

Committee for Development Policy
Global Health Partnerships and Health Inequalities

Briefing by Professor José Antonio Alonso

We are living in a time when important and multiple changes are happening in the international aid system. There is a new and shared development agenda, new frameworks in the relationships between donors and recipient countries, new instruments to deliver aid, new donors and actors in the international arena, and new recommendations to improve aid effectiveness. In relation to all these changes, donors have also tried to find new mechanisms and institutions to deliver aid in a more visible, fast and predictable way than traditional aid agencies do. The emergence of Global Health Partnerships (GHPs) should be understood in the context of these changes.

GHPs aim to establish a connection between different kinds of agents (public and private) in order to mobilize public opinion, political will and resources on a large scale against specific diseases that are rampant in developing countries. Nevertheless, under the GHP umbrella there are a whole range of diverse initiatives, with disparate objectives, sizes, operative methods, governing structures and trajectories. In the last 25 years more than 80 international alliances have been created in the field of health.

1.- GHP: an outlook

The World Health Organization (WHO) has identified *global partnership* among different actors as a key way of achieving effective improvements in the field of health.

In general, GHP activities are oriented to some of the following tasks:

- *Research and development* to find new treatments, products and vaccines.
- *Technical assistance and service support* towards the definition of policies.
- *Advocacy* to improve the response capacity to certain diseases.
- *Funding* to raise resources for specific programmes.

Many GHP are performing more than one of these tasks. As we can observe (see graph 1), the bulk of the initiatives are aimed at the development of new products and treatments, at the improvement of access by the poorest populations to treatments as

well as increasing the capacity of response to diseases. By contrast, there are a limited number of GHP which aim at strengthening national health services.

The three diseases which had the attention of the largest number of GHP are HIV/AIDS, Tuberculosis and Malaria. But, also, there is a small number of GHP devoted to other diseases which are less well-known, such as dengue, chagas, guinea worm, etc (see table 1).

Multilateral organizations are frequent partners in the GHPs (particularly WHO, UNICEF or World Bank). While different foundations are supporting GHPs, the *Bill and Melinda Gates Foundation* is the leader in terms of both participation and resources committed. In terms of the contributions to the GHP, the *Bill and Melinda Gates Foundation* is the leader institution, even above official donors.

There are four main reasons that justify the creation of GHP:

- Firstly, because fighting against certain diseases (especially contagious diseases) is a global public good, therefore it requires global and effective responses.
- Second, because focusing on a specific disease can mobilise public opinion and resources in a more effective way
- Third, because there are reasonable doubts about the levels of efficiency and effectiveness of traditional aid channels.
- And finally, because certain diseases have high externalities that demand a concentrated and massive effort for fighting them.

2.- The potential of the GHP

GHPs have had both positive and negative effects. More precisely, GHPs' main contributions would be the following ones:

a) They show an acceptable operative efficiency

Although it is difficult to get the overall picture, the evaluations carried out so far suggest that GHPs have functioned quite well, especially in improving access to treatments, therapies and medicines. For instance, the number of people who received treatment for HIV/AIDS in Sub-Saharan Africa increased eightfold

between 2003 and 2005. At the same time, a significant reduction in the price of some pharmaceutical products has taken place in developing countries. An evaluation done by McKinsey (commissioned by the Bill and Melinda Gates Foundation) concluded that “more than 80% of public health alliances appear to be working”; and that is the same impression which is drawn from the evaluation on GHP carried out by DFID (2004).

b) GHPs have mobilised additional resources to tackle health goals

Between 1990 and 2004, foreign assistance for health rose from 2 billion to 12 billion dollars (a six-fold increase). This increased in funding is not only due to the contribution of official donors, but also to the private agents – such as foundations and companies. Nevertheless, it should be remembered that the principle of additionality of the contributions has not been respected in all cases.

c) They have raised awareness of some forgotten diseases

The main efforts of GHPs are oriented to well known diseases, but also there are GHPs that have given support to diseases which had been overlooked by donors. This support has promoted a more intense effort in the field of research for treatments and products against diseases like Chagas, dengue, buruli ulcer, lepra or tripanosomiasis, etc.

d) Development of markets and new products

The much larger scale that the GHPs operate has helped to reduce production costs of research and development for new products and treatments (*a push drive*); while, additionally, the increased demand has fostered innovation as well (*a pull drive*). As a consequence, new markets and products have appeared related to the treatment of different diseases. This is the case, for example, of CoArtem and Lapdap for malaria or Impavido for leishmaniasis (Light, 2005).

e) Involvement of multiple agents

Finally, one of the clearest contributions of the GHPs is that they have been able to integrate agents, with different perspectives, skills and experiences, into a shared and explicit goal

3.- Main Shortcomings

As all new initiatives, GHPs show some shortages. I am going to concentrate my attention on the effects of GHP: i) on national health systems ii) on the foreign aid system; and iii) on health inequalities.

i) The effects on national health systems

The first problem is related to the potential conflict between the horizontal approach of national health systems and the vertical approach of the GHPs. The 'horizontal approach' seeks to tackle the overall health problems on a wide front and on a long-term basis, while the 'vertical approach' calls for solution of a given health problem by means of single-purpose machinery.

General health services, based on the horizontal approach, have the advantage of being more comprehensive and more embedded in the community and social life. In that sense, they are more willing to reach the deeper causes of the illness (frequently conditioned by social factors). On the other hand, vertical approaches can be justified when trying to combat a disease that affects a high proportion of population. When the treatment has important dynamic externalities and the disease has specific causes, the intertemporal optimization criteria would suggest bursting a big investment effort through a vertical approach in order to guarantee irreversible achievements. Nevertheless, it is important to say that in the long run, an organized and efficient health service system is what countries need.

Therefore, it is not a question of a mutually exclusive choice or a dilemma between these two options. But if we want to take advantage of both approaches it seems essential: first, to carefully define the circumstances when a massive effort is the best answer against a disease; and second, to achieve an adequate coordination between general health services and vertical funds. Improved coordination will however require that the number of vertical initiatives is limited.

In fact, the present situation seems to be characterized by runaway proliferation of vertical funds. As a consequence, it is very difficult for the fragile national health

systems of poor countries to coordinate the activities of the GHPs. Nevertheless, the efficient treatment of any of the diseases targeted by GHP seems conditioned by the capacity of the national health system to integrate preventative, diagnostic and therapeutic measures in a whole, comprehensive approach.

The pressure from multiple vertical funds can even weaken national health systems. As DFID (2004) highlights, “there is a serious risk that weak human resource and systems capacity at central and local levels can be overwhelmed by the growing proliferation of GHP with separate demands”. This aspect was also considered by the *International Task Force on Global Public Goods*, which underlined that “donors should increase the quantity and quality of their capacity building support (for health systems) and be especially cautious in the implementation of global health programs, which too often erode rather than enhance national capacity”.

Therefore, the problem is not the existence of some vertical funds, but their proliferation and the overlapping of their mandates and goals, and in certain cases, its lack of justification (in terms of inter-temporal optimisation).

ii) GHPs and the Foreign Aid System

The proliferation of vertical funds has created a second problem in relation to the coherence and effectiveness of the foreign aid system. GHPs have implied more money and efforts towards health challenges than ever before. But, this money is being disbursed in a largely uncoordinated way. The independence with which each GHP operates, even among those working in the same field, makes it difficult to maintain the overall coherence of the system, with severe implications for its effectiveness. The problem is exacerbated if we take into account that most GHP are *issue-specific*– and *quick-result oriented*.

In fact, in some GHPs aid is tied to short-term numerical targets (such as increasing the number of people receiving drugs or increasing the number of bed nets, etc). Numerical targets are reasonable if we want to establish an incentive system for a better performance, but they could also have some shortcomings. National governments try to reach these numerical targets to obtain more support. However, the fulfilment of these

targets is not the same as to obtain a sustainable improvement in the health care of the population: achieving this aim requires more time and, probably, different signals.

The GHPs activities can raise important questions about the ownership of health care policies. This problem is evident in the case of the GHPs that operate following a top-down approach (PEPFAR could be an example), but it also affects GHPs that rely on recipient countries to define initiatives to be funded (for example, the Global Fund). In this case the problem is similar to the “ventriloquist syndrome”: countries say what donors expect to hear. National governments know quite well in which circumstances and for what kind of initiatives donors are willing to give their money and support.

Furthermore, GHPs can have undesirable effects on recipient countries’ capacity to manage the public budget. Firstly, there may be problems of *absorption* of the funds received; second, in some cases there is limited *predictability* of the activities under the initiatives and the corresponding inflow of resources; third, some contributions are made outside the budget and can weaken the fiscal discipline, generating a problem of *financial stability*; an fourth, there may be problems with the *sustainability*, since the GHP raise the level of intervention far beyond what the government can independently support.

iii) GHP and health inequalities

Equity is a proclaimed policy priority in global health assistance. Nevertheless, the experience reveals that the health sector reforms only benefit poor people and women if health care issues of access and outcomes are explicitly addressed. We may consider three aspects regarding the relation between GHP and equity: i) the selection of the diseases treated; ii) the geographical patterns of the aid allocation; iii) the procedures and policies followed by GHP.

i) Diseases treated

In relation to the first problem, there is a clear relationship between poverty or gender inequities and a large part of the diseases targeted by GHPs. That is the case, for example, of the HIV: existing social and gender inequality increases people’s risk of

infection and, once infected, poverty and gender inequalities act as barriers to treatments, care and support.

Nevertheless, we should not forget that today the top three killer diseases in most poor countries are maternal death around childbirth and respiratory and intestinal diseases leading children to death from pulmonary failure or uncontrolled diarrhoea. But there is no lobbying or celebrity paying attention to these diseases, and there is not a GHP to support the eradication of these diseases. It is obvious that there is no need to create a GHP to fight against these illnesses: it should be a task of the national health system. The problem is that an important part of donors' attention and resources skew to the new Funds instead of supporting national health systems.

ii) Aid allocation

Aid should be allocated in a way to support the fight against health inequalities among countries. As we know, in 37 of the 54 low income countries, public health expenditure was less than 10 dollars per person per year (in 2004), in contrast with the 40 dollars per person per year cost of an adequate package of healthcare intervention, as defined by the WHO's Commission on Macroeconomics and Health. So, GHP activities and resources should be oriented to these poorer countries, especially those in the sub Saharan region. And that is precisely what is taking place: for example, 60% of the approved funds in Rounds 1-8 of the Global Fund are for Sub-Saharan Africa.

As we have seen, GHP are mainly oriented to fight against infectious diseases and 90% of the burden of this kind of diseases is concentrated in developing countries, where these countries account for only 12% of global health expenditure. Therefore, the GHP aid allocation seems to be in correspondence with the purpose of reducing international inequalities.

Some GHPs have a clear mandate to choose poorer countries to direct their support. For example, in the case of GAVI, grants are offered only to countries with per capita income of less than US\$ 1,000. When GHPs have a top-down governance structure, the board may give priority to poor countries, if they want. When the GHP has a bottom-up governance structure (as the Global Fund), the recipient countries are the ones that

apply for the funds. This procedure assures a greater degree of national ownership. Nevertheless, this process might have a detrimental effect on the poorest countries, since they have less resources and capacity to design suitable initiatives to be funded. For this reason, it is necessary more technical assistance to allow poorer countries to fully access to the benefits of a GHP.

iii) Tackling the poverty-disease nexus

If we tackle the poverty-disease nexus we have to provide support to national health systems. Poor people tend to suffer higher rates of mortality and morbidity than those who have a higher income; and, despite the fact that their needs are greater, they attend to health services less frequently than rich people. These inequalities are not the consequence of the differing preferences among social groups, but rather of unequal restrictions faced by them.

Improving the access to health services is an important aspect to reduce social and gender inequality. So, it is important to analyse the specific barriers that affect poor and vulnerable people in each situation and country. Furthermore, it is necessary to go beyond having a disease-specific focus and to ensure that the causes of social and gender inequities that determine access to health are accurately addressed.

So, tackling the poverty-disease nexus and fighting against the specific diseases, as in the case of GHPs, demand a more sound support to national health systems. AIDS treatment cannot be provided in isolation from the health systems and it is impossible to fight against malaria without the support of the primary health care. Model-generated estimations tell us that Africa alone needs more than a million new health workers (which require more health education programmes, training systems, skills shifting, improved human resource management, higher wages and better working conditions to retain workers and to stop brain drain). And human resources are not the only problem of national health systems in Africa.

But strengthening national system is not necessary the same as exclusively adopting a horizontal approach. A better strategy would be to combine specific interventions with the general approach. Or, more precisely, it is necessary to use explicit intervention

priorities to drive the required improvements into the health system. One should avoid both undesirable extremes: to create isolated islands of sufficiency in a sea of under provision (if only vertical approach is supported), and to maintain a generalised insufficiency, without improvements in severe diseases (if only horizontal approach is supported). It would be better to build certain areas of sufficiency surrounded by a system in process of improvement, trying to connect these areas gradually. This calls for greater integration between the diseases initiatives and the underlying health care delivery. In part, the decision adopted by the Global Fund in 2007 to consider comprehensive country health programmes for financing goes in this direction.

iv) Reaching out

In spite of what I have said before, there is no guarantee that the investment in health and primary care is oriented to poor people, even if dedicating attention to poorer countries and diseases that mainly affect poor people. For example, the World Bank, in a report about health and poverty in 56 developing countries and countries with economies in transition, confirms that the rate of use of standard primary health care interventions (such as immunisation, oral rehydration therapy, medical treatment of diarrhoea and acute respiratory infection and attended birth deliveries) is higher in upper socioeconomic groups than in lower groups. Another analysis of seven Sub-Saharan countries reveals that government expenditures on primary health care benefit people in the top socioeconomic quintile around 50% more than those in the lower quintile. Poor population groups require greater efforts because of their limited resources and abilities to use even heavily subsidised health services.

To sum up, there are doubts on whether anti-poverty and gender equality approaches are being properly integrated into the GHP practices. An evaluation by DFID (2004) concludes that “GHP are in practice only as pro-poor or gender-sensitive as the policy environment and health systems they operate within”.

4.- Conclusions and Recommendations

Let me finish by summing up some conclusions. Health has become a key focus of international action in addressing inequities among countries and citizens within a country.

- GHPs are an innovative instrument that can help to reduce inter and intra country inequities. Nevertheless, in the last twenty years an excessive number of GHP were created, in several occasions without a well grounded justification. So it is necessary to curb the creation of new GHPs to reduce the potential conflict between “mass campaigns” and general health services.
- Second, to integrate both approaches it is necessary to strengthen national health systems, which implies overcoming several challenges: insufficient human resources, inappropriate procurement systems for drugs and health products, lack of infrastructure, laboratory and medical equipment and inadequate monitoring and evaluation systems. If the GHPs want to strengthen national health systems they will have to support improvements in all these areas.
- Third, the GHPs need to see their actions as part of an overall approach to tackle a country’s health problems and to address the system-wide impact of their programmes to avoid health system distortions.
- Fourth, GHPs should analyse the specific factors that limit the access of poor people to health services and they need to ensure that their interventions help to overcome these limits. Thus, GHP policies and programs should be checked for their potential long-term impact on social and gender inequities before they are implemented.
- Fifth, it is necessary to empower national health systems to influence GHPs policies and programmes and to prevent social and gender inequities associated with GHP implementation.
- Finally, it is necessary to integrate social and gender equity considerations in health with other development policies. There is need to go beyond a disease-specific focus and to ensure that the causes of social and gender inequities that determine access to health care are accurately addressed.

Graph 1

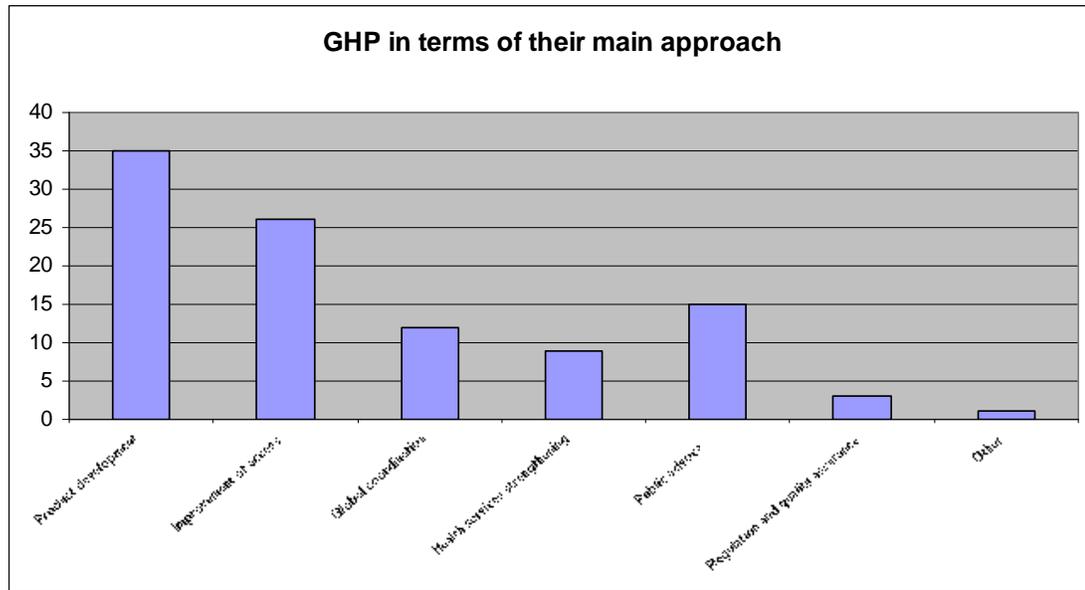


Table 1

GHP in terms of diseases or conditions

Disease/Condition	N°GPH		N°GHP
All human diseases and medical conditions	1	Leprosy	2
Blindness	3	Lymphatic Filariasis	2
Cataract	1	Malaria	18
Chagas	2	Meningitis	2
Chemical safety information	1	Micronutrient deficiency	2
Communicable diseases	2	Neglected diseases	1
Counterfeit and standard drugs	2	Onchocerciasis (river blindness)	4
Dengue	2	Parasitic an other neglected diseases	1
Diarrhea dehydration	1	Pneumococcal vaccines	1
Digital divide	1	Polio	1
Diseases of the poor	1	Reproductive health	5
Guinea worm disease	1	Schistosomiasis	1
Harmonization drug application	1	Sexually transmitted infections	7
Health policies and health systems	1	Tetanus, maternal and neonatal	1
HIV/AIDS	20	Trachoma	3
Human African trypanosomiasis	4	Tuberculosis	10
Human Hookworm Infection	1	Vaccine vial monitors	1
Injection safety, syringes	2	Vaccine-preventable diseases	5
Lassa fever	1	Vitamin A deficiency	1
Leishmaniasis	3		

Source: Ito (2007), pag. 74