WFPHA: World Federation of Public Health Associations

www.wfpha.org

Journal of Public Health Policy (2010) **31,** 100–109. doi:10.1057/jphp.2009.54

THE FEDERATION'S PAGES

Editorial: Global health initiatives and the new dichotomy in health systems

The WFPHA proposes to lead a discussion about global aid and Global Health Initiatives (GHIs), beginning in these *Federation Pages*. In this issue (*JPHP* 31.1), we have invited authors from the Department of Public Health from the Institute of Tropical Medicine Antwerp, Belgium, and from the Federal Ministry of Health, Addis Ababa, Ethiopia to discuss the 'New dichotomy in health systems' strengthening and the role of global health initiatives'. Next, the WFPHA will take a very active part in the upcoming Geneva Forum, 19–21 April 2010, entitled *Globalization, Crisis & Health Systems: Confronting Regional Perspectives* (http://www.ghf10.org/). The problems of GHIs will be the topic of a special session. In it, the organisers will integrate views of researchers, such as the contributors here, along with those of GHIs professionals, and participants from recipient countries.

The questions underpinning foreign aid are many, and cover a wide area. We have to look at the ethical and moral assumptions behind the belief that foreign aid 'does good'. We must ask: 'Where has aid failed?' and then explain why. As has Roger Riddell,[1] we will ask not only if aid works, but also, 'Is it needed?'. GHIs and foreign aid remain fragmented, suffering from lack of coordination among donors. The under-resourced, local governments are burdened by duplicative reporting requirements, with each donor insisting upon different forms and formats to collect the same sorts of information. Even after the international consensus conferences in Paris

and Accra to confront this challenge, progress is not encouraging (as demonstrated by the Organization for Economic Cooperation and Development (OECD) in its 2008 Survey on Monitoring the Paris Declaration).

Why does harmonisation of foreign aid remain so difficult after the declared willingness of large donors to coordinate in this way? Several reasons are likely. For example, each donor has its own agenda, all must demonstrate accountability to their governance bodies and many fear mismanagement by recipients. Many recipients prefer competition among donors, with the view that the competitive dynamic may yield more resources. They worry that greater visibility of harmonised aid might lead to reduction, not only of funding, but also of recipient autonomy and leadership role for setting the development and health agendas for their own countries.[2]

In this way foreign aid may undermine the countries' sovereignty and weaken the legitimacy of the state. If the attention of the citizens focuses on donor projects, their willingness to support their own states may decrease.

These multiple influences are intensified by the recent and severe shock in the international financing system. The economic shockwaves will influence attitudes among participants of both groups: within the GHIs, and within the recipient countries or organisations.

By taking the example of Ethiopia, the contribution below by Ooms *et al* shows why the new dichotomy may be decidedly unhelpful. It leads these authors to mention: 'in addition to a global fund to fight infectious diseases, Ethiopia would need a global fund to fight child mortality, a global fund to fight maternal mortality, a global fund to fight neglected tropical diseases and a global fund to strengthen health systems, or even better: a Global Health Fund'.

Bettina Borisch, MD, MPH, FRCPath,
Special Editor

Contact:
Institute of Social and Preventive Medicine
University of Geneva
University Medical Center
1, rue Michel Servet
CH – 1211 Geneva 4
SWITZERLAND
E-mail: Bettina.borisch@unige.ch

1. Riddell, R. (2007). *Does Foreign Aid Really Work*. Oxford: Oxford University Press.
2. Deutscher, E. and Fyson, S. (2009). Committing to effective aid: Why can't donors walk their talk? wwwl.worldbank.org/devoutreach/articleid522, accessed 1 December 2009.

The New Dichotomy in Health Systems Strengthening and the Role of Global Health Initiatives: What Can We Learn from Ethiopia?

Introduction

The report of the first working group of the *High-Level Taskforce on Innovative International Financing for Health Systems* (Taskforce) reveals two different approaches to health systems strengthening (HSS) in low-income countries (LICs).[1] One approach, developed by the WHO, is a plan for more health centres, staffed with 'classic' health workers: physicians, nurses and midwives.[2] The other approach, has been developed by the World Bank, UNICEF, UNFPA, and the Partnership for Maternal, Newborn and Child Health. The 'Marginal Budgeting for Bottlenecks (MBB) approach', as it is called, requires more health posts and health workers with more basic training.[3]

These approaches are not new. For the first time though, a taskforce co-chaired by the United Kingdom and the World Bank presents them as *alternative* approaches, rather than *complementary* approaches. The estimate of additional costs for HSS in LICs withheld by the Taskforce implicitly assumes that countries will adopt either the WHO approach, or the MBB approach, but not both.

We fear that we are witnessing the genesis of a new dichotomy in the global health arena, one that encompasses several old dichotomies. Acknowledging that the evidence in favour of one or the other approach is lacking – if a choice between them had to be made – we fear that this new dichotomy contains all the paralyzing forces of the old dichotomies it encompasses. As a matter of principle, and learning from Ethiopia's recent HSS efforts, we believe that each country should be encouraged to develop its own combination of both approaches.

We are particularly interested in the role Global Health Initiatives (GHIs) could play regarding this new dichotomy. Aiming for rapid disease-control results, GHIs might encourage LICs to adopt the MBB approach.

Conversely, having the ability to provide long-term reliable international funding, GHIs might enable the WHO approach, or a combination of both.

The new dichotomy and the old dichotomies it encompasses

Figures can probably illustrate the new dichotomy better than comments (Table 1). The WHO approach requires more health centres staffed by physicians, nurses and midwives; the MBB approach requires more health posts staffed by community health workers. As a result, the MBB approach is cheaper (additional costs per annum in 2015: US$36 billion versus $45 billion), and strikingly less demanding in terms of recurrent costs ($17 billion versus $43 billion).

The new dichotomy thus encompasses many old dichotomies:

1. between facility-based health services and community-based health services;
2. between comprehensive training of fewer health workers and basic training of more health workers;
3. between different visions of sustainability: one holding that international health funding could and should be sustainable, at least in LICs,[4] the other insisting that only domestic health funding is sustainable;
4. between comprehensive primary health care (PHC) and selective PHC,[5] since comprehensive PHC was abandoned because it was considered unaffordable for LICs;[6]
5. between 'horizontal' – that is, non-disease-specific – and 'vertical' – that is, disease-specific – health services, in as much as one cannot expect basically trained community health workers to be able to respond appropriately to the entire spectrum of health problems.[7]

Table 1: The new dichotomy in figures: Additional resources needed to strengthen health systems in 49 low income countries[1]

Additional resources by 2015	*WHO normative*	*MBB medium*
Health centres	88 960	12 307
Health posts	0	57 816
Physicians	349 953	35 879
Nurses and midwives	1 699 107	203 013
Community health workers	950 705	1 642 076
Costs per annum in 2015 (US$ billion)	45	36
Recurrent costs per annum in 2015 (US$ billion)	43	17

The rationale behind the new dichotomy

The fact that WHO's normative leadership in HSS is now openly challenged by the World Bank, UNICEF and UNFPA is not a minor issue. What is the rationale behind this new dichotomy?

The first reason might be the new hope that community health workers (CHWs) can provide the huge step forward needed to achieve the health-related Millennium Development Goals (MDGs) or even make the all important difference needed – across the board. In 1998, Haile Kahssay and colleagues argued that 'community health workers have fallen short of initial expectations'.[8] Since then, however, the deployment of CHWs has again gained popularity. Simon Lewin and colleagues argued that '[Lay Health Workers] show promising benefits in promoting immunisation uptake and improving outcomes for acute respiratory infections and malaria, when compared to usual care. For other health issues, evidence is insufficient to justify recommendations for policy and practice'.[9] In a different article, Joanne Stein and colleague emphasize the essential role CHWs are playing in delivering anti-retroviral treatment.[10] The suspicion that WHO might be institutionally biased towards high-level trained health workers, and therefore reluctant to acknowledge the role of basically trained CHWs, might cause other actors to overestimate the potential role of CHWs.

The second reason might be the WHO's apparent failure to implement its ambitious 10-year health workforce strengthening plan laid out in its World Health Report for 2006.[11] One must admit that none of the 'immediate' interventions, planned for 2006, materialised in 2006, and that it looks increasingly unlikely that the 'mid-point' interventions, scheduled for 2010, will happen in 2010.

The third reason might be old scepticism about the sustainability of international health funding. The World Bank considers that the 'volatility [of development assistance] makes it an unreliable source of funding for permanent increases in recurrent expenditures'.[12] The additional $17 billion for recurrent costs (for HSS in LICs) under the MBB approach would be covered entirely by anticipated increases in domestic health funding, while the additional $43 billion for recurrent costs under the WHO approach would rely partially on sustained international health funding. Perhaps this is the main reason why the World Bank challenged the WHO approach; it simply cannot accept that LICs would rely on international health funding for recurrent costs.

Why the new dichotomy might be unhelpful: The case of Ethiopia, combining both approaches

Ostensibly, Ethiopia's recent HSS efforts followed the MBB approach – using mainly CHWs. But in reality, Ethiopia combined both approaches – including more health facilities (3200 health centres by the end of 2010, coming from less than 700 health centres at the end of 2007),[13] and more highly trained health workers.[14] Ethiopia's Ministry of Health somehow 'lost' physicians in the process of disease-control efforts, but these physicians were often replaced by highly trained health officers, not by the more basically trained health workers.[15]

Ethiopia wants to continue its two-pronged approach. The cost is estimated at $1.9 billion per year (for 80 million people, still less than $25 per person per year). This estimate has been validated by the WHO, World Bank, UNFPA, UNICEF and several donor countries including Ireland and Spain, in the form of a 'Joint Financial Arrangement', according to which Ethiopia would need to spend $1.4 billion per year on health care, in addition to the $0.5 billion it spends on health care at present.[16] About 80 per cent of $1.9 billion per year would have to come from international health funding, and would have to be sustained in the long run.

The Global Fund provides reliable funding to Ethiopia, but only for three diseases. Even so, Ethiopia uses Global Fund funding for HSS purposes such as health centre construction, improving supply chain management and health workforce retention. But Ethiopia cannot count on a Global Fund stretching its mandate, at least not to secure $1.6 billion per year in a reliable manner, considering that the Global Fund is again facing a financing crisis. It cannot count on bilateral international funding either, as bilateral funding has been unreliable in the past. In addition to a global fund to fight infectious diseases, Ethiopia would need a global fund to fight child and maternal mortality, a global fund to fight neglected tropical diseases and a global fund to strengthen health systems, or even better: a Global Health Fund.

The role GHIs could play

In May 2008, the Institute of Tropical Medicine Antwerp, Belgium convened a workshop to review the evidence on the effects of international AIDS response interventions on the broader health systems.[17] The extent to which the international AIDS response strengthens or weakens the

health workforce emerged as the critical issue. The 'Maximizing positive synergies between health systems and Global Health Initiatives research effort of the WHO, also launched in May 2008, confirmed the crucial importance of health workforce strengthening, but found that GHIs investments in the health workforce have been focused on in-service training for disease-specific programmes, task-shifting, and on increasing numbers of less qualified health workers who require limited training.[18]

The WHO approach, requiring doubling or tripling of the number of nurses in some countries, calls for a long-term strategy: develop training capacity first, then train, and finally hire additional health workers.[19] Returns should not be expected within the next five years. Can GHIs adopt such a long-term perspective? The 'Raise it, Spend it, Prove it' slogan of the former executive director of the Global Fund[20] illustrates the pressure to deliver results on the short term under which the Global Fund was and is probably still operating. A 'Raise it, Spend it, Prove it' approach would probably encourage the MBB approach to HSS, more than the WHO approach.

Paradoxically perhaps, while GHIs are somehow pushed towards the MBB approach, they may be the key to enabling the WHO approach. As mentioned above, a crucial difference between them is that, for recurrent costs, the MBB approach relies on domestic health funding, while the WHO approach relies partially on international health funding. Chris Lane and Amanda Glassman argue that international health funding is, in general, unpredictable and 'therefore poorly suited to fund recurrent costs'.[21] But they continue: 'Parts of the new institutional architecture, such as the Global Fund, appear to deliver stable and predictable financing'. The WHO approach to HSS thus depends on GHIs.

Conclusion

Reading the World Bank, UNICEF, UNFPA and the Partnership for Maternal, Newborn and Child Health justification for rejecting the WHO approach to HSS in LICs, and for favouring an alternative MBB approach, recalls the Comprehensive Primary Health Care (PHC) versus Selective Primary Health Care dichotomy of three decades ago. Once again the World Bank and UNICEF join forces against the WHO, proposing something cheaper, and – so they seem to believe – more efficient.

The Comprehensive PHC approach was never formally overruled; the Selective PHC approach was never formally adopted. It was the

willingness of the international community to finance the Selective PHC approach, and its obvious reluctance to finance the Comprehensive PHC approach, that tilted the balance. There is a lesson in it for GHIs: unintentionally, they might tilt the balance towards the MBB approach, away from the WHO approach to HSS in LICs.

Following the recommendation by the Taskforce, the Global Fund, the World Bank, and the Global Alliance for Vaccines and Immunization (GAVI) agreed to create a common HSS funding platform.[22] This common HSS funding platform – or even better, a single Global Health Fund[23] – could finance the recurrent costs needed for a stronger health workforce in LICs in a reliable manner. If so, the new dichotomy between the WHO and the MBB approaches to HSS in LICs could be overcome.[24] It sounds revolutionary, but it would be nothing more than the realisation of the human right to health.[25]

Gorik Ooms, Department of Public Health, Institute of Tropical Medicine, Nationalestraat 155, B-2000, Antwerp, Belgium, E-mail: gooms@itg.be [Contact person]
David Hercot*, Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium
Yibeltal Assefa, Medical Services Directorate, Federal Ministry of Health, Addis Ababa, Ethiopia
Wim Van Damme, Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium

*Corresponding author

References

1. Taskforce on Innovative International Financing for Health Systems. (2009) Working Group 1 Report: Constraints to scaling up and costs, http://www.internationalhealthpartnership.net/CMS_files/documents/working_group_1_-_report_EN.pdf, accessed 4 December 2009.
2. World Health Organization. (2009) Background document for the Taskforce on Innovative International Financing for Health Systems, http://www.internationalhealthpartnership.net/CMS_files/documents/who_background_to_constraints_to_scaling_up_and_costs_EN.pdf, accessed 4 December 2009.
3. World Bank/UNICEF/UNFPA/Partnership for Maternal, Newborn and Child Health. (2009) Health systems for the Millennium Development Goals: Country needs and funding gaps, background document for the Taskforce on Innovative International Financing for Health Systems, http://www.internationalhealthpartnership.net/CMS_files/

documents/wb,_unicef,_unfpa,_pmnch,_background_to_constraints_to_scaling_up_and_costs_EN.pdf, accessed 4 December 2009.
4. Ooms, G. (2008) Shifting paradigms: How the fight for 'universal access to AIDS treatment and prevention' supports achieving 'comprehensive primary health care for all'. *Globalization and Health* 4(11), http://www.biomedcentral.com/content/pdf/1744-8603-4-11.pdf, accessed 4 December 2009.
5. Magnussen, L., Ehiri, J. and Jolly, P. (2004) Comprehensive versus selective primary health care: Lessons for global health policy. *Health Affairs* 23(3): 167–176, http://content.healthaffairs.org/cgi/content/full/23/3/167, accessed 3 December 2009.
6. Maciocco, G. (2008) From Alma Ata to the global fund: The history of international health policy. *Social Medicine* 3(1): 36–48, http://journals.sfu.ca/socialmedicine/index.php/socialmedicine/article/view/186/380, accessed 3 December 2009.
7. Ooms, G., Van Damme, W., Baker, B., Zeitz, P. and Schrecker, T. (2008) The 'diagonal' approach to global fund financing: A cure for the broader malaise of health systems? *Globalization and Health* 4(6), http://globalizationandhealth.com/content/pdf/1744-8603-4-6.pdf, accessed 3 December 2009.
8. Kahssay, H., Taylor, M. and Berman, P. (1998) *Community Health Workers: The Way Forward*. Geneva, Switzerland: World Health Organization.
9. Lewin, S. *et al* (2005) Lay health workers in primary and community health care. *Cochrane Database of Systematic Reviews* (1). Art. No.: CD004015, DOI:10.1002/14651858.CD004015.pub2.
10. Stein, J., Lewin, S. and Fairall, L. (2007) Hope is the pillar of the universe: Health-care providers' experiences of delivering anti-retroviral therapy in primary health-care clinics in the Free State province of South Africa. *Social Science & Medicine* 64(4): 954–964.
11. World Health Organization. (2006) *The World Health Report 2006: Working Together for Health*. Geneva, Switzerland: World Health Organization, http://www.who.int/whr/2006/whr06_en.pdf, accessed 4 December 2009.
12. World Bank. (2004) *The Millennium Development Goals for Health: Rising to the Challenges*. Washington DC: World Bank, http://www.hlfhealthmdgs.org/documents.asp, accessed 3 December 2009.
13. Ethiopian Ministry of Health. (2006) Health and health related indicators 2006/07, http://cnhde.ei.columbia.edu/indicators/accessed 4 December 2009.
14. Ethiopian Ministry of Health. (2009) *Human Resources for Health Strategic Plan, 2009–2020*. Addis Ababa, Ethiopia: Federal Ministry of Health.
15. Assefa, Y., Jerene, D., Lulseged, S., Ooms, G. and Van Damme, W. (2009) Rapid scale-up of antiretroviral treatment in Ethiopia: Successes and system-wide effects. *PLoS Med* 6(4): e1000056, http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1000056, accessed 3 December 2009.
16. Ethiopian Ministry of Health Ethiopia. (2009) Joint Statement of the Government of Ethiopia and Signatory Development Partners. 15 April 2009, Addis Ababa, http://www.internationalhealthpartnership.net/pdf/IHP%20Update%2013/Zambia/Joint%20Statement%20of%20The%20Government%20Of%20Ethiopia%20and%20Signatory%20Development%20Partners.pdf, accessed 3 December 2009.
17. Ford, N., Ooms, G., Laga, M., Pirard, M., Van Damme, W. and Loewenson, R. (2008) 'Antwerp in Geneva' Workshop on the AIDS Response and Health Systems Strengthening in Sub-Saharan Africa, http://www.tarsc.org/publications/documents/ITM%20AIDS%20workshop%20report.pdf, accessed 3 December 2009.
18. World Health Organization. (2009) *Initial Summary Conclusions: Maximizing Positive Synergies between Health Systems and Global Health Initiatives*. Geneva, Switzerland:

World Health Organization, http://www.who.int/healthsystems/GHIsynergies/en/index.html, accessed 4 December 2009.
19. Chen, L. *et al* (2004) Human resources for health: Overcoming the crisis. *Lancet* 364(9449): 1984–1990.
20. Feachem, R. (2003) Opening Address from Richard Feachem, 4th Board Meeting of the Global Fund, http://www.theglobalfund.org/en/board/meetings/fourth/openingspeechfeachem/?lang=en, accessed 3 December 2009.
21. Lane, C. and Glassman, A. (2008) *Smooth and Predictable Aid for Health: A Role for Innovative Financing?*. Washington DC: Brookings Institution, http://www.brookings.edu/~/media/Files/rc/papers/2008/08_global_health_glassman/08_global_health_glassman.pdf, accessed 3 December 2009.
22. Taskforce on Innovative International Financing for Health Systems. (2009) More money for health and more health for the money, http://www.internationalhealthpartnership.net//CMS_files/documents/taskforce_report_EN.pdf, accessed 3 December 2009.
23. Cometto, G., Ooms, G., Starrs, A. and Zeitz, P. (2009) A global fund for the health MDGs? *Lancet* 373(9674): 1500–1502, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61740-2/fulltext, accessed 4 December 2009.
24. Ooms, G., Van Damme, W. and Temmerman, M. (2007) Medicines without doctors: Why the global fund must fund salaries of health workers to expand AIDS treatment. *PLoS Med* 4(4): e128, http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0040128, accessed 3 December 2009.
25. Ooms, G., Derderian, K. and Melody, D. (2006) Do we need a world health insurance to realise the right to health? *PLoS Med* 3(12): e530, http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0030530, accessed 3 December 2009.