



INTERNATIONAL BUDGET PARTNERSHIP
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Budget Brief

Year 01. No.4. 2008

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Towards a Global Health Fund: Extending the Health Finance Revolution of the Fight against AIDS to General Health Services Gorik Ooms, Institute of Tropical Medicine, Antwerp

The Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) established an international mechanism to finance health services that were previously considered unaffordable or unsustainable for the poorest countries. Countries with the means to assist contribute to the Global Fund, and those in need draw from it. This is very similar to national health finance systems, with the financial risk of individuals getting sick and needing treatment being spread over a large pool of member-contributors.

The Global Fund offers a model for a global fund for general health systems and services, or comprehensive primary healthcare, as defined 30 years ago by the Alma Ata Declaration.¹ A Global Health Fund, to which rich countries would contribute (in accordance with their means) a sufficient amount of funding to help finance comprehensive primary healthcare in poor countries (in accordance with their needs), is not difficult to imagine. Without replacing national social health protection mechanisms, it could provide an international foundation on which these national mechanisms could be built.

Financing international social health protection: the Global Fund to Fight AIDS, Tuberculosis and Malaria

A mechanism that was different from existing development channels was needed to make an international perspective on AIDS treatment a reality. In 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) was established.

The Global Fund finances treatment in countries that will likely not be able to replace international funding with domestic resources, without expecting recipient countries to “take over” the financial burden of treating these diseases. Its proposal form mentions explicitly: “Applicants are not required to demonstrate financial self-sufficiency for the targeted interventions by the end of the proposal term.” This implies a commitment to continued financing after the end of the proposal term.

¹ The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care, Almaty (*formerly Alma-Ata*), presently in Kazakhstan, September 6-12, 1978. It expressed the need for urgent action by all governments, all health and development workers and the world community to protect and promote the health of all the people of the world. It was the first international declaration underlining the importance of primary health care. To read more:

http://en.wikipedia.org/wiki/Alma_Atta_Declaration

This implicit commitment to sustained financing was confirmed by the United Nations General Assembly. Its Special Session on HIV/AIDS of June 2006 led to a declaration in which member states committed themselves “to supporting and strengthening existing financial mechanisms, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as relevant United Nations organizations, through the provision of funds in a sustained manner” (emphasis added). Hence, the affordability and sustainability of AIDS treatment no longer depends on the financial capacity of affected countries, but on the capacity of the global economy.

The Global Fund became, de facto, an international social health protection mechanism.

Changing the affordability and sustainability paradigm: the fight against AIDS

Which health services are affordable and sustainable? The answer depends on the perspective one uses. Should we look at the financial capacity of the individual needing healthcare? Should we look at the capacity of the country where this individual lives? Or should we look at the capacity of the global economy to finance healthcare?

The annual income of an individual living in a poor country might be US\$ 500 or lower. The individual’s willingness and ability to pay for healthcare would probably not exceed two weeks of income (4 percent), or US\$ 20. Health services costing more than that amount most probably would not be used.

If we look at the capacity of the country in which this person lives, the answer changes. Because of burden-sharing — through national social health protection mechanisms — more expensive health services can become affordable and sustainable. Not all of a country’s people will need the complete package of health services every year, and thus a package of health services that costs about US\$ 100 per patient per year may end up costing no more than US\$ 20 per person per year.

If we look at the global economy, the answer to our question about affordability and sustainability changes dramatically. The World Bank estimates the sum of the 2006 Gross Domestic Product (GDP) of all countries to be about US\$ 48,000 billion, or an average GDP per person per year of about US\$ 7,500. If we assume that the global economy can afford to spend the equivalent of 4 percent on health — which is far less than what most countries are currently spending — then a health expenditure level of US\$ 300 per person per year would seem easily affordable and perfectly sustainable. Furthermore, since not all people would need the complete package of healthcare every year, health services costing up to US\$ 1,500 per patient per year may be both affordable and sustainable.

Table 1: Different perspectives on affordability and sustainability of health services

Perspective	Economic product per person per year	Cost of affordable health services per <i>person</i> per year without burden-sharing	Cost of affordable health services per <i>patient</i> per year with burden-sharing
Individual living in low-income country	US\$ 500	US\$ 20	-
Low-income country	US\$ 500	US\$ 20	US\$ 100
Global economy	US\$ 7,500	US\$ 300	US\$ 1,500

Is it realistic to assume that one day our global decision makers will use this international perspective? In fact, it already happened for the fight against AIDS. However, as the World Bank's "Health Financing Revisited – A Practitioner's Guide" explains: "Sustainability has generally been described in terms of self-sufficiency." This paradigm imposes a national perspective on affordability and sustainability. International financial support is at best temporary — self-sufficiency is the ultimate goal. Therefore, when AIDS activists demanded treatment for all people living with AIDS (costing at least US\$ 500 per patient per year, at that time), including those in the poorest countries of the world, their demands were initially rejected as unaffordable and unsustainable. But AIDS activists were not satisfied with this answer: even if domestic resources were insufficient in some countries, surely the world was rich enough.

The so-called Harvard Consensus Statement of April 2001, which became the blueprint for the Global Fund, was very explicit: AIDS treatment may be too expensive for some countries, but it was cheap for the global economy. As self-evident as it may have sounded, it was in fact a revolutionary shift in how people thought about health finance.

What would it cost?

In 1978 the Alma Ata Declaration laid out an ideal of comprehensive primary health care, which was abandoned because it seemed unaffordable and unsustainable, at least for the poorest countries in the world. This may have been true if one looked only at domestic financing capacity. But, as mentioned above, the fight against AIDS effectively changed the paradigm of affordability and sustainability. Would the ideal of comprehensive primary healthcare still fail to pass the affordability/sustainability test if one uses the international perspective?

There are no recent estimates about the costs of comprehensive primary health care. Those that come closest are provided by the Commission on Macroeconomics and Health (CMH), established by the former World Health Organization (WHO) Director-General Gro Harlem Brundtland in January 2000.² In December 2001 the CMH issued its final report that estimated that the interventions required to meet the health-related Millennium Development Goals (MDGs) in low-income countries would require about US\$38 billion per year, by 2015. These estimates assumed that low-income countries themselves would substantially increase their domestic contributions, as well.

The World Bank estimates the sum of the 2006 GDPs of all high-income countries that are members of the Organisation for Economic Co-operation and Development (OECD) at about US\$ 35,000 billion. Therefore, it would take only a little bit more than 0.1 percent of the sum of the GDP of OECD member states to finance US\$ 38 billion per year.

It is not unusual for high-income countries to spend the equivalent of 7 or 8 percent of their GDPs on national social health protection. According to the National Health Accounts database of the WHO, total expenditure on health in France was 11.2 percent of GDP in 2005, of which 79.9 percent was government expenditure (8.9 percent of GDP); for Germany it was 10.7 percent of GDP, of which 76.9 percent was government expenditure (8.2 percent of GDP); and for the UK it was 8.2 percent of GDP, of which 87.1 percent was government expenditure (7.1 percent of GDP). Therefore, if high-income countries contributed only 1.5 percent of their national social health protection budgets to an international social health protection mechanism, sufficient funds would be available to realise the health-related Millennium Development Goals as a first major step towards comprehensive primary healthcare for all.

² The CMH report is available at <http://www.cid.harvard.edu/archive/cmh/cmhreport.pdf>

It would not be necessary to completely internationalise social health protection. Internationalising only a small share of current national health protection budgets of high-income countries would be sufficient to create a foundation on which national social health mechanisms in low-income countries could be built, or a permanent global solidarity or burden-sharing in health. Over time, low-income countries can become middle-income countries (no longer receiving from, but not yet contributing to, a Global Health Fund), or even high-income countries (contributing to a Global Health Fund), while some high-income countries could become middle-income countries (no longer contributing to, but not yet receiving from, a Global Health Fund), in accordance with the principles on which social health protection is based: contributions in accordance with needs, and drawing rights in accordance with needs.

There is a human rights basis for international social health protection

Creating an international social health protection mechanism is not only a matter of moral obligations or a means to realise efficient primary health care delivery. It is also, first and foremost, a matter of meeting international legal obligations.

Two covenants completed the Universal Declaration of Human Rights: the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. The latter prescribes in Article 1(2): “All peoples may, for their own ends, freely dispose of their natural wealth and resources without prejudice to any obligations arising out of international economic co-operation, based upon the principle of mutual benefit, and international law” (emphasis added); and in Article 2(1): “Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means” (emphasis added).

The Committee on Economic, Social and Cultural Rights, which was created to oversee efforts to implement the Covenant, added in regard to the right to health: “For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide international assistance and cooperation, especially economic and technical, which enable developing countries to fulfil their core and other obligations” (emphasis added).

Therefore, inasmuch as some countries need financial assistance to realise the right to health, international assistance is not a matter of charity but, rather, one of international legal obligations. Individual states have the primary responsibility to realise the right to health for their people, but once they have exhausted their domestic resources, they can claim assistance from other states. In other words, they become rights-holding states, while wealthier states (those “in a position to assist”) become duty-bearing states — they bear a secondary responsibility to realise the right to health for the inhabitants of states needing assistance.

Conclusion

Money alone cannot buy additional health workers and infrastructure, but long-term reliable financial assistance can. Take health workers, for example: commitments that are sufficiently long-term enable countries to increase training capacity (two to three years), to train additional health workers (three years for nurses, six years at least for medical doctors), and to give them a reasonable career perspective (10 to 15 years).

Bilateral grants — typically valid for three to five years — cannot solve this problem. As a result they get stuck in a vicious circle: additional aid becomes available, but the human capacity needed to transform it in better health services is lacking, therefore the

additional aid does not produce the expected results and donors become frustrated (and might discontinue their support). A Global Health Fund could provide international health aid for many decades, and that would allow poor countries to solve their health systems' problems.

It is possible to reconsider concerns about the affordability and sustainability of general health services from an international perspective. The internationalisation of only a share of national social health protection spending, through the creation of a Global Health Fund, would be sufficient to realise the health-related MDGs. It would create an international social health protection foundation on which even the poorest countries can build national social health protection mechanisms.