involved in the Highly Indebted Poor Countries (HIPC) initiative[14] and compares this to available resources (domestic and external) and expected savings from debt relief. It concludes that 16 of the 21 will be unable to meet basic needs even after their debt service payments have been reduced under the HIPC initiative.[15] This study used very conservative estimates of required health spending – $12 per capita, or one-third of the WHO estimate.

If debt relief is to contribute to poverty reduction, then resources released by debt initiatives need to be spent on poverty-reducing activities. A recent WHO review[16] which looked at health sector spending in the PRSPs[17] of 10 HIPC countries suggests that it is still to early to tell whether this will be the case. It found that:

- seven countries provide sufficient information to estimate health spending over the five-year PRSP period.[18] Of the seven, data for all except Mozambique suggests that health spending as a proportion of government spending will increase over the PRSP period.[19] But this may not result in a real increase: for example, where government expenditures will be a declining per cent of GDP (as in Bolivia and Burkina Faso). The net effects of real GDP growth rates, the share of total government expenditure, and the share of health in total government expenditure also need to be considered.
- planned increases fall far short of what is needed. At the end of the PRSP process, Tanzania will have a per capita health expenditure of just over $3, Uganda $5.30, and Mozambique $10.30 – far below the $30-$40 per capita recommended by WHO.
- it is not clear whether these planned increases reflect existing government spending plans, or additional spending resulting from the PRSP process. Most countries do not distinguish between planned spending in their investment budget and additional planned spending under the PRSP, so it is very difficult to track the flow of funds from debt relief to health.

Finally, and perhaps most importantly, it is not possible to track pro-poor spending in the health budgets of PRSPs. It cannot be assumed that all health spending (or all "social sector" spending) is pro-poor: the particular needs of the poor must be identified, and programmes designed to meet them. Close monitoring of resources released by the HIPC initiative is required to ensure that poverty reduction is prioritized.

SUMMARY POINTS

- Resources released by current debt relief efforts will fall far short of amounts required to meet basic health needs; significant increases in aid to health and related sectors is required to bridge the gap.
- More transparent monitoring of the use of resources released by the HIPC initiative is required in order to judge the impact of debt relief on poverty reduction.

CONCLUSION

The health agenda is a concrete illustration of the complexity, magnitude and urgency of the action needed to address the social development needs of the poor and thereby reduce poverty. It also illustrates why a massive scaling-up of resources is needed, and gives some indication of how money can be spent effectively and efficiently.

Proper investment in a country's human capital is a powerful engine for economic growth. Health is increasingly recognized as a prerequisite of economic growth and thus one indication of sound economic policy; it can no longer be characterized as only a "service" or "safety net".

Only a broad approach to development will ensure achievement of the MDGs. Social objectives (including health) need to be placed at the centre of policy-making, rather than seen as by-products of improvements in overall economic performance. Such an approach has been adopted and accepted and now needs to be put into practice. This will require the following action by the international community and recipient countries:

- Mobilizing additional finance from *all* sources. Large and immediate increases in ODA are fundamental to the success of this goal.
- Channelling and managing funds efficiently and effectively. Integration with existing development processes such as PRSPs and SWAps is important, as is efficient use of local resources and increased transparency, accountability and community involvement.
- Ensuring coherence between economic, environmental and social development and trade policies, and (at the national level) across sectors.
- Improving monitoring and evaluation capacity, and ensuring that lessons learnt are fed back into policy-making.
- Making measurable progress in providing Global Public Goods.

The world community has an overriding task in the first decade of the new century: to make life better for the hundreds of millions of poor people who do not receive their fair share of the world's health, wealth and opportunities. The world must act in the interests of human security: poverty steals hope, it breeds despair and provokes frustration. But the world should also act because it is *right*. Securing the resources needed to improve and protect the health of the world's poor is a key part of that response.

ENDNOTES AND REFERENCES

[1] The Commission on Macroeconomics and Health was set up by WHO in January 2000. It brought together some of the world's leading macroeconomists and health and development experts to investigate the connections between health an economic growth. Its final report, Macroeconomics and Health: Investing in Health for Economic Development, was presented to WHO in December 2001.

[2] Poor health directly reduces cognitive potential and indirectly undermines schooling through absenteeism, insufficient attention to lessons, and early dropping out. Evidence cited by CMH shows that iron and vitamin A deficits are associated with cognitive deficiencies, and that treatment of intestinal parasites is associated with better school attendance and educational achievement.

[3] Bonnel, R. (September 2000) Economic Analysis of HIV/AIDS, background paper for the Africa Development Forum 2000, World Bank/UNAIDS.

[4] Different methodologies have been used by CMH and EIP/WHO to arrive at the similar estimates.

[5] In this text, billion = 1,000 million, i.e. 65.5 billion = 65,500 million.

[6] OECD, available at: www.oecd.org

[7] Fortanier, F., Maher, M. (2001) Foreign Direct Investments and Sustainable Development, OECD.

[8] CMH, op cit., p. 79.

[9] CMH, op cit., p. 80.

[10] Estimated from data in World Bank (2001) World Development Indicators, Washington D.C. Other countries with tax revenues below 20 per cent of GDP and trade taxes representing more than one-quarter of the total include Botswana, Congo, Democratic Republic of the Congo, Dominican Republic, Jordan, Lebanon, Lesotho, Mauritius, Nepal, Sierra Leone, Viet Nam and Yemen.

[11] Chanda, R., (2001) Trade in Health Services. Paper Nr 5, WHO Commission on Macroeconomics and Health, Working Group 4, available at: www.cmhealth.org/docs/wg4_paper5.pdf

[12] CMH, op cit., p. 18.

[13] Foster, M., Brown, A., Conway, T., (June 2000) Sector-Wide Approaches for Health Development – A review of experience WHO/GPE/00.1

[14] HIPC is a World Bank initiative to provide partial debt relief to poor countries with very high levels of debt.

[15] Eurodad (October 2001) Putting Poverty Reduction First – Why a poverty approach to debt sustainability must be adopted.

[16] HDE/WHO (December 2001) Health in PRSPs – WHO submission to the World Bank/IMF Review of PRSPs.

[17] All HIPC countries are required to produce a PRSP to qualify for debt relief.

[18] Bolivia, Burkina Faso, Ghana, Mauritania, Mozambique, Tanzania and Uganda.

[19] In Mozambique, health spending already has a relatively high share of government expenditure, consuming 12 per cent of the government budget, compared to 2 per cent in Tanzania.