Round Table

The work of the Commission on Macroeconomics and Health

A central recommendation of the Commission is that both donor countries and developing countries should greatly increase their investments in the health sector. The *Bulletin* asked three members of the Commission if they were optimistic that these new resources would be made available. And if substantial additional resources did indeed become available were they confident that they would be well spent and achieve large and sustainable improvements in health.

More funds for health: the challenge facing recipient countries

Anne Mills[1]

The *Report of the Commission on Macroeconomics and Health* makes a strong case for a substantial increase in investments in health sector development. However, as the *Report* recognizes, we should not ignore the challenges of ensuring that any additional funds are spent effectively. This will require new ways of working on both sides of the donor–recipient country partnership. Here, I want to focus on the challenges that recipient countries will face. This focus should not be interpreted as implying that there are no difficulties associated with the aid instruments — clearly there are — but I will leave others to address them.

A major area of emphasis in the thinking adopted by Working Group 5 of the Commission on Macroeconomics and Health was directed towards achieving a better understanding of the "constraints" to improving health outcomes and how such constraints might be overcome. Constraints were conceived to be conditions that hamper efforts to scale up the provision of effective interventions. Following this reasoning, we developed a typology of constraints (*1*) and examined evidence for strategies that can "buy out" or otherwise ameliorate constraints (*2*). In addition, case studies were prepared on Chad (*3*), the Indian states of Karnataka and Tamil Nadu (*4*), and the United Republic of Tanzania (*5*). We classified factors that constrain the expansion of services into the following categories, according to the area in which they operate: community and household; health services delivery; health sector policy and strategic management; overall public policy; and environmental characteristics. Subsequently, we examined the extent to which the constraints could be bought out by additional funds.

Lack of money is often a governing constraint, especially at the peripheral level, and any attempt to scale up will require significant increases in expenditure. However, the fact that progress is not possible without money does not mean that it is assured if money becomes available. Without a health system that can use money well, spending will not merely be inefficient — it may be useless, or conceivably counterproductive. Most of the world's poorest people lack access to an adequate health system, and this limits all efforts to scale up the provision of effective interventions. In many cases these systemic problems will become governing restraints if spending is quickly increased, driving the marginal benefit of spending on materials or staff to zero.

The removal of structural constraints and the building of new management and service delivery capacity are thus necessary precursors to the scaling up of health interventions. But this does not mean that the need for a commitment to greatly increased funding is deferred or lessened. Instead, money must be used immediately to remove constraints as quickly as possible. There must be system-wide spending in order to make progress, with a deliberate focus on careful phasing of investments that will increase absorptive capacity.

Historically, one way of avoiding the problems of limited capacity has been to adopt a "vertical" approach to a particular intervention or family of interventions. There is great value in the concentration of expertise and commitment that drives such approaches when they are successful. However, such approaches are an *adjunct* to the broader health service rather than an *alternative* to it and, in the context of greatly increased coverage of a significant number of interventions, the benefits of overall strengthening are clear. When spread across a number of interventions, the costs of the three major improvements needed — expanded physical infrastructure, improved training and performance of health workers and managers, and strengthened links between the health system and communities — will be smaller than the costs of trying to bypass the problems of limited capacity.

Finally, it is important to emphasize that our knowledge on how best to scale up health care services, particularly in the most constrained countries, is limited, and that research on this is badly needed. It is also quite possible that many successful experiences are being ignored by experts simply because the settings in which they take place are not well served by mechanisms for communicating and disseminating results. There is thus a need for both further research and for better ways of exchanging ideas on best practice. ■

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2. Oliveira-Cruz V, Hanson K, Mills A. *Approaches to overcoming health systems constraints at the peripheral level: a review of the evidence*. Working

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Additional resources will mean better health

K.Y. Amoako[1]

There is no doubt in my mind that developing countries should increase their investments in their health sectors, a key component of moves to increase the quality of life and reduce the poverty of their citizens as well as to promote economic growth. For too long, a high burden of preventable disease has been a major handicap to the economic performance of poor countries, especially in Africa, as well as taking a high human toll on their populations. In addition to the perennial problems that Africa suffers from malaria, tuberculosis, malnutrition and vaccine-preventable childhood diseases, it is also the region worst affected by the global HIV/AIDS pandemic, which is killing millions of its people, reversing a generation-long trend of increased life expectancy, and seriously harming economic prospects. Overcoming the diseases of poverty will be an essential and significant step towards meeting Africa's international development goals.

Over the past decade, both public and private expenditure on health have increased in Africa. As a percentage of GDP, the continent's health expenditure approximates the global average. But in objective terms, the amounts involved remain far too small, especially in view of the costs of treating HIV/AIDS, even with the recent welcome reductions in the price of antiretroviral treatments. There is a general consensus that Africa needs a major increase in investment in health sector development.

I am optimistic that the required new resources, as recommended by the *Report of the Commission on Macroeconomics and Health*, will be made available, will be well spent, and will achieve large and sustainable improvements in health. Many African countries accept the need to mobilize more resources, and it is a matter of principle and effectiveness that the first dollar in additional spending should come from domestic rather than donor sources. However, the international community will have to meet the greater part of the bill. Best practice development cooperation modalities, such as the New Partnership for Africa's Development, provide a mechanism for effective joint action towards these mutually agreed and mutually beneficial goals. Achieving global health is a global public good: it is in everyone's interests to contain and eliminate infectious agents such as drug-resistant strains of TB and HIV.

As well as a resource constraint, Africa faces a severe capacity constraint. Health systems need to be strengthened from the ground up, so that the additional resources proposed by the Commission can be utilized effectively. As prerequisites, this requires peace and improved governance, as a foundation for building the capacities of health institutions, training more health professionals (and retaining those who have been trained), and establishing partnerships between civil society and the private sector. Fortunately, more and more developing countries, including many in Africa, are moving in this direction. We witness greater transparency in public expenditure and budgetary decisions, ensuring greater compatibility between spending allocations and disbursements, and more effective monitoring by civil society groups. I look forward to better funding for health research, improved medical care, more and better drugs, and more modern health facilities, all of which will contribute to better health, longer and more productive lives, and steady progress in overcoming poverty. ■

Increased health investment: a normative path or a mirage?

Takatoshi Kato[2]

In my view, the *Report of the Commission on Macroeconomics and Health* has succeeded in presenting a coherent normative path for solving the worsening health conditions that prevail in many low-income developing countries. The logical framework adopted in the *Report* is strong enough to convince sceptics that, if maximum contributions are obtained from all stakeholders of low-income countries, donor countries, and international institutions, investing in health can make this world truly different from what it is today.

There is no question that the end objective of the *Report*'s proposals is desirable. Nevertheless, translation of its vision into results is by no means certain; and some individuals might even claim that it is not realistic.

I can think of several reasons why a nationwide close-to-client (CTC) system (health centres, health posts, and outreach services from these facilities), as proposed by the Commission in its *Report*, could turn out to be something like a mirage. First, the enormous human resources needed, clearly a "must" for making the system operative, might not be realistically available, even in the medium term. Second, establishing a nationwide CTC system requires extraordinary dedication by the governments of low-income developing countries and presents them with a dilemma: such governments might not feel inclined to take up the challenge involved unless they are sufficiently convinced they can depend upon secular flows of enormously scaled-up donor funding.

There are other criticisms that can be raised. For example, examining the situation from the point of view of

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the donors, we find that current domestic health expenditures in G7 countries are around 10% of their GDP (ranging from 6.7% in the United Kingdom to 13.0% in the USA), according to the 2001 World Development Indicators. Thus, G7 donor countries that scale up by 0.1% of GDP their investments in health care in low-income developing countries (as proposed by the Commission) will be faced with an additional annual bill of roughly 1% of their existing domestic expenditures on health. I have no idea how the electorates of G7 countries will react to this idea. The *Report* estimates conservatively that by 2015 an economic gain of at least US$ 180 billion per year will result from the scaled-up annual donor contributions that it is proposing. Those benefits would accrue not only to people in low-income developing countries but also to the global community at large. In this context, it is important that taxpayers in G7 countries be made aware of the tangible and direct benefits that they will derive if the Commission's recommendations are followed by their governments.

Now that the *Report* has been published, its recommendations need to be widely disseminated so that most countries can be inspired into action and support its vision. Luckily, there will be ample of opportunities for this to happen in 2002. The International Conference on Financing for Development, to be held on 18–22 March in Monterrey, Mexico, is sure to receive worldwide publicity; it will be an ideal opportunity to draw the attention of world leaders to the findings of the *Report*. And, on a personal level, I will be attending the Annual Meeting of the Board of Governors of the Asian Development Bank, in Shanghai, China, in May, and will take this opportunity to introduce to a wider Asian audience to the key messages of the *Report*. ■