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INVESTING IN HEALTH: A GLOBAL PRIORITY

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Introduction

1. Over the past decade, the international health community has participated in a process of dialogue and discovery that has raised the profile of health, and has staked out new territory for concerted action and partnership. Increasingly, improved health has been recognized not only as an end in itself, but as an essential means of achieving broader social and economic development goals.
2. Improved health is seen as a critical pathway for addressing world poverty. At the 55th Session of the UN General Assembly in September 2000, world leaders resolved, as part of the Millennium Declaration^[1], “to have [by the year 2015] halted, and begun to reverse, the spread of HIV/AIDS, the scourge of malaria and other major diseases that afflict humanity.” The World Bank, the International Monetary Fund, and the OECD quickly pledged their support to the Millennium Development Goals (MDGs), and began to focus their efforts on implementation and the development of indicators for measuring progress. Three of the 8 MDGs and 17 of the 48 indicators selected are health-related.
3. Health is also understood as a critical pathway towards economic growth and development. This view was underscored in the Report of the Commission on Macroeconomics and Health (CMH) which was released in December 2001. The CMH was convened in January 2000 by Dr Gro Harlem Brundtland, Director-General of the World Health Organization. Brundtland brought together a prestigious group of eighteen internationally-recognized leaders to study linkages between health, economics and development over a two-year period. The CMH reviewed critical evidence, analyzed new data, and debated controversial topics such as aid effectiveness, access to medicines in developing countries, and potential macroeconomic constraints on health spending. A major conclusion of the final Report was that substantially higher investments in health – of the order of \$27 billion per year or \$30 to \$40 per person per year, from external sources – would be needed to jump-start economic growth and reduce poverty in developing countries.
4. Thus, improved health is no longer of sole concern to the international health community, but rather to a rapidly widening circle of development specialists and economists. For example, trade officials have now begun to wrestle with difficult questions relating to developing countries’ access to affordable medicines – a topic which until recently was unfamiliar to all but a very narrow field of experts in international health. The increased public scrutiny has yielded some positive results. A recent Ministerial meeting of the World Trade Organization held in Doha, Qatar in November 2001 upheld the importance of public health objectives within global trading agreements.

5. The heightened visibility of health on the international development agenda has generated an impressive array of new financial commitments to international health spending from non-traditional sources. Two new Funds have been created within the past five years. The financial arm of the Global Alliance for Vaccines and Immunizations (GAVI) was formed with an initial contribution of \$750 million from the Bill and Melinda Gates Foundation. The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) was launched with pledges of \$1.3 billion from governments of the industrialized countries, and nearly \$100 million from private industry. The debt relief initiative will potentially free substantial sums of money for social spending including health in many countries, particularly in Africa. It is expected that these financial contributions from new sources will be additional to resources already made available for health sector spending.

6. The energetic focus during the past few years of mobilizing new financial commitments for health, and broadening the circle of concerned stakeholders, has indeed borne fruit. However, there has been precious little opportunity for reflection on how to make the best use of resources that are now becoming available, and ensuring coherency of the various components of the emerging agenda. A diverse group of stakeholders acting in partnership must set priorities and agree upon a common plan of action for the coming decade.

7. The aim of the 674th Wilton Park Conference on “Investing in Health for Economic Growth and Poverty Reduction” was to provide a forum for international leaders in health and finance to reflect on the emerging agenda and discuss the challenges that lie ahead. The participants ranged from representatives of the respective international agencies, senior developing country government ministers and officials, academia, the private sector, and civil society. Senior officials in health and finance and other sectors of government from 8 countries in Africa, 3 in Asia, and 2 in Latin America were present. The Department for International Development (DFID), the Norwegian Agency for Development Cooperation (NORAD), and the Institute for Global Health (University of California, USA) were co-sponsors of the conference.

8. This short report summarizes the major themes of the conference, and highlights areas in which participants felt further work would be needed to address unresolved questions and concerns. Discussions took place under “Chatham House Rules” of confidentiality, meaning that no individual speaker or participant should be quoted (nor their identity or affiliation revealed) without their express permission. This report therefore refers generally and without specific reference to the information and views discussed during the conference.

Major Themes and Unresolved Issues

9. The conference’s discussions revolved around several major themes, such as the importance of securing the place of health within the development agenda, mobilizing increased resources for health, achieving clarity regarding the health systems agenda, building human resource capacity, and addressing potential macroeconomic constraints on health sector spending. Participants welcomed obvious signs of progress within each of these areas, but were also concerned that unresolved issues could undermine further gains.

Securing the Place of Health within the Development Agenda

10. At no other time in the past half a century has health featured so prominently on the international health agenda as now. The once narrow circle of medical professionals and public health advocates has widened to include a cadre of development experts and others focused on using targeted health interventions to achieve important economic and social objectives, including economic growth and poverty reduction.

11. The work of the CMH played an important role in securing the place of health within the broader international development agenda, since its focus was on building the evidence base linking health investments with labour productivity gains and macroeconomic growth. A growing body of evidence relating cycles of ill health to the poverty trap has also played a major role.

12. First launched by the World Bank and IMF in 1999, the Poverty Reduction Strategy Papers (PRSPs) are designed to provide a framework for poverty reduction in the context of growth-oriented strategies. Within each country, the PRSP is prepared collaboratively by government representatives, development partners, and civil society. Some sixty countries have engaged in dialogue and discussions around the PRSPs to date. Nine countries have fully completed PRSPs, and thirty-two interim PRSPs are now in place.

13. The PRSP framework should provide a promising mechanism for nurturing cross-cutting linkages between health, economic growth, and poverty reduction during the planning process. However, given the increasingly complex environment and financing mechanisms in health, participants expressed some scepticism about the robustness of the PRSP process as a vehicle for achieving the broader developmental aims of the health community.

14. Participants felt that important gains had been made over recent years linking health to the overall development agenda, and that progress could be pursued through the use and improvement of common planning frameworks, such as the PRSPs. There is also increasing country ownership. However, they noted that the primary focus has been on developing new approaches and refining the process, rather than on achieving results. The latter will be the major challenge of the next phase of work.

Mobilising Increased Resources for Health and Aid Instruments

15. Wilton Park participants were optimistic that calls for additional resources in health would be heeded. Significant sums of new money have already become available through GAVI and the Global Fund, for example, and the CMH Report laid the groundwork to justify even more increased spending. Donors were concerned that the emergence of new funding mechanisms would undermine the effectiveness of basket funding^[2]. However, developing country representatives were far less concerned.

16. The CMH Report estimated that \$30-\$40 per person per year would be required to cover the cost of a basic package of essential health care interventions targeting the major causes of morbidity and mortality among the poor in developing countries. (The primary targets are: HIV/AIDS, malaria, tuberculosis, maternal and perinatal conditions, child mortality, vaccine-preventable illnesses, and tobacco-related disease). However, current levels of spending in low-income countries are nowhere close to these levels, and sometimes fall well below \$10 per person per year.

17. Participants were sceptical that dramatic increases in spending such as those recommended by the CMH could be achieved. Several illustrative examples were considered. For example, per capita spending on health in Mozambique is under \$8 per person per year. External funding will be the only significant means of increasing resources to the health sector, despite a strong economy that is growing at approximately 8-9 percent annually. Yet, the governments of many donor agencies still have not met the target of spending 0.7 percent of GDP on overseas development assistance. Extrapolating from current trends, the level of health spending in Mozambique from combined domestic and external resources will reach \$12 per person per year by 2015 – an amount far below levels recommended by the CMH.

18. Yet, participants cited concrete reasons for optimism. Resources available to GAVI after only three years of operation have now reached \$1.1 billion, and some participants expressed hope that the Global Fund could grow to \$5 billion – that is, if the Fund can prove it is an effective instrument for tackling the three major killers of the world's poor.

19. Discussion at the conference also focused on the participants' concern about the impact of multiple funding mechanisms on existing budgetary processes in recipient countries. On the one hand, some donors worried that the new mechanisms would undermine recent efforts to strengthen health systems and work through a common funding basket or through direct budgetary support. Sector Wide Approach (SWAs), which usually entail some degree of common financing, represent a major innovation in donor-government coordination, lowering transaction costs for recipient countries and working to government policies and plans. Direct budgetary support within a single planned expenditure framework is thought to strengthen country ownership, ensuring that the overall expenditure plan reflects local needs rather than global priorities.

20. Developing country representatives, on the other hand, were far less concerned with the re-emergence of multiple funding mechanisms. Although budgetary support could increase ownership some challenged the notion that it decreased risk for developing country governments. It was suggested that multiple funding mechanisms continue to have a role to play and allow countries to diversify their risk.

21. On balance, participants seemed to adopt a “wait-and-see” approach, with the understanding that more work is needed to reconcile global strategies (in this case, multiple funding mechanisms) with country realities. Meanwhile, donors were challenged to accept more of the risk that countries currently face in adjusting to the changing strategies.

Clarifying Macroeconomic Constraints on Investing in Health

22. The promise of sharply increased financial flows to the health sector triggers the inevitable questions about the potential impact on macroeconomic indicators. Economic theory suggests that there is an upper limit to how much foreign capital can be allowed into a country without destabilizing the economy. An influx of foreign currency will cause the exchange rate to appreciate (that is, the domestic currency increases in value relative to other currencies). If the monetary effect is large enough, the appreciating currency will weaken the export sector and create inflationary pressures within the domestic economy. At least in theory, these combined effects could derail the export-led growth strategies that developing countries are advised to pursue.

23. Wilton Park participants focused on the apparent mixed messages that result from this and similar observations – on the one hand, the international and donor communities have recognized that more money is needed to make significant progress toward attaining the Millennium targets; on the other, there is concern that developing countries may be unable to absorb the large increases in financial resources that may be required.

24. Participants also focused on the question of whether the upper limit is likely to be reached, in practice, given the projected levels of increased spending contemplated by health and development experts. The CMH Report estimated the cost of scaling up in order to meet the Millennium targets by the year 2015. If the rapid injection of external assistance needed to achieve these targets is in fact likely to destabilize the economies of recipient countries, what is to be done?

25. Discussion focused on the Ugandan case which was then unfolding. IMF officials had allegedly advised the Ugandan government to reject new donor grants for health since the influx of additional money “might lead to undue appreciation of the currency.” The IMF later denied the allegation and clarified its position. In a press release dated June 7, 2002, the IMF Director of External Relations, Thomas C. Dawson, stated:

Effectively managing large aid flows and their impact on the economy at large is a legitimate concern for governments. The macroeconomic impact of such flows would, however, depend on the size of the flows, the import composition of the use of these flows, and whether these flows are spent effectively and productively. In the specific case of Uganda, given that the aid flows in question are to be used for top priority spending such as imports of life-saving drugs and other essential medical supplies, we do not see any adverse effects on the macroeconomy. Moreover, even if these aid flows placed pressure on the exchange rate and the competitiveness of the economy, these effects could be minimized through monetary and exchange rate policies.

26. What matters most is the type of spending in question. If external assistance is provided in the form of “gifts”, or imports that are free of charge (in the case of drug donations and/or medical supplies), the effect on the monetary system is small or non-existent. If, on the other hand, resources are spent on goods and services within the country, there is an increased likelihood of currency appreciation. Countries are likely to be faced with both types of scenarios in their quest to increase spending on health and make progress on the Millennium targets. Furthermore, if the former strategy of resorting to ‘gifts’ or in-kind contributions is adopted, a new contradiction would result. Development assistance has been moving away from the unsustainability and fragmentation resulting from tied aid or gifts, and toward fostering developing country ownership and capacity to plan and procure according to country needs.

27. The Ugandan case, although now resolved, serves as an example of the quandary that developing countries may face if they seek to implement the recommendations of the CMH by scaling up investments in health. Participants at the conference called for an independent analysis that would enable the countries to understand the tradeoffs involved, and enable them to make intelligent choices about them should the eventuality arise. The hope of course is that the issue is a red herring, since it is unlikely that health spending in any given country will rise to 2015 levels in a single year.

Achieving Clarity regarding the Health Systems Agenda

28. Health has increasingly moved centre-stage of the development agenda in part because the international health community has succeeded in simplifying its message. A focus on disease-specific interventions has been useful for galvanizing support around critical health issues. However, the broad consensus that has been forged outside the traditional parameters of the international health community has distracted attention away from internal house-keeping matters. The simplicity of the public debate has belied the importance of a more complex task – the development of a clear agenda for health, with a well-developed and agreed-upon set of priorities and policies.

29. The task is difficult because traditional models of organization and finance have come under increasing stress. The boundaries of the “public” health system have blurred. Developing country governments are working to strengthen their public health systems, but they must simultaneously adopt a multi-sectoral approach, attract private sector involvement, and undertake what are potentially de-stabilizing reforms in the short-run, such as decentralization and civil service reform.

30. One way through the conundrum is to strengthen ways of “learning by doing.” Participants stressed the importance of sharing best practices and comparing experiences across countries and regions to inform policy choices. Systems of monitoring and evaluation must also be strengthened, but duplication of global, regional, and national efforts must be avoided.

31. Despite the difficulties involved, developing country representatives underscored the importance of working toward greater clarity regarding the health systems agenda. They voiced the concern that they lack detailed information and guidance about what will be required of them in order to scale up their health care systems. They indicated the need for better information on the expected impact of health spending on poverty reduction (what one participant referred to as the “poverty bonus”), and pointed out that despite the clearer links between health and poverty there were still no adequate poverty and health indicators by which to demonstrate success. In short, they called for a more elaborated plan for scaling up that is evidence-based and focused on country realities rather than utopian ideals.

Building Human Resource Capacity

32. Regardless of the content of the eventual elaborated plan for scaling up, participants strongly agreed that little can be achieved without addressing the constraints on countries’ human resources capacity. Structural adjustment, declining public sector wages, and the devastating impact of AIDS in Africa in particular have all taken their toll over the past decade and have severely weakened the programmatic capacity of developing country health systems. Further compounding the problem, many low-income countries are experiencing “brain drain” – the loss of skilled professionals to the more highly developed countries. A recent report estimated that Africa lost approximately 60,000 middle and high level professionals to emigration between 1985-90. While all sectors of the economy are affected, the impact on health is particularly acute. There seems little chance of achieving the MDGs if a satisfactory response to the challenge cannot be found.

33. Participants debated whether the responsibility for curbing the exodus of skilled workers from Africa and the Caribbean in particular lies first and foremost with middle and high income countries. The specific recruitment of trained health professionals by South Africa, Canada, and the UK (to name only a few examples) was sharply criticized. It was also suggested that African countries should study ways to train health professionals in “appropriate technologies” that might make them less attractive to the higher income countries (e.g. training health practitioners instead of medical doctors). Or more radically that perhaps health staff should be looked upon and developed as an export commodity.

34. Participants also discussed more immediate steps that could be taken to address weakened health sector capacity. For example, they supported the adoption of creative incentives (such as housing and/or education subsidies) to entice health professionals to posts in rural areas.

35. Few approaches typically pursued by the donor community were favourably viewed. The practice of “topping up” salaries can benefit selected individuals assigned to special projects, but it also tends to distort incentives within the civil service ranks as a whole. Donating capacity to fill gaps was dismissed as a stop-gap measure, appropriate for emergencies only. Training programmes that were not linked to national training systems were criticized for responding to donor rather than country-owned priorities. Furthermore, it was recognized that skills development alone fails to respond to the more fundamental problems affecting employee retention, including low salaries, poor working conditions, and limited career opportunities.

36. By and large, participants agreed that some means of external support for salaries must be found. Most donors were in agreement that the resources of the common funding baskets could be used for this purpose. However, the issue of sustainability was an important consideration for countries. Developing country governments may find it difficult or even impossible to raise the salaries of health workers, or a sub-set of health workers, without raising the salaries of public sector workers across the board. Thus, there was widespread recognition that constraints on human resource capacity cannot be easily addressed outside the context of public sector reform.

Conclusions

37. There was a widely shared feeling of optimism and great opportunity among Wilton Park participants, but also recognition of the enormous responsibility that falls on those involved. Now that health has begun to take its place within the broader development agenda, much work remains to be done to ensure that partners coordinate and focus their efforts on achievable goals by setting priorities and agreeing to a set of coherent strategies for action over the next decade. Within the group, there was an acute awareness of the fact that 73 countries are already “off-track” for meeting the 2015 Millennium targets for reductions in infant mortality rates, and 66 may not meet the targets for child mortality. Thus, continued advocacy is essential. Partners must build upon their successful track record and continue to push for greater investments in health to support economic growth and poverty reduction.

38. However, participants at the conference also recognized that progress can only be achieved if the focus shifts quickly away from planning to decisive action. Specifically,

they called for a greater coherency of the diverse agendas of development partners, linking global priorities to country realities; harmonizing health systems approaches; supporting multi-sectoral collaboration for improved health; and resolving contradictory messages regarding growth and development strategies. They also emphasized the importance of supporting results-oriented approaches, blending a willingness to take risks (in order to break out of vicious cycles) with performance based funding (to reward good behaviour). Finally, participants agreed that a focus on building capacity within countries is the only truly viable route to sustainable progress.

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Wilton Park Reports are brief summaries of the main points and conclusions of conferences. The reports reflect rapporteurs' personal interpretations of the proceedings; as such they do not constitute any institutional policy of Wilton Park nor of those organisations associated with the conference, and nor do they necessarily represent the views of rapporteurs.

[1] The eight Millennium Development Goals are to eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases; ensure environmental sustainability; and develop a global partnership for development.

[2] Through common basket funding, donors support the health sector by financing a single agreed upon budget administered by the Permanent Secretary of the Ministry of Health. A major goal is to simplify financial and administrative procedures, thus reducing the transaction costs to the Ministry of Health incurred by a large number of external donors.