From Alma Ata to the Global Fund: The History of International Health Policy

Prepared by the Italian Global Health Watch

"Global Funds are like stars in the sky, you can see them, admire them, appreciate their abundance… but fail to touch them."
Ministry of Health Official, Malawi

Abstract

This paper traces the evolution of international health policies and international health institutions, starting from the birth of the World Health Organization, the setting up of the Health for All target at the Alma Ata conference in 1978 and the rise of neo-liberal policies promoted by international financial institutions from 1980 to the present. The paper looks at different issues surrounding public-private partnerships and the setting up of the Global Fund to fight AIDS, Tuberculosis and Malaria and the influence of these institutions on the health systems in poor countries.

1. The birth of the World Health Organization

The World Health Organization (WHO) was formally established in June 1948 as a specialized agency of the United Nations. This organization resulted from the unification of 3 different international agencies concerned with hygiene, public health and health emergencies: the Office of International Public Hygiene (located in Paris), the League of Nations Health Organization (located in Geneva) and the United Nations Relief and Rehabilitation Administration (UNRRA, in New York). The Pan American Health Organization (PAHO), set up in 1901, then took on the role of the American Regional Office of WHO. During the 1960's and 70's the WHO direction was influenced by political events related to the emergence from decolonization of African nations, of nationalist and socialist movements (mainly supported by the non-aligned countries) and the new theories of long term socioeconomic growth as opposed to short term technical interventions. Even in the United States of America there were changes in the political climate after an electoral victory by supporters of more liberal approaches and the affirmation of civil rights. In this context the Primary Health Care strategy was developed to address unsolved problems of basic health care such as malaria, to reinforce health infrastructures especially in rural areas, as well as support economic and social development. The WHO Director General (1973-1988), Halfdan Mahler, strongly supported this approach and convened an International Conference .[1]

2. The Alma Ata Conference

The International Conference on Primary Health Care (PHC) was held in Alma Ata, capital of the Soviet Republic of Kazakhstan, in September 1978. This was an historic event for several reasons. It was the first time that representatives from all countries in the world met to define a reference structure for the promotion of health care for all; it was also the first time that the health care problems of the poorest countries, many of whom had been under oppressive colonial rule, were seriously taken into consideration. At this conference both health needs and development were strongly linked; it was a particularly opportune moment to reaffirm health as "a state of physical, mental and social wellbeing, not only the absence of disease or infirmity" and a fundamental human right. In addition, access to the highest level of health was also seen as an extremely important social objective of global interest that presupposed the participation of numerous social and economic sectors, not only the health sector.

The Conference generated a document rich in recommendations, and a solemn Declaration that resumed the principal indications derived by the Assembly.[2] The strong and significant political message was the definition of Primary Health Care:

> *"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full*

Institution: Italian Global Health Watch (OISG)
Corresponding author: Dr Gavino Maciocco, President Italian Global Health Watch, Via Borselli 4-6, 40135 Bologna, Italy, Email: gavino.maciocco@unifi.it
Webpage: http://www.saluteglobale.it/
Conflict of Interest: None declared; Peer-reviewed: No
The Italian Global Health Watch would like to thank Jennifer Sardo Infirri for her invaluable contribution to the English translation of the Italian version of this paper.

participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. (...) It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. (…) It includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs. (…) It involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors."[2]

3. PHC: Selective versus Comprehensive Care: the "Counter- revolution"

Less than a year had passed after the Alma Ata conference (where the conclusions were unanimously adopted), when an article was published in the New England Journal of Medicine entitled: "*Selective primary health care: an interim strategy for disease control in developing countries*".[3] The principle proposed at the Conference that a "comprehensive" approach to the solution of health care problems in the poorest countries was theoretically the most just was challenged by the World Bank (WB). The costs of such an approach were estimated as too high (between 5.4 to 9.3 billion dollars by the year 2000) and a postponement of these approaches suggested. Instead, it was proposed to pursue the fight against a limited number of diseases by concentrating on specific interventions that, according to the authors, would be most cost-efficient: vaccinations, promoting longer breast feeding, anti-malaria activities and oral rehydration. The article by J.A. Walsh and K.S.Warren was not just an academic exercise of two distinguished researchers of the Rockefeller Foundation. It represented the start of a movement (called Selective PHC) in a direction exactly opposite to the Alma Ata declaration. UNICEF, although a co-promoter of the Conference, had no difficulty in climbing on board the Selective PHC movement by launching a campaign in 1982 called "A Children's Revolution"[4] built on the need to concentrate on four specific cost-effective objectives: oral rehydration to combat diarrhea, vaccinations, promotion of breast feeding and the systematic use of the growth chart. Growth charts would substitute for anti-malarial therapy in the list of priorities, as the latter was judged to be too expensive.

From that moment on, international organizations adopted Selective PHC as their strategy even though confronted with all the evidence that the determinants of progress and improved health in any population go well beyond the fighting against only one or two diseases. In April 1985 a meeting with the title "Good Health at Low Cost" was organized by the Rockefeller Foundation in Bellagio (Como, Italy). The meeting was attended by officials, economists and demographers from China, Sri Lanka, Costa Rica and Kerala State, India. These four areas, all with low gross national product and limited resources dedicated to health care, had nonetheless been able to produce good results in terms of their populations' health.[5] The participants, after having examined the results presented at the conference, unanimously adopted the following recommendations: "*The four states that had obtained 'good health at low cost' have demonstrated a clear political and social commitment towards an equitable distribution of income in their societies. Given this commitment, it seemed that three other factors played a major role in their success, shown by the marked decline in infant mortality and death rates of children below 5 years of age, and increased life expectancy at birth, approaching the levels of developed countries. These factors brought the participants to give the following recommendations for development programs in other countries:*

- *equitable distribution of income, access to public health care services for all, and primary health care reinforced by secondary and tertiary services;*
- *an education system accessible for all, particularly at primary level, with possibility to continue to secondary and tertiary levels;*
- *food security and adequate nutrition for all levels of society*."[6]

The rather academic recommendations from the conference report were soon forgotten; a political choice had already been made (in New York, London or Geneva) to favor sectorial inter-

ventions and vertical programs, an orientation that marked international health cooperation for decades. Prof. Andrew Green of the Nuffield Institute for Health in Leeds writes: "*The vertical programme approach is contrary to the idea of integrated PHC services. The use of centrally defined criteria to select the problems to be addressed reduced the possibility of involving populations in the choice of priorities. All this implicates a return to the medical health model that ignores the importance of development in the wider sense and at the practical level this strategy does not take into account the need to reinforce or construct an adequate infrastructure without which no programs succeed.*"[7] According to the late Professor K.W. Newell, from the Liverpool School of Tropical Medicine, "*Selective PHC is a threat and must be considered as a counter-revolution. It is a form of health feudalism that is destructive rather than an alternative. Attractive to professionals, financing agencies and governments that are seeking results in the short term, but it is a pure illusion.*"[8]

4. The eclipse of WHO and the advent of World Bank domination

4.1. The economic recession of the eighties and the policy of "Structural Adjustment"

The petrol crisis of the 1970s and 1980s, followed by the Arab-Israeli war (1973) and the Iranian revolution (1979), had profoundly negative effects on the global economy, seriously affecting all petrol-importing countries. Further, the measures adopted to cope with the increased cost of energy, and the resulting inflation, triggered a period of grave recession. For developing countries, that during the sixties had achieved significant economic growth, the consequences were doubly devastating because the increase in price of petrol (and other products imported from industrialized countries) added to the drop in price of their principal exports (primary commodities), caused by a global slump in demand. In the industrialized countries recovery from the petrol shock was rather rapid. For several countries, mainly Asian (South Korea, Taiwan, Singapore), this was the opportunity to restructure their economies and increase internal production (for export). For most of the poorest countries, mainly African, with fragile and vulnerable political, social and economic structures, the petrol shock was the initial sign of a long (and still ongoing) period of crisis, increased poverty and debt. The recipe devised by the WB, the IMF and the US Treasury (the so called "Washington Consensus") during the eighties for "recovery" or "structural adjustment" of the poorest and most indebted countries (and the contractual conditions for obtaining credit) were simple, pitiless and coherent with the neo-liberal policies dominant in the USA and Great Britain in that period. These bold recommendations included drastic cuts in consumption and public spending (including social services such as health and education) to reduce inflation and public debt, privatization in all sectors, decentralization, and a lower profile for central governments.

Little consideration was given to the entirely predictable catastrophic effects of degrading levels of education and health care (adding to the tragedy of the HIV/AIDS epidemic entering the scene in that period) on the fundamental basis of any future possible development in those countries. In 1987 the WB published the first document entirely dedicated to health[9], a technical appendix to the structural adjustment policy. It contained a series of prescriptions, obviously mandatory for the most indebted countries, for restructuring health services in developing countries. The document comprised four chapters, each containing a specific directive:

- Enforce fee payment for health services (justified as follows: "*the most usual approach in developing countries was to consider that health care is a right for all citizens and so provided free; this approach generally does not work.*")
- Encourage the privatization of health services
- Promote (private) insurance programs
- Decentralize the management of health care.

These four directives are strongly linked. The introduction of user fees in government structures is not only a way of making users pay, it is also essential for promoting insurance systems. On the other hand without an insurance system the government hospitals cannot apply tariffs sufficient to cover costs. The privatization of services and program decentralization are the other two essential components of the proposed strategy, clearly meant to reduce to a minimum the role of governments in health care, leaving space for systems of private care and health insurance. The effects of structural adjustment policies were soon rapidly and dramatically evident. At the same time, in its 1989 annual report[10], UNICEF denounced structural adjustment ("*inhuman, unnecessary, inefficient*") as the cause of the worsening conditions of life and health ("*at least half a million children have died in the last 12 months as a consequence*

of the economic crisis that has enveloped the developing countries").

4.2 The eclipse of WHO.

In 1988 a Japanese researcher, Hiroshi Nakajima, was elected Director General of the WHO. His election marked the beginning of a decade of grave crisis in the institution. This was due to a number of factors, only partially linked to the new Director's low profile (the exact opposite of his predecessor H. Mahler).[11-13] The lack of an influential guide at the head of WHO aggravated a series of problems:

A frozen budget and the conflict between WHO and USA: Beginning in 1980 the WHO budget remained unaltered, progressively losing value due to inflation. In spite of this, Nakajima doubled the number of staff at the director level and the USA repeatedly withheld funding. The USA was irritated by the Mahler administration's bold promotion of the International Code on Breast Milk Substitutes (a move seen as an attack on the free market) and the launching of the Essential Drugs Program (fiercely opposed by the pharmaceutical industry).

Program financing through extra-budgetary funding: While, on the one hand, the WHO ordinary budget, set by the country representatives at the World Health Assembly, was increasingly reduced (thus undermining the institutional core of the Organization), on the other hand, programs were being financed *ad hoc* through extra-budgetary funds provided by various donors. These were the rich nations and multi-lateral agencies such as the WB. By the early nineties the extra-budgetary funds represented 54% of the entire budget of WHO. Such financing generated "vertical" programs such as those to combat AIDS or provide universal vaccination coverage. In these programs decisions were made by the donors and so that they were effectively outside of the control of the Organization. Donors justified this approach by pointing to WHO's inefficiency and their lack of confidence in the internal management of WHO. It was better, they argued, to finance and manage important programs directly. However, it was already clear that such programs were not functioning, particularly the vaccination programs funded mostly by UNICEF and other partners such as Rotary International. At the end of the eighties huge efforts had been made to attain maximum coverage in the poorest countries thanks to generous incentives provided to local staff to reach targets. The results were absolutely brilliant but ephemeral. Ghana attained 100% immunization coverage of children in 1990, only to return to the preceding levels of 40-50% when the incentives were reduced. A similar situation occurred in Nigeria: maximum coverage of 70% was attained in 1990, then fell below 20% by 1994.

4.3 The medical trap of the poor

The WB entitled its 1993 annual report *Investing in Health*.[14] To write the document, a highly paid team of internationally renowned experts was recruited. With this report the WB made a spectacular entrance as the major financial institution in the health scene, further tarnishing and obscuring the role of WHO (an institution that had already been discredited).[15] The report addressed two important technical-scientific themes:

- the definition (and economic estimate) of the package of essential clinical services and public health interventions that governments should assure to their entire population;
- the introduction of a new indicator to measure the state of a country's health: the DALYs (Disability Adjusted Life Years). The DALYs measure the burden of diseases of a community by combining two different indicators: the loss of life due to premature death and the loss of healthy life due to disability. The role of these variables was to measure the cost of interventions for prevention and/or cure of specified diseases, then using this evaluation instrument to allocate resources and define priorities.[16]

This type of selective approach to PHC provided further grist to the mill confirming the hostility of the WB to the conclusions of the Alma Ata Conference. Notwithstanding the WB experts' recommendations of "*Investing in Health*", the health of the poorest countries, and particularly the sub-Saharan African, precipitated into an abyss. The quota of the gross national product (GNP) destined to health care fell[17]; so did the amount spent on public services which varied from $ 2 to $8 per capita yearly, quite below the $14 recommended by the experts to fund the essential package of health interventions. A flood of privatization occurred within already crumbling public structures. Outside of the public institutions a private health care market was thriving, a market based largely on the sale of pharmaceuticals, available everywhere, in private clinics, in drug stores, on market stalls and street corners. These pharmaceuticals were often out of date or counterfeit, and almost always distributed by un-

registered people. The reason for this drug boom was soon clear: lack of access to the formal but too expensive private services (hospitals, health centers, public and private non profit and private for profit, all by payment) forced the vast majority of the population to turn to anyone able to provide care for the few coins they had in their pockets. The most simple care: a pill or an injection.

> *"In the past two decades, powerful international trends in market-oriented health-sector reforms have been sweeping around the world, generally spreading from the northern to the southern, and from the western to the eastern hemispheres. Global blueprints have been advocated by agencies such as the World Bank to promote privatisation of health-service providers, and to increase private financing—via user fees—of public providers. Furthermore, commercial interests are increasingly promoted by the World Trade Organisation, which has striven to open up public services to foreign investors and markets.This policy could pave the way for public funding of private operators in health and education sectors,especially in wealthy, industrial countries in the northern hemisphere.*
>
> *Although such attempts to undermine public services pose an obvious threat to equity in the well established social-welfare systems of Europe and Canada, other developments pose more immediate threats to the fragile systems in middle-income and low-income countries. Two of these trends—the introduction of user fees for public services, and the growth of out-of-pocket expenses for private services—can, if combined, constitute a major poverty trap.*[18]

This is the introduction to an important article published in the Lancet[18] by Margaret Whitehead (Professor of Public Health at the University of Liverpool, and consultant to the British government), Goran Dahlgren (Director of the National Institute of Public Health in Stockholm) and Timothy Evans (Director of the Health Equity Division of the Rockefeller Foundation of New York). The authors present an impressive list of the consequences produced by WB health policies in the poorest countries, summarized in four categories: 1) Untreated diseases, 2) Reduced access to care, 3) Irrational use of drugs, and 4) Long term impoverishment. The most serious social and development consequences are: 1) when people are forced to purchase health care, they often jeopardize other aspects of their existence since health care costs are rarely discretionary and thus 2) families become indebted, being forced to sell their assets (a piece of land or animals) or to forsake other vital expenditures such as their children's education.

The negative social impact of user fees for health care is greater than in other sectors of life because these expenses are not foreseeable and the total cost is unpredictable and unknown until the end of the treatment.

5. Public-Private-Partnership (PPP)

In 1998, when the credibility and the prestige of the WHO were at their lowest, the former Prime Minister of Norway, Gro Harlem Brundtland, was elected Director General. Her election stemmed the Organization's decline and returned the question of health to the international political agenda. Important initiatives achieved under her direction include the publication of World Health Report 2000 which established evaluation criteria for health systems (criteria subjected to considerable debate); the institution of the Macroeconomics and Health Commission presided by Professor Jeffrey Sachs, and the adoption by the WHO Assembly of the "WHO Framework Convention on Tobacco Control". However, the policy adopted by the Bruntland leadership was not significantly different from that of the WB and the road map for WHO was obviously adopted from the 1993 WB Report "*Investing in Health*.[9] In the 5 years of her direction (from 1998 to 2003) there was also a proliferation of activities financed by extra-budgetary mechanisms; these soon greatly outnumbered those funded by the WHO regular budget ($1.40 billion as opposed to $800 million in 2002). The following programs were promoted and financed by public and private donors (PPP): European Partnership Project on Tobacco Dependence, Global Alliance for TB Drug Development, Global Alliance to Eliminate Lymphatic Filariasis, Global Alliance to Eliminate Leprosy, Global Alliance for Vaccines and Immunization, Global Elimination of Blinding Trachoma, Global Fire Fighting Partnership, Global Partnerships for Healthy Aging, Global Polio Eradication Initiative, Global School Health Initiative, Multilateral Initiative on Malaria, Medicines for Malaria Venture, Partnership for Parasite Control, Roll Back Malaria, Stop TB and the UNAIDS/Industry Drug Access Initiative.

The most prominent of these ventures was the Bill and Melinda Gates Foundation's donation in

September 2002 of $2.8 billion, $750 million of which was for a Global Alliance for Vaccines and Immunization (GAVI), a PPP in which WHO had a very marginal role. In another PPP, Roll Back Malaria, there were more than 80 partners among bilateral, multilateral, NGOs and private organizations (including the WB, Gates Foundation, Amref, Bayer, Novartis, ENI, the Italian Government); here WHO had a dominant role. However, the multiplicity of actors caused serious management and governance problems in both the center and periphery so that WHO itself decided to set up an autonomous institute for malaria, the Global Malaria Program.[19] As already been noted, PPP, the latest trend in vertical programming, causes more problems than they solve as detailed by Gavin Yamey, the author of a series of articles on WHO in the *British Medical Journal* in 2002 (see references 19 and 20).

6. The AIDS pandemic and the Global Fund

In 2001, 148 Harvard academics denounced the fact that in sub-Saharan Africa less than 40,000 people were receiving antiretroviral treatment in an area where 25 million people were infected by HIV or ill with AIDS and where the epidemic caused 2.2 million deaths each year. Andrew Natsios, then director of USAID (U.S. Agency for International Development), proclaimed his opposition to the distribution of antiretroviral drugs in Africa on the basis that its inhabitants were unable to take them at regular intervals because they had no watches and no correct cognition of time.[20] This comment indicated the level of attention given to the AIDS pandemic and its tragic impact on the African continent at the beginning of the new millennium, six years after the successful introduction of antiretroviral treatment in the rich countries. However, on the 25-27 June 2001, a special session of the UN General Assembly in New York dedicated to HIV/AIDS, and entitled "Global Crisis - Global Action", changed things:

> *We, the heads of States and governments, present at the UN for the 26th General Assembly, agree on the urgent necessity to re-examine and confront the problem of HIV/AIDS in all its aspects, ensuring a global commitment to the improvement and growth of the coordination and intensification of the efforts at national, regional and international levels to combat this phenomenon in all its components.*

These words introduced the final document of the special session of the Assembly which indicated $7-10 billion as the annual amount the international community should allocate to adequately tackle the "global crisis." The UN Secretary General, Kofi Annan, personally endorsed the creation, outside the UN, of a Special Fund for HIV/AIDS open to governments, the private sector, foundations and individuals in a "new partnership."

Several weeks later, the concluding meeting of the Genoa G8 summit approved the creation of a special fund dedicated to HIV/AIDS, Tuberculosis, and Malaria. "The Global Fund to Fight AIDS, Tuberculosis and Malaria" (GF) was formally instituted on the 29th of January 2002 in Geneva. Its aim was to "*attract, manage and allocate added resources through a new private public partnership providing a significant and sustainable contribution to the reduction of the infection, illness and mortality caused by HIV/AIDS, Tuberculosis and Malaria, mitigating their impact on needy countries and aiding poverty reduction as part of the "'Millennium Development Objectives.*'"

6.1. The GF: functions and structure.

The GF (www.theglobalfund.org) is a financing agency and not an implementing or project managing entity. It receives funds from public donors (93% from governments) as well as private donors, mainly Bill Gates (7%), and it allocates funds to projects developed locally by public and private organizations. At the national level, project selection takes place through the Country Coordinating Mechanisms (CCM), a collegial body made up of representatives from governments, universities, bilateral and multilateral institutions, NGOs, private organizations and patients. At the central level, project evaluation is carried out by a group of experts, the Technical Review Panel (TRP), whose recommendations are used by the GF Board in their decisions on project feasibility. The GF Board is made up of representatives from donor and receiving countries, NGOs, private organizations and affected communities. There are 20 members plus non voting representatives from multilateral institutions, WHO, UNAIDS and the WB (which acts as the GF bank). At the present moment the management of the GF is in the hands of a Secretariat composed of 335 people under the leadership of Executive Director Michel Kazatchkine (France). Project proposals are called for on annual basis. Round 8 of the GF will open in March of 2008.

6.2. The GF: the results.

The most recent GF document from February

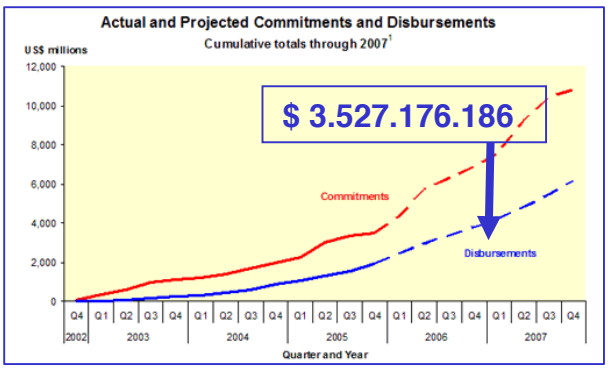


Figure 1: Source: The Global Fund

2007, *Partners in Impact. Results Report*, provides the following data. As of 31 December 2006, the GF had signed agreements and funding commitments for a total of $5.3 billion, for 410 projects in 132 countries. Overall, in more than 3 years, the GF allocated $3.5 billion (precisely $3,527,176,186 by Feb. 2007). **Figure 1**. On the 1st of December 2006, 770,000 people were undergoing antiretroviral treatment, 2 million were in DOTS treatment against tuberculosis, 18 million mosquito nets treated with insecticides had been distributed to protect families from malaria. **Figures 2 and 3**. As a consequence of these results, the GF report claims that by the 31st of January 2007, 1,460,000 lives had been saved (3,000 a day). The breakdown of funds for the three illnesses was as follows: 56% for AIDS, 28% for malaria and 16% for tuberculosis. GF

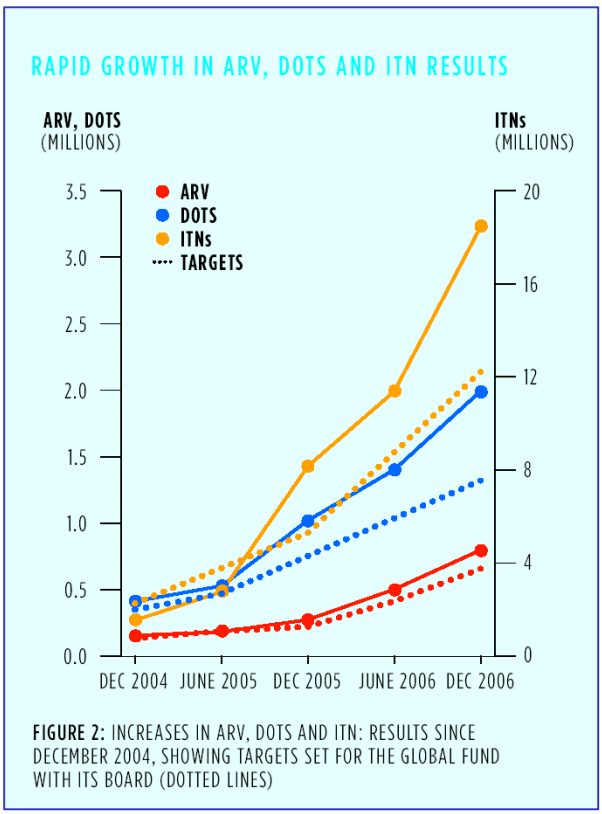


FIGURE 2: INCREASES IN ARV, DOTS AND ITN: RESULTS SINCE DECEMBER 2004, SHOWING TARGETS SET FOR THE GLOBAL FUND WITH ITS BOARD (DOTTED LINES)

funds went to governments (59%), NGOs (30%), multilateral agencies (9%), and private organizations (2%), and covered the following sectors: prevention (33%), treatment (44%), assistance and support (7%), administration (7%), strengthening of health system (6%), monitoring and evaluation (1%), other (2%). **Figure 4.**

Does the GF work or not? How can these results be evaluated in terms of resources spent (input), services delivered (output) and the health results achieved (outcome)? In attempting to answer these questions we will look particularly at HIV/AIDS the condition which has absorbed most of the GF funds.

6.2.1: Inputs

The financial objective recommended in the final document of the special UN Assembly in June 2001 for the campaign against AIDS was $7-10 billion per year. However, the funds effectively spent by the GF were on average slightly more than $1billion per year for the 3 illnesses. Of these, only about $600 million were spent on AIDS. As is shown in **Figure 5** the GF contributed only 21% of the $3 billion spent globally on AIDS; this is less than half the objective set by the UN. Moreover **Figure 6** shows that in recent years there has not been a significant increase in funds *per capita* in the campaign against AIDS throughout the world, with only Sub-Saharan African countries registering a slight but constant increase. (+$ 0.50 per capita in four years).

6.2.2: Outputs

In September 2003 the WHO Director General, Lee Jong-Wook, the UNAIDS Director General, Peter Piot, and the Executive Director of GF, Richard Feacham, declared that the current low level of access to antiretroviral drugs was unacceptable in countries with low and medium levels of development and that it was necessary to launch a powerful campaign to rapidly expand treatment access. This was called "3 by 5", aiming to treat 3 million people by 2005, or in other words reach 50% of the population eligible for treatment. (**Figure 7**) The results of the "3 by 5" were disappointing. At the end of 2005 according to UNAIDS data, only 1,300,000 people were in treatment (43% of the target, 20% of the eligible population). The coverage achieved was the result of multiple initiatives leading to a situation where the sum of the levels of coverage claimed by the various actors was greater than that certified by UNAIDS. To the 770,000 people in treatment at the end of 2006 cited by GF we must add PEP-

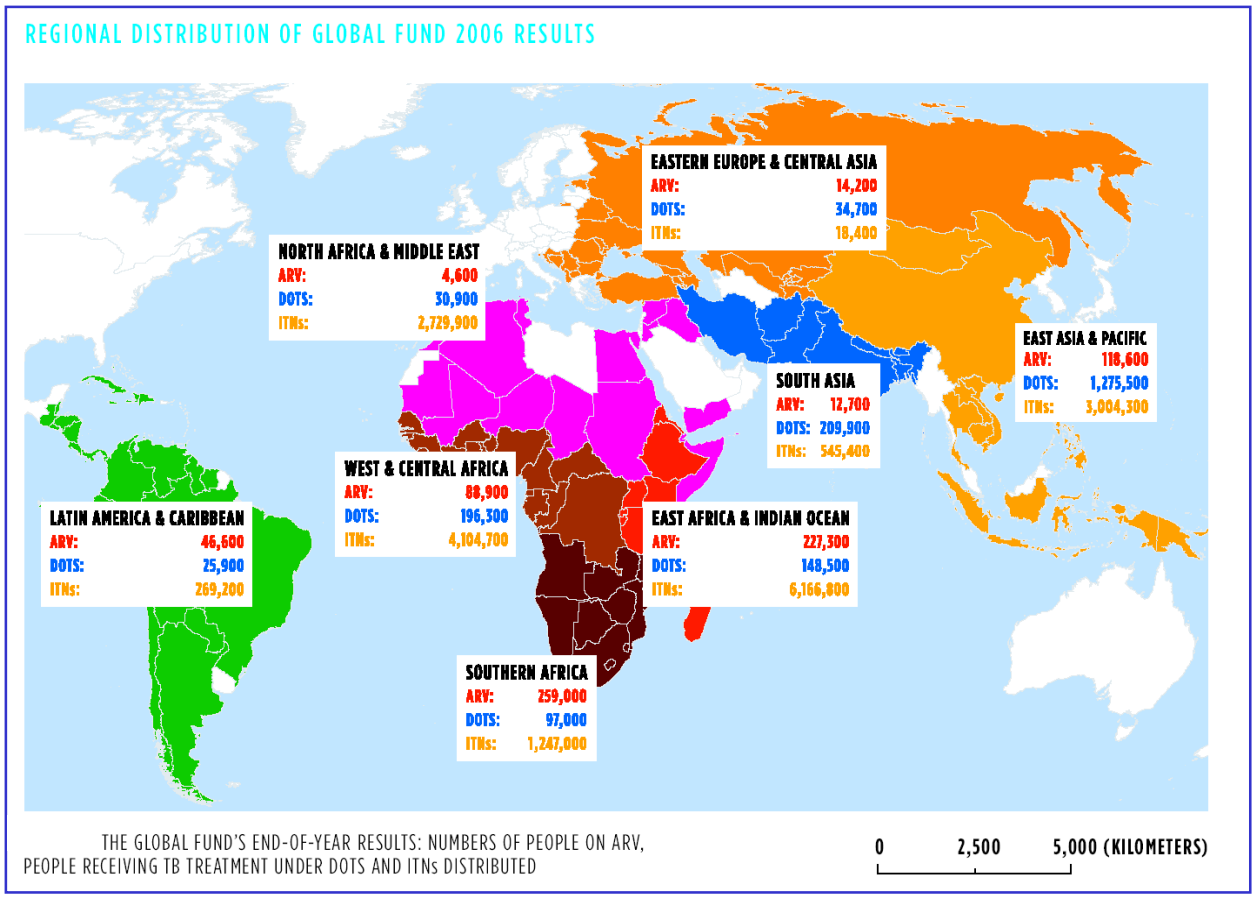


Figure 3 (Source: The Global Fund)

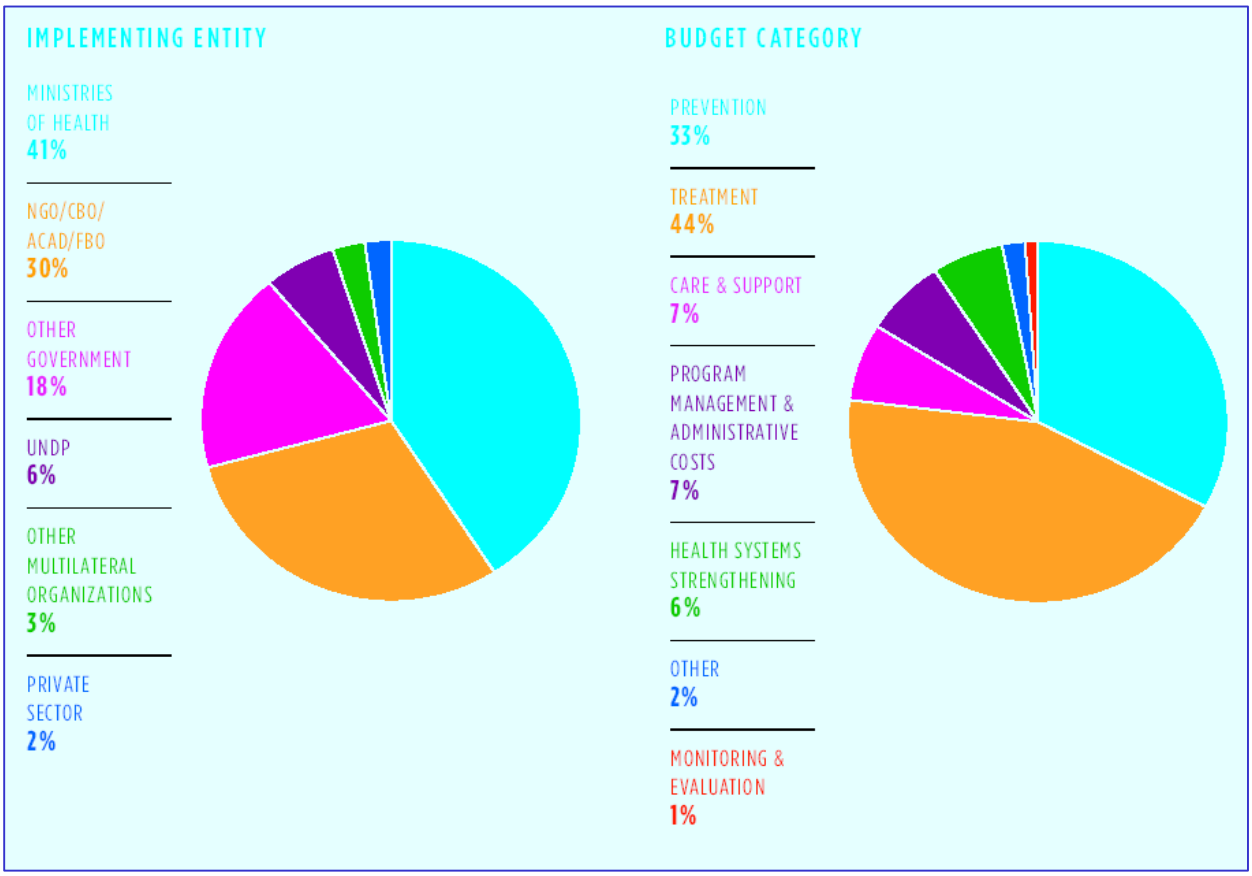


Figure 4: Use of GF Funds (Source: The Global Fund)

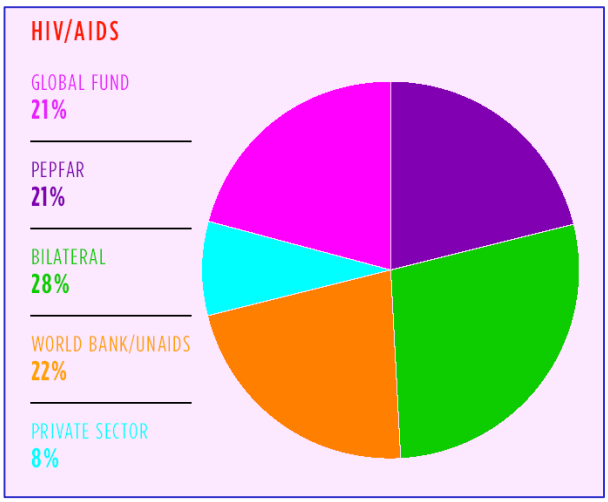


Figure 5: HIV/AIDS Funding Sources: Source: The Global Fund

FAR (www.pepfar.gov, the President's (Bush) Emergency Plan for Aids Relief) with 822,000; CHAI (www.clintonfoundation.org, the Clinton Foundation HIV/AIDS Initiative) with 415,000; the many foundations of Bill Gates (65,000 in Botswana alone). Deciphering the data on the levels of antiretroviral treatment is extremely difficult as an analysis of the UNAIDS document shows strongly contrasting data from different sources.

6.2.3. Outcomes

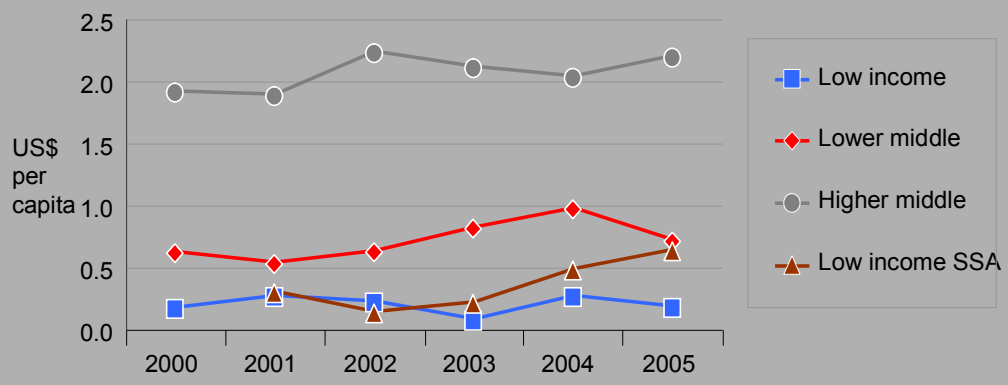
The GF claims one and a half million lives saved, a rate of 3,000 per day. Although these figures are acceptable, outcome evaluation is much more complex. The opportunity cost of the GF must be taken into consideration, i.e. what other alternatives have been forfeited in adopting the GF strategy. Thus, although the GF achieved several health objectives in the area of HIV/AIDS, Tuberculosis and Malaria, during the same period there was a decline in African health standards in the maternal and child sector (**Figure 8**); maternal and child health are considered the most accurate index of the general functioning of a health system in terms of access and quality of services and personnel. This decline could also be a direct result of the GF policy and mechanisms such as the competitive recruitment of its own staff and consequent neglect of other activities such as pre-natal programs and infant assistance (not included in special funds or vertical programs).

6.3. Implementation crisis.

The apotheosis of the PPP: how else can we define such a relentless growth of these phenomena in the arena of global health? The PPP "Global Fund to Fight AIDS, Tuberculosis and

Figure 6

Per capita HIV and AIDS expenditures by country income level*



• *Trends based on a sample of 25 countries from sub-Saharan Africa and 57 countries from other regions*

Source: UNAIDS

3.9

Malaria" came into existence when there were already specific PPPs for each of the areas concerned (AIDS, Tuberculosis and Malaria) such as UNAIDS (www.unaids.org), Roll Back Malaria (www.rbm.who.int), Stop TB (www.stoptb.org). Although many PPP actors are omnipresent, this is often not sufficient in itself and they set up actions and autonomous finances within the same sectors (eg. G.W.Bush's PEPFAR) leading to a excess of actors and protagonists at all levels: finance, programming, management, field work, and evaluation. This situation was the subject of a report by UNAIDS in 2005,[21] which noted with concern that a significant increase in available finances was accompanied by a serious lack of co-ordination in fund management and organization producing duplication and competition between various sponsors and provoking what the UNAIDS defined as "the implementation crisis", caused by unsustainable organizations and extremely high administrative costs. The chaotic situation is shown well in **Figure 9**, which describes the various functions of the AIDS program and the mass of sponsors involved in various ways. A recent Lancet editorial[22] focuses on a paradoxical aspect of this disorganization, caused by the verticalization of services. The coexistence of HIV/AIDS and Tuberculosis compounds the problem, affecting about 11 million patients who are also those with the greatest concentration of resistance to antiTb drugs (XDR-TB). Although it is crucial that patients suffering from the two diseases be treated by the same service and health workers, the reality is that two programs (AIDS and TB) operate separately causing enormous problems for patients.

Figure 7

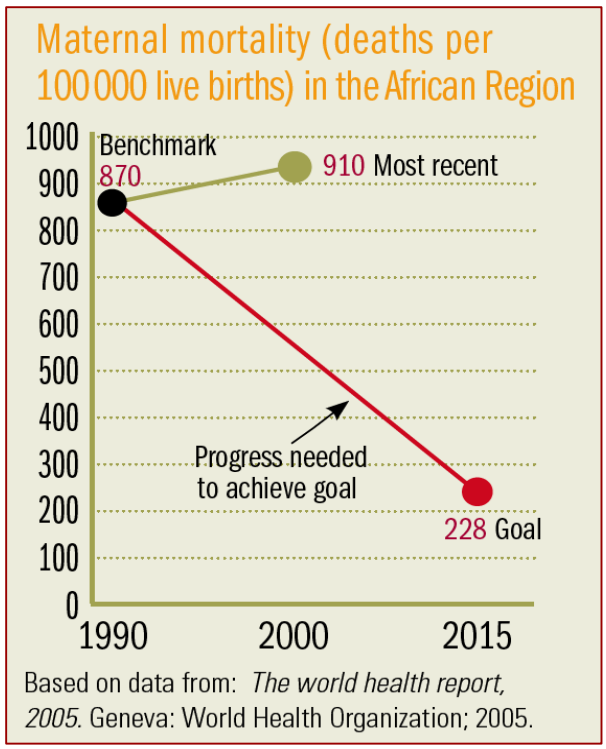


Figure 8

6.4. Strengthening health systems.

"Perversely, the large inflows of donor assistance targeted to these diseases (through so-called vertical disease programs) have weakened the infrastructure and drained the human resources required for preventing and treating common diseases (such as diarrhea, and upper respiratory infections) that may kill many more people. Furthermore, multiple donors, each with their own priorities, bureaucratic requirements, and supervisory structures, have created waste and confusion with recipient nations. Lastly, an important concern is the sustainability of these vertical programs, since donors' funds may not prove stable or longlasting. For recipient countries, these inflows have created difficult challenges in the management of the health sector."[23]

It is surprising that such statements appear in a recent IMF document (particularly a Working Paper), given that this institution (the twin of the WB) bears all the responsibility for the promotion of vertical programming and PPP. It is probably sign that the time for these strategies is over and they are no longer defendable. Some rethinking on the issue has also gone on within the technical structure of the GF, the Technical Review Panel, triggered by the Malawi incident.

In Malawi funds were made available only for

drugs and laboratory tests, totally excluding investment in human resources. An already overworked staff was suddenly overwhelmed by an enormous quantity of new work in precarious conditions. The GF action also was in direct contradiction to Malawi government policy which had recently adopted the Sector Wide Approach, another WB recipe (from the late '90s and now out of date) which established that local governments have the prerogative to decide on the destination of donations.[24] Following protests from the government, the GF, in Round 5, conceded an additional fund of $40 million to Malawi. This was used to hire 5,228 community health workers for Malawi's Essential Health Package program which included actions for HIV/AIDS, malaria, tuberculosis, and other illnesses.

Round 5 (2005) permitted for the first time the submission of projects oriented towards the strengthening of health systems. Rwanda was one of the few countries that took advantage of this ability and obtained funds for the promotion of social security. Round 7 also provided this possibility of HSS (Health System Strengthening). In this context the useful and worthy work of Physicians for Human Rights (PHR http://physiciansforhumanrights.org/) should be mentioned including their publication in March 2007 (**Figure 10**) of a guide to promote the use of GF for strengthening health systems.

The GF and its first Executive Director, Richard G. Feacham, also addressed this issue in a Lancet article of August 2006[25] offering a generally positive and highly optimistic picture of GF activities. In the last two paragraphs, however, he is more critical. First, on the question of the "vertical programming versus strengthening the health systems" Feacham ends with a proposal taken from the Shakow Report concerning a division of roles between the GF which is assigned tasks of rapid intervention for specific illnesses, and the WB which is responsible for developing a strategy of long term change in health systems.[26] Second, on the issue of restriction of funds at the disposal of the GF, Feacham states that "*The original vision was to allocate $7b to the GF just for HIV/AIDS*" but *"the results obtained show that it was worthy of more funds"*.

Alexander Shakow, a retired WB official, proposed solutions to the health problems in poor countries in line with established policies of WB and IMF:

> *"The area of expertise of the WB lies in its capacity to reconstruct in a systematic manner the health care sector. This characteristic is fundamental to progress not only for the AIDS action, but also the other diseases and more generally to ensure the sustainability of all the*

Technical support areas	Lead Organizations	Main Partners
1. STRATEGIC PLANNING, GOVERNANCE AND FINANCIAL MANAGEMENT		
HIV/AIDS, development, governance and mainstreaming, including instruments such as PRSPs, and enabling legislation, human rights and gender	UNDP	ILO, UNAIDS Secretariat, UNESCO, UNICEF, WHO, World Bank, UNFPA; UNHCR
Support to strategic, prioritized and costed national plans; financial management; human resources; capacity and infrastructure development; impact alleviation and sectoral work	World Bank	ILO, UNAIDS Secretariat, UNDP, UNESCO, UNICEF, WHO
Procurement and supply management, including training	UNICEF	UNDP, UNFPA, WHO, World Bank
HIV/AIDS workplace policy and programmes, private-sector mobilization	ILO	UNESCO, UNDP
2. SCALING UP INTERVENTIONS		
Prevention		
Prevention of HIV transmission in healthcare settings, blood safety, counselling and testing, sexually-transmitted infection diagnosis and treatment, and linkage of HIV prevention with AIDS treatment services	WHO	UNICEF, UNFPA, ILO
Provision of information and education, condom programming, prevention for young people outside schools and prevention efforts targeting vulnerable groups (except injecting drug users, prisoners and refugee populations)	UNFPA	ILO, UNAIDS Secretariat, UNESCO, UNICEF, UNODC, WHO
Prevention of mother-to-child transmission (PMTCT)	UNICEF, WHO	UNFPA, WFP
Prevention for young people in education institutions	UNESCO	ILO, UNFPA, UNICEF, WHO, WFP
Prevention of transmission of HIV among injecting drug users and in prisons	UNODC	UNDP, UNICEF, WHO, ILO
Overall policy, monitoring and coordination on prevention	UNAIDS Secretariat	All Cospnsors
Treatment, care and support		
Antiretroviral treatment and monitoring, prophylaxis and treatment for opportunistic infections (adults and children)	WHO	UNICEF
Care and support for people living with HIV, orphans and vulnerable children, and affected households	UNICEF	WFP, WHO, ILO
Dietary/nutrition support	WFP	UNESCO, UNICEF, WHO
Addressing HIV in emergency, reconstruction and security settings		
Strengthening HIV/AIDS response in context of security, uniformed services and humanitarian crises	UNAIDS Secretariat	UNHCR, UNICEF, WFP, WHO, UNFPA
Addressing HIV among displaced populations (refugees and IDPs)	UNHCR	UNESCO, UNFPA, UNICEF, WFP, WHO, UNDP
3. MONITORING AND EVALUATION, STRATEGIC INFORMATION, KNOWLEDGE SHARING AND ACCOUNTABILITY		
Strategic information, knowledge sharing and accountability, coordination of national efforts, partnership building, advocacy, and monitoring and evaluation, including estimation of national prevalence and projection of demographic impact	UNAIDS Secretariat	ILO, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, WFP, WHO, World Bank
Establishment and implementation of surveillance for HIV, through sentinel/population-based surveys	WHO	UNAIDS Secretariat

Figure 9. The Implementation Crisis (Source: UNAIDS)

means to improve human health in the poorest countries. This is an intervention area that is complex and difficult and for which no other agency has the power, experience and competence of the WB, including the ability to link the health sector into the macroeconomic and financial context of each country. Similarly the WB would be able to help governments to be more strategic and selective in establishing the priorities in the field of AIDS and other health care activities; thus, encouraging countries to use their own limited capacities to implement those activities that would have the maximum impact on the epidemic"

A proposal of this nature (with due justification in appendices) might seem to be a provocation or even a spoof, but the nature of the source is such that we can be sure that there are serious intentions at foot to institutionalize the role that the WB has *de facto* carried out in the last two decades, i.e. a "global super health ministry."

With regard to the application of macroeconomics to health issues, all the documents proclaim that GF funds should be additional to local government budgets and not substitutes for them. However this is often not the case. In reality (e.g. Mozambique and Uganda[27]) a macroeconomic school of thought (WB and IMF) focuses on the risks to local economies posed by too generous aid funds (increase in inflation, strengthening of local currency, reduced competitiveness for exports, etc.), a syndrome called the Dutch Disease.[28,29]

Lastly, as in general with other types of foreign aid, the issue of sustainability of the Global Fund initiative over time has not yet been explicitly addressed. Rather, some of the examples quoted above (e.g. Malawi) point to the potentially perverse effects of interventions that tend to concentrate on the immediate delivery of goods and services at the expense of human and institutional capacity building efforts aimed at making local health systems and communities at least partly self-sustainable in the long run.

Conclusions

The overview of the last sixty years of international health policy presented in this paper results in the uncomfortable impression of a substantial shift from a publicly funded, comprehensive system approach to ensuring the right of health for all (enshrined in the Alma Ata Declaration) to a privately-influenced, segmented, "just-for-some" provision of health care goods and services typified by the work of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Although it has been promoted as a foundation -- not a U.N. agency or a broader development agency -- and as such acting primarily as a financing mechanism, rather than an implementing agency, the Global Fund "works in cooperation with other groups -- multilateral organizations, bilateral agencies, NGOS, civil society and faith based groups -- that help design programs, provide technical assistance, and otherwise provide support for country programs."[30] As such the Global Fund has been and still is very influential in shaping major international health policy choices that warrant serious scrutiny from the global health community.

The Global Fund's failures described in this paper may be summarized in the limited resources provided as compared to the Fund's declared ambitions, its disappointing results (e.g. in terms of treatment coverage) and its wider harmful consequences due, for instance, to the competitive recruitment of staff in privileged areas of intervention and consequent neglect of other sectors. As these "collateral effects" have long been described since the earliest debate on comprehensive as opposed to selective Primary Health Care in the '80s, the Global Fund story represents in our opinion a further example of how difficult it is to learn from history, that is to aim at an evidence-based international health policy. No health system in the world is actually built on "vertical" programs. Nonetheless because of the GF an unduly strict selective approach to health care delivery has often been introduced into poor countries in the early stages of their development; this has had destructive effects on their health systems, as even the IMF itself has been forced to admit. In this world-view, a false distinction has been perpetuated whereby the legitimate exercise of setting priorities among competing needs has been translated into rigid, self-contained programs that have often jeopardized local health systems.

As it is clear that the different financing mechanisms that support international health policy choices have inevitably a substantial bearing on health outcomes, it is imperative that those mechanisms are adopted that are designed to:

- Ensure universal access to basic health care, giving absolute priority to the poorest and most vulnerable groups in the population (children and women);
- Reinforce whole health systems, instead of basing strategies on vertical programs;
- Strengthen infrastructures, organization and

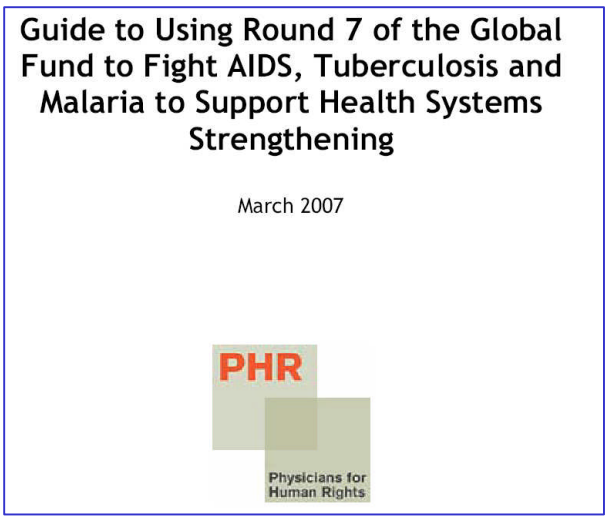


Figure 10

control of programs, purchase and distribution of essential medicines (including antiretroviral drugs for the treatment of AIDS);

- And, above all, invest in human resources within the public health sector through training, motivation, appropriate and just remuneration of health personnel that will help block the drain of staff to the private sector and abroad.

References

1. T.M. Brown, M. Cueto, E. Fee, The World Health Organization and the Transition from "International" to "Global" Public Health, American Journal of Public Health, January 2006, Vol. 96, 62-72
2. WHO-UNICEF, Alma-Ata 1978 Primary Health Care, "Health for all" Series, No. 1, WHO, Geneva, 1978
3. J.A. Walsh, K.S. Warren, Selective primary health care: an interim strategy for disease control in developing countries, New Engl. J. Med. 301, 18, 1979, pp. 967-73. The text was presented at the meeting "Health and Population in Developing Countries", sponsored by the Ford Foundation and the Rockefeller Foundation, held in Bellagio in April 1979.
4. J.P. Grant (UNICEF), The State of the World's Children, 1982-83, Oxford University Press, 1982.
5. K.S. Warren, The evolution of selective primary health care, Soc. Sci. Med., Vol. 26. No. 9. Pp. 891-898, 1988.
6. Conference Summary Statement. In "Good Health at Low Cost" (Edited by Halstead S.B., Walsh J.A. and Warren K.S.), p. 136. The Rockefeller Foundation, New York, 1985, in K.S. Warren, The evolution of selective primary health care, Soc. Sci. Med., Vol. 26. No. 9. Pp. 891-898, 1988
7. A. Green, An Introduction to Health Planning in developing countries, Oxford Medical Publications, Oxford, 1999, p. 62.
8. K.W. Newell, Selective primary health care: the counter revolution, Soc. Sci. Med. Vol. 26, No. 9, pp. 903-906, 1988.
9. The World Bank, Financing Health Services in Developing Countries. An Agenda for Reforms. Washington DC, 1987.
10. J. Grant (UNICEF), The State of the World's Children, 1989, Oxford University Press, 1989.
11. F. Godlee, The World Health Organization: WHO in crisis, BMJ 1994; 309:1424-28
12. F. Godlee, WHO in retreat: it is losing its influence? , BMJ 1994; 309:1491-95
13. F. Godlee, The World Health Organization: WHO's special programs: undermining from above, BMJ 1995; 310: 178-182.
14. The World bank, World development Report 1993, Investing in Health, Washington DC,1993
15. K. Buse, G. Walt, Role conflict? The World Bank and the world's health, Social Science & Medicine, 50 (2000) 177-179.
16. C .J .L Murray, A:K. Understanding DALYs, Journal of health Economics, 16 (1997) 703-730.
17. M. Jowett, Bucking the trend? Health care expenditure in low income countries 1990-1995, Int. J. Plann. Mgmt. 14, 269-285 (1999)
18. M. Whithead, G. Dahlgren, T. Evans, Equity and health sector reforms: can low-income countries escape the medical poverty trap? Lancet 2001; 358:833-36.
19. R. Levine, Open letter to incoming director general of the World Health Organization: time to refocus, BMJ 2006; 333: 1015-7.
20. L. Garret, The challenge of global health, Foreign Affairs, January-February 2007.
21. UNAIDS technical support division of labour. August 2005
22. Editorial, Stopping tuberculosis proves hard to do, Lancet 2007; 369: 965.
23. W. Hsiao, P.S. Heller, What should macroeconomists know about health care policy?, IMF, Working Paper, WP/07/13, January 2007.
24. PHRplus, System-Wide Effects of the Global Fund in Malawi: Baseline Study Report. October 2005. http://www.phrplus.org/
25. R.G. Feacham, An examination of the Global Fund at 5 years, Lancet 2006; 368: 537-540.
26. A. Shakow, Global Fund-World Bank HIV/AIDS programs: comparative advantage study. 2006.
27. G. Ooms, T. Schrecker, Expenditure ceilings, multilateral financial institutions, and the health of poor populations, Lancet 2005; 365: 1821-23
28. L. Garret, The challenge of global health, Foreign Affairs, January-February 2007.
29. C. Ebrahim-zadeh, Back to Basic, Finance and Development, March 2003, Volume 40, Number 1.
30. http://www.cgdev.org/content/opinion/detail/10881/