EXECUTIVE SUMMARY

Report of the Special Meeting of Working Group 1 and the CMH on "Priorities for Health Investments in Africa in the Context of Alternative Strategies for Poverty Reduction"

Bellagio, Italy, 12-16 February 2001

I. BACKGROUND OF MEETING

The Commission on Macroeconomics and Health (CMH) is a two-year World Health Organization (WHO) supported initiative launched in January 2000 to study how concrete health interventions can lead to economic growth and reduce poverty. The Bellagio meeting was convened to provide a forum for dialogue with African policy makers and practitioners on the current status and potential for investments in health (including family planning and nutrition), education, and other sectors to accelerate economic growth and poverty reduction in Africa.

Participants at the meeting included academics, practitioners and policy makers from health and finance ministries of African countries (Ghana, Nigeria, Rwanda, Senegal and South Africa) as well as representatives of donor agencies (Swedish SIDA and U.K. DFID) and international agencies (ECA, IMF, UNDP and WHO). Several members of CMH (two Commissioners, two Working Group Chairs, the Executive Secretary and the Senior Economist/assistant to the Chair) were also in attendance. The chair of CMH, Professor Jeffrey Sachs, presided over the meeting (see appendix 1 for participation list). The Rockefeller Foundation funded and hosted the event.

II. SUMMARY OF VIEWS

This document summarizes many of the views and arguments expressed by participants in the meeting papers, presentations and discussions. It is not meant to be a consensus statement. Indeed, obtaining such a consensus was not the objective of the meeting. This document includes the main points made in the chair's oral summary and elaborates on several of the issues he highlighted. The views of the African participants are given greater prominence since an explicit objective of the meeting was to engage African professional and political leadership.

The meeting began by noting that it was critically important that the analytical work and findings of the Commission should be informed by country and region specific experiences. The Bellagio meeting thus provided an excellent opportunity for the Commission to engage members of the African constituency in order to obtain a fuller understanding of the issues impacting on health investment and related decisions in health and poverty reduction. Accordingly, the meeting discussed a number of country experiences, focusing on the interrelations between health investment, economic development and poverty in the context of Africa, but more particularly on what is or is not working in the way of policy instruments and interventions. The following is a summary of the key points made by participants.

A. The pervasiveness of the crisis

All the country presentations and the general discussions that followed them testified to the reality of a deepening and pervasive health and economic crisis. The presentations and discussions underscored the urgent need to scale up resources and improve the quality of policy and technical responses to the crisis. In this regard, it was also felt by some that the work of the Commission ought to be put in the context of the International Development Goals (IDGs). Without specific and large-scale interventions in disease control and in building shattered public health systems, the IDGs would not be met (see appendix 2 for relevant IDGs).

There was general agreement that in spite of the sheer enormity and complexity of the crisis, there is encouraging evidence that there is in Africa the political will to find solutions. This is evident from the many important attempts at health policy reform in the region generally.

B. Constraints and drawbacks in current efforts:

1. Financing

It was clear from the country-specific experiences that one of the major constraints in current efforts is one of financial resources. The general sense of the meeting was that there is some latitude for increased funding for health from domestic resources and that although the gains are unlikely to be significant, greater efforts at improving efficiency were still critical. A number of participants noted that there was a need to pay greater attention to country-specific conditions as well as the needs of the poor in the choice of instruments for stepped-up domestic resource

mobilization. In this regard, it was noted that the introduction of user fees can, as the presentation from Ghana showed, lead to a dramatic decline in hospital attendance and a consequent fall in access even as it fails to generate significant additional resources.

Participants generally agreed that much larger flows of official development assistance in addition to debt relief under HIPC would be needed to deliver the scale of resources required for the attainment of the minimum standards set by the IDGs. It was recognized that the African countries needed to establish transparent financing and monitoring systems to assure improved accountability for the use of donor funds.

2. Human resources

Another major constraint in current reform efforts is the training and retention of health personnel. Several participants stressed the importance of training and retaining nurses and public health specialists. The meeting heard a presentation from the South African experience suggesting that a good program of training in public health could be provided in the range of US$2000 per head, and that training programs can be scaled up dramatically at relatively little cost. In the area of training, international financing could be key. For example, donor support could enable a significant and rapid scaling up of the training in public health of nurses and doctors throughout Africa.

The meeting noted that with globalization bidding up prices in the labor market, the loss of doctors and skilled medical personnel often trained at public expense is heavy and by all indications getting worse. The countries themselves have a responsibility to ensure that they provide moral incentives in the form of an overall political environment that rewards merit. However, financial incentives appeared to all participants to be the decisive factor. Governments have an increasingly difficult time attracting qualified health professionals to rural areas in particular. By all accounts, the brain drain is having a trenchant impact on public health provision, in rural and urban areas alike, as doctors and nurses move to the private curative sector, or emigrate abroad in increasing numbers.

The meeting urged that the Commission explore appropriate ways in which the international donor community might assist national governments in addressing the shortage of health care professionals and workers.

3. Policy

Attention was drawn to a number of policy weaknesses in traditional health sector programs. The African participants in particular felt strongly that programs that almost exclusively focus on primary health care, and by implication neglect secondary and tertiary facilities, are misguided. While it is undeniably necessary to invest in primary health care facilities, it is important that a proper balance be struck in the overall context of the prevailing country-specific conditions. In this regard, several participants underscored the key fact that in most African countries the tertiary institutions are not only treatment centers of last resort for the majority, but are also the main (and in some cases the only) centers for training doctors and other personnel, and for medical and public health research. In a number of cases reported, it is the reproduction of these high-level skills in the tertiary institutions that prevented the complete collapse of the health-care systems as doctors left the public service in large numbers. Thus, in the view of these participants, it is not a matter of funding one sector to the neglect of the other, but of promoting both, making sure of course that tertiary institutions play the desired role and serve all sections of the population.

A number of participants noted that inflexibility in the advocacy of "vertical" or "horizontal" approaches must, as with the primary-tertiary health care split, give way to greater pragmatism. Both vertical and horizontal aspects of the health delivery systems are needed in almost all cases and the weighting of each aspect must depend on country circumstances and on the particular service being delivered.

There was significant agreement, for example, that categorical programs for key diseases are essential. Thus, there was strong support for self-standing programs for HIV/AIDS, malaria, tuberculosis, and Guinea worm, among other programs. These categorical programs are vital for mobilizing leadership, creating a pool of trained specialists within the country, carrying out detailed surveillance, establishing sound epidemiological protocols, maintaining political energy to support a high level of service delivery, and in drawing resources as necessary from outside the narrow health sector. Community-based control of malaria, for example, depends on a national cadre of trained entomologists and epidemiologists, who can help to monitor mosquito breeding sites, understand the biting behavior of the vectors, and recommend complementary approaches of vector control (bednets, residual spraying, application of larvicides, etc.).

In well- targeted cases, the South African experience showed for instance that infant mortality could be lowered dramatically at relatively little cost. This required a specific form of integrated management protocols (GOBI – or growth monitoring; oral rehydration; breastfeeding; and immunization) in the case of the South African success story.

4. Insufficient engagement of African technical and academic professionals

There was a strong feeling among the African participants that the region's academic institutions and technical expertise of African origin could add enormously to the design and implementation of policy. For example, the academic sector was often excluded from the policy debate. Academic centers of excellence have existed in Africa, but they are currently cash-strapped, and are in many cases neglected by both government and donor institutions. Policies are often initiated without consultation or involvement of the leading academic medical, public health and economics faculties. This undermines the quality of the programs, and equally important, fails to cultivate a core local constituency that can play a key role in governance of public-sector health programs. The meeting's attention was drawn to the importance of inter-African cooperation through exchanges at the health, scientific and policy levels in order to fully harness the potentialities of the African countries themselves.

C. Donor contributions to the effort

In spite of the tremendous effort that has gone into the reform of development cooperation (including aid coordination) over the past few years, the country experiences suggest that in many instances donor assistance to the health sector is still marked by frequent shifts in policy and focus and an absence of a long-term perspective consistent with the countries' own strategies. Moreover, individual donors still tend to support individual favored projects, rather than large-scale public health interventions. Scaled-up health interventions supported by additional donor funding would therefore need to be coordinated by the countries themselves, and above all must be undertaken in support of the countries' own programs and strategies. The meeting was unanimous in stressing the fundamental role of country leadership, from both the public and academic sectors, in health policy reform and implementation.

The country programs would be scrutinized, of course, by international expert reviews to ensure that the programs are consistent with international best practices. The programs should also be monitored for their effectiveness. Independent monitoring and evaluation, by local experts where they are available, should be a standard built into all major country programs.

D. Comments on past health-sector interventions

Several factors have contributed to a dissociation between priorities in economic policy reforms and the needs of public health and medical care. This dissociation has both domestic and international origins. The following factors were identified by one or more members of the group.

1. Past development strategies in the 1980s and 1990s, under the supervision of the international institutions, were not based on the complementary pillars of social development and economic reform. Structural adjustment programs neglected the social dimension of development, thereby exacerbating extreme financial stress on the health sector. Even with initiatives such as the Program Action to Mitigate the Social Costs of Adjustment (PAMSCAD) in Ghana, the financial squeeze in the public health sector was too severe to protect the social development agenda.

2. Standard economic analyses of health interventions focused on short-term and non-comprehensive measurements of the health-development linkages. Such analyses neglected long-term microeconomic, macroeconomic, and demographic effects of poor health. Such limited analyses also encouraged the view that only very low-cost interventions (e.g. $50 per life year saved) should be adopted, even though in the rich countries the standards for interventions were of higher orders of magnitude (e.g. $100,000 per life year saved in mainstream U.S. analyses).

3. More recently, the rapid move to channel all donor funds through the headquarters of ministries as part of a "common basket" approach has, in some cases, resulted in yet another swing from one policy extreme to the other. Instead of a sudden centralization of donor funds, the need is for gradual reductions of the plethora of donor programs that are not fully coordinated by headquarters while simultaneously building the required capacities at the center to disburse donor funds to sub-national levels and monitor the donor-supported

programs. The latter approach is less likely to reverse some of the progress that has been made towards decentralization as part of national primary health care strategies.

E. Other critical and relevant observations

1. In the absence of appropriate investment responses, there has been an erosion of gains in life expectancy, in many countries very steep. This has been caused by multiple factors including: the spread of chloroquine-resistant plasmodium, without a new and viable anti-malarial strategy; the dearth of epidemiological surveillance and research; the collapse of basic health services, including brain drain of doctors and nurses; and the lack of any treatment strategy for HIV/AIDS.

2. Reduced health manpower resources has become a serious threat to efforts to improve health and is the consequence of: (a) AIDS – in Southern Africa a significant proportion of medical personnel, including nurses, die of AIDS before they complete their training; (b) poor remuneration and incentives, in absolute terms and relative to the global market, coupled with the active recruitment efforts of developed countries for medical personnel that result in the emigration of trained health professionals; and (c) attrition due to inadequate career prospects.

3. There has been a declining capability of health manpower as a consequence of: (a) the trend towards limited – and insufficient – training of health staff, such as six-months training for village health care workers (rather than one-year training for qualified nurses to become public health nurses) that fails to provide the capacity to engage in self-education and unsupervised problem solving. Retraining after a relative short time period is then required in order to ensure the effectiveness of this type of health worker, but such retraining is often not available.

4. Technical assistance, which constitutes about a third of all official development assistance flows, could usefully be unbundled, made more transparent and better targeted with the gains going to support capacity development in the health sector.

F. Required international action in the light of current knowledge and public opinion

The African participants agreed on a basic set of recommendations for the international community.

1. Provision of an appropriate level and modality of development assistance to Africa is urgent. The justification for dramatic increases in aid flows for health investment and radical departure from the dominant forms of donor assistance include the following:

   (a) Developed countries are far from achieving the target of 0.7% of their GNP for development assistance. Assistance to Africa from a number of rich economies has been far less than to selected middle-income economies, such as those of the Middle East and Eastern Europe.

   (b) There has been an absence of massive donor effort comparable to the "Marshall Plan" in the face of social and economic devastation caused by HIV/AIDS in Africa, a disaster similar to that caused by war or national catastrophes in other regions.

   (c) In the short and medium term, highly indebted countries lack the economic means to overcome current fiscal constraints. Initiatives such as HIPC will make available at best a small fraction of the required resources for improvements in the health infrastructure and the provision of public health and medical care to African populations. Estimates presented at the meeting suggest that HIPC might save around $700 million per year in actual debt service flows, of which perhaps 10 percent, or $70 million, will be directed at the health sector. An estimate provided of Africa's need for donor support for public health, including disease control, was in excess of $10 billion per year. Thus HIPC is only a small, albeit necessary, part of the story.

   (d) The prescriptive and oscillating policy positions of donor agencies has contributed to disengagement of African professionals in the policy making process and has frustrated the evolution of long-term oriented polices tailored to the extreme economic and social realities of Africa. It has produced alternating periods of concentration on one of the pillars of development with the neglect of the other. Cold War politics neglected issues of governance and helped set the stage for the current problems in this area. The myopic

focus on economic reforms and fiscal restraint during the era of structural adjustment, to the neglect of the social sectors, undermined public health. The structural adjustment period has been followed by a swing in the other direction, focusing heavily on resolving symptoms and partial causes of social under-development, with relatively less attention to sound long-term development strategy.

2. There is a need to redress the adverse consequences of economic globalization on trade in health-related commodities. Action required in this regard includes the following:

   (a) Resolution of intellectual property rights issues preventing access to essential medicines, including the drugs needed for treatment of HIV/AIDS (including treatment of opportunistic infections, and anti-retroviral therapies). The introduction of highly active anti-retroviral therapy (HAART) into Africa on a large scale is urgently needed, and requires a massive political and financial investment on the part of the international community.

   (b) Costing of health investment using true market prices for human resource inputs – that takes a realistic view of the extent of brain drain. Doctors and nurses in Africa need much higher salaries, to give incentives for them to remain in Africa. Realistic salaries, however, must be coupled with a commitment of donors to fund this component of health intervention as part of development assistance.

III. CONCLUSION

All participants agreed that the discussions had been frank and stimulating and had provided many helpful insights into the political economy of health sector reforms in Africa and the many factors that affect the prioritization of investments in the sector. Many felt that the Commission could make an invaluable contribution to the search for increased health sector financing and for more efficient policy instruments if its findings were informed by country and region-specific experiences.

Bellagio Executive Summary Appendix 1:

Participation List

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Bellagio Executive Summary Appendix 2:

Relevant International Development Goals (IDGs)

•Reduce extreme poverty by half by 2015

•Universal primary education by 2015

•Eliminate gender disparity in education by 2005

•Reduce infant and child mortality by two-thirds by 2015

•Reduce maternal mortality by three-quarters by 2015

•Universal access to reproductive health services by 2015