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WORLD HEALTH ORGANIZATION FINANCING HEALTH CARE IN THE CONTEXT OF THE GLOBAL RECESSION

“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”¹

“In an age of explosive development in the realm of medical technology, it is unnerving to find that the discoveries of Salk, Sabin, and even Pasteur remain irrelevant to much of humanity.”²

“The current economic crisis has grave implications for global health. As incomes fall, people on life-saving medications in hard-hit sub-Saharan Africa may no longer be able to afford the cost of their treatment.”³

Introduction

In a world divided by ideologies, religions, languages, and cultures, the most fundamental divide may well be in the access to quality health care. Throughout the world, the poor suffer from a sustained lack of access to quality health care during all stages of life. While some countries have established public health systems that extend much further into poorer communities than others, it is clear that the poor are systematically underserved in terms of access to high-quality health care as well as in the research agendas of governments, corporations, physicians, pharmacists, pathologists, and related care-givers. Given that the poor suffer disproportionately from the deadliest and most infectious pandemic diseases and that their poverty and ill-health act to viciously reinforce each other, it is vital that much greater attention and financial resources be devoted to researching, alleviating, and curing the diseases and public health threats that plague the most vulnerable elements of society.

In the context of the contemporary global economic recession, concerns about overburdened public health systems and the rapid spread of pandemic diseases feature prominently in public discourse and in the platforms of political parties and candidates. HIV/AIDS and H1N1, commonly referred to as swine flu, are not the only pandemic infectious diseases placing severe strains on national and international public health systems; malaria, tuberculosis (TB), including multi-drug resistant tuberculosis (MDR-TB), avian flu, and SARS have all terrified the world in recent years. As

¹ *Universal Declaration of Human Rights*.

² Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* University of California Press Berkeley, California 2005 p. 144.

³ Said A Ibrahim, “Health Inequities: A Global Concern” *American Journal of Public Health* July 2009 Vol. 99 No. 7 p. 1162.

governments struggle to respond to these enormous challenges, questions about access to high-quality health care and the costs of that high-quality care are at the forefront of public and political debate. Delegates to the World Health Organization (WHO) will address fundamental questions about the equitable distribution of health care resources, the roles of governments, non-governmental organizations (NGO's), and the private sector in the provision of health care services in the context of the current global recession, as well as the necessary investments that societies must undertake to ensure adequate and equitable health care in the future.

Health Care: Commodity or Human Right?

The heart of the matter in this multistakeholder dialogue is the struggle between those who see high quality health care as a fundamental human right and those who see health care as a profitable commodity that must be distributed strictly based upon market forces of supply and demand. Providing health care to all citizens is expensive in any society, especially in societies that are being ravaged by pandemic diseases. In the current global recession, the emphasis on restricting health coverage and benefits, beyond clear emergency situations, to citizens of their respective host countries has become a more visible concern for policy-makers and many of their constituents.⁴

Economists and many health care industry specialists argue that in poor countries with very limited resources it is not “cost-effective” to treat all patients and that expensive medicines manufactured in the wealthy countries of the world are not practical for people whose annual incomes are less than 10% of the annual cost, in the high-income societies at least, of the prescribed drugs. Furthermore, containing health care costs is extremely difficult to contain in any society, rich or poor. “National health systems in different countries appear diverse, but all of them are forms of insurance against unexpected medical bills. This means that the bulk of health care is paid for by third parties, whether private insurers or governments. Medical technologies are developed for and used in a market that is much less sensitive to budget constraints than individual consumers would be.”⁵ But when someone is sick and needs care, particularly if their illness or disease is highly contagious, is it cost-effective to not treat them? And what is the ethical and moral price to be paid for neglecting the sick and dying? Dr. Paul Farmer, a Harvard-trained physician and anthropologist who operates a medical clinic in Cange, Haiti, writes, “a human rights approach to health economics and health policy helps to bring into relief the ill effects of the efficacy-equity tradeoff; that is, only if unnecessary sickness and premature death don't matter can inegalitarian systems ever be considered efficacious.”⁶

Caring for the Economy, Caring for People

⁴ Duff Wilson, “An Airing of Border Issues, But No Coverage for ‘Illegal Immigrants’” *The New York Times* August 29, 2009.

⁵ *The Economist* “No Reverse Gear” July 15, 2004.

⁶ Paul Farmer, *Pathologies of Power* p. 19.

Health care systems are often complex and account for significant portions of public and, often, private expenditures. According to 2004 World Health Organization (WHO) statistics, health care spending, public and private, varies immensely, however, between countries, ranging from \$6,000+/person in the United States to just under \$3.00/person in Burundi.⁷ Policy-makers around the world are confronting a litany of challenges and demands amidst the contemporary global recession. As governments at all levels consider the possibilities of budget cuts and reordering their spending priorities, government agencies and programs, including those directly related to health, must present their cases to not only their respective national legislatures but also, at least in more open and/or democratic societies, to their populations.

Recessions create additional burdens for health systems for several reasons. Delegates to the recent High-Level Consultation of the World Health Organization (WHO) on The Financial Crisis and Global Health noted that “in contrast to public spending, **private out-of-pocket expenditure** usually tends to decline in recession, particularly if services are available at lower cost in the public sector.”⁸ One major reason why private out-of-pocket health expenditures fall during recessions is that many people delay or avoid important checkups and treatments.⁹ When private health expenditures decline, governments must either increase public health expenditures or risk a serious deterioration of the overall health situation in their respective societies. A related reason why health systems confront additional burdens during recessions is that large numbers of people lose their jobs and in societies where people obtain their health insurance primarily through employers, such as in the United States, unemployment generally means a loss of private health insurance. In early 2008, the Center for Economic and Policy Research predicted that “a recession could result in 4.2 million people losing health coverage” in the United States alone.¹⁰ When unemployed workers lose their health insurance, their spouses and children frequently lose the private insurance that the family previously enjoyed; some states provide low-cost or free health insurance for children, particularly poor children, while the adults must seek other forms of private insurance or must rely upon heavily burdened public health systems.

Protecting Existing Health Systems

As politicians, health care professionals, non-governmental organizations (NGO's), and related civil society representatives debate difficult funding and spending options, the World Health Organization (WHO) and partner organizations, including the World Bank, have argued for protecting existing health systems as a minimum first step. While maintaining overall health spending is a crucial goal, the orientation of that spending is equally crucial. World Health delegates argue that “A policy of protecting overall health spending may be necessary, but it is not always sufficient. In Brazil, experience has shown the need the need to specify the proportion of state and municipal

⁷ World Health Organization (WHO), “Spending on health: A global overview” Fact Sheet # 319 March 2007.

⁸ World Health Organization (WHO), “The Financial Crisis and Global Health: Report of a High-Level Consultation” Geneva January 19, 2009 p. 10.

⁹ Karen Nash, “Recession’s effects: Slower payments, postponed care” *Urology Times* July 2009.

¹⁰ Catherine Arnst, “Health Care: Not So Recession-Proof” *BusinessWeek Online* March 25, 2008.

budgets that must be allocated to health. The World Bank highlighted the need to ensure that health spending was **targeted to the poor**, as experience shows that otherwise the benefit of spending in health may be captured by richer households.”¹¹ These concerns about the targeting of public health spending towards poorer households are quite prescient; the fastest way for previously middle class families and individuals to fall into poverty is through catastrophic or chronic illness. Anirudh Krishna writes that “health and healthcare expenses are the leading cause for people’s reversal of fortune.”¹²

Protecting, and where possible enhancing, existing health systems is particularly vital in the midst of this contemporary global recession for another reason: it is much easier, financially, institutionally, legally, and politically, to scale up existing social safety nets and health systems than to create entirely new programs. Existing programs already have critical infrastructure, often domestic political constituencies, and budgets. As can be seen in many different UN member states, existing programs face significant potential budget cuts, even entrenched programs like the British National Health Service (NHS).¹³ Attempting to create new health programs or systems in the midst of a severe global recession will likely encounter massive political resistance as well as potentially divert needed resources from existing health programs and systems. The International Labor Organization (ILO) recently asserted that “a basic social protection package of a modest cash benefit for children and a modest pension for the elderly and persons with disabilities, together with access to basic health care, can be constructed progressively without overstraining public budgets.”¹⁴

Combating a Pandemic During a Recession: Swine Flu and the Economy

The H1N1 influenza virus reached pandemic status with unprecedented rapidity and is expected to hit countries such as the United States twice in 2009. As H1N1 spreads throughout all regions of the world, its impact on economies and political systems becomes more profound. Estimates of the economic impact on many countries range from .5% to 1.5% of Gross Domestic Product (GDP) lost due to the direct medical costs of treating the ill as well as particularly the lost productivity when large numbers of workers and businesses are idled.¹⁵ Countries may limit the costs to their economies and societies through effective pre-planning and effective policy coordination. A classic contrast offered by many analysts is between the responses of Argentina and Chile, with Chile’s response being lauded as the more effective response to the threat posed by H1N1. Mexico, the country that suffered the first major impact from swine flu in early 2009 and saw tourism decline precipitously in the immediate term, has received serious accolades for its subsequent response to H1N1.¹⁶

Health care reform in the United States?

¹¹ WHO, “The Financial Crisis and Global Health: Report of a High-Level Consultation” January 19, 2009 p. 5.

¹² Anirudh Krishna, “Reversal of Fortune” *Foreign Policy* May/June 2006 p. 62.

¹³ *BBC News*, “NHS challenges in a time of recession” July 27, 2009.

¹⁴ Juan Somavia, “Shortening the Global Recession, Accelerating Recovery, and Setting Course for Inclusive and Sustainable Development” April 25-26, 2009 p. 3.

¹⁵ *The Economist*, “The cost of swine flu” July 27, 2009.

¹⁶ *The Baltimore Sun*, “Mexico wins praise for swine flu response” July 4, 2009.

The public health system in the United States is a unique mixture of reliance on the market, government, charities, and religious organizations in terms of providing health care and private insurance, government programs for the elderly and the poorest Americans, and out-of-pocket expenses in terms of paying for health care. As was mentioned above, health care costs are a primary factor in plunging families into poverty in countries where national health insurance is not provided to all by the government. Within the US, public sector workers and employees of large corporations are the most likely to have employer-provided or subsidized health care while the unemployed, employees of small firms, and low-wage workers are far less likely to have health insurance or coverage.

The varying proposals emanating from the Obama administration and Congress present both short-term and long-term reforms to the American public health system but all come with significant financial and political costs. Politically, discussions of health care reform in the United States generate highly acrimonious debate, with well-financed interest groups¹⁷, including the American Medical Association (AMA), asserting that the establishment of a national health insurance (NHI) plan would reduce consumer choice, discourage doctors from entering the field because of excessive regulation and government-imposed limitations on earning potential, and the creation of further government bureaucracy. The AMA's proposed solutions for addressing the problems of lack of access and cost containment are to have employers provide fixed amounts of assistance, or "defined contributions", along with government tax credits and then to allow consumers to choose from an array of competing health insurance plans. "Defined contributions" would be preferable for many American employers as they could set contribution levels and then not worry about escalating insurance premiums. While this combination of employer contributions and tax credits might increase access for some working Americans, it would do nothing to remedy the lack of access to health care for the unemployed nor would it address the root causes of escalating health care premiums.

At the same time, though, the AMA notes with alacrity that "the lost economic value due to the uninsured is between 65 billion and 130 billion dollars annually."¹⁸ The critique about increased government bureaucracy also must be tempered by a critique of the already existing and rapidly growing private insurance bureaucracy. Paul Krugman notes that "a recent study found that private insurance companies spend 11.7 cents of every health care dollar on administrative costs, mainly advertising and underwriting, compared with 3.6 cents for Medicare and 1.3 cents for Canada's government-run system."¹⁹ As long as insurance providers, hospitals, and pharmaceutical companies strive to keep the health care industry amongst the most profitable in the United States and they are able to set prices, determine which procedures will be covered and which will not, and continue to lobby Congress for tax breaks, lax regulation, and the exclusion of pharmaceuticals from overseas from the American market²⁰, health care costs will continue to consume ever greater amounts of American income and resources.

¹⁷ Dan Eggen, "Hospital Lobbyists Try to Minimize Damage" *The Washington Post* July 25, 2009.

¹⁸ Michael Maves, "The challenge of health system reform" speech to the Civic Entrepreneurs Organization St. Louis, Missouri April 7, 2006.

¹⁹ Paul Krugman, "The Health of Nations" from *The Great Unraveling: Losing Our Way in the New Century* W.W. Norton & Company New York 2004 p. 459.

Washington DC is clearly one of the epicenters of hyperbole but the negative consequences of the current recession are likely to impact the long-term fiscal health and political popularity of programs such as Medicare and Medicaid. Current projections of the fiscal solvency of Medicare have reduced the time frame until Medicare begins running a deficit from 2017 to 2015.²¹ While the United States already operates large-scale government-run health care programs including Medicare, Medicaid, and the Veteran's Administration (VA), reforming the health system to include a "public option" for consumers who would prefer to purchase health insurance from a government-run plan versus from private providers has been criticized as a massive encroachment of federal power as well as a potential death blow to private health insurers in the US because the government would provide subsidies for lower-income families to purchase the government health insurance. While the Republican opposition to President Obama's health care proposals is not surprising, particularly considering their earlier opposition to President Clinton's proposed overhaul of the American health care system, opposition has also come from within the Democratic Senate leadership.²² Many people from different political backgrounds have also questioned the wisdom of striving to reform the American health system in the midst of a severe global recession.²³

European and Canadian Health Care Systems

The World Health Organization no longer ranks different health systems; their last rankings came out in 2000. In that 2000 report, the US ranked 37th out of over 100 countries surveyed. Number one on that list: France. In fact, 7 of the top 10 countries on the list were European countries, the largest of which were France, Italy (#2), and Spain (#7). These countries all use some form of a single-payer system or national health insurance (NHI) where the government provides health insurance to all citizens, irrespective of level of income, and the government also regulates how much health providers may charge. The government can also negotiate much lower prices for pharmaceuticals as it acts as a huge bargaining agent. In France, most people supplement the national health insurance plans through additional insurance provided through their employers. One of the most frequent criticisms of the French systems is that the French now use health care services too frequently and that they underestimate the real costs of their public health system. Even *The Economist* notes, however, that "France's health system, a mix of private and public provision, manages both to guarantee universal coverage and produce a relatively healthy population for half the cost per person of America's, and with shorter waiting lists than Britain's somewhat cheaper version."²⁴

²⁰ "From 1997 to 2000, the most recent year for which complete data is available, the [health care] industry spent \$734 million lobbying Congress and the executive branch. Only the finance, insurance, and real estate lobby exceeded that amount in the same period, with a total of \$823 million." Donald L. Barlett and James B. Steele, *Critical Condition: How Health Care in America Became Big Business- and Bad Medicine* Broadway Books New York 2006 p. 69.

²¹ Robert Pear, "Recession Drains Social Security and Medicare" *The New York Times* May 12, 2009.

²² Sam Stein and Ryan Grim, "Budget Buster: Kent Conrad's Long Opposition to the Public Option" *Huffington Post* August 21, 2009.

²³ Joseph Berger and Derrick Henry, "Lieberman Suggests Health Care Reform May Have to Wait" August 23, 2009.

²⁴ *The Economist*, "Vive la différence!" May 7, 2009.

Recent reports have indicated that France's public health system is running a persistent and growing deficit but that French voters are unwilling to face any major overhaul of the existing system, particularly one that provides less coverage. Furthermore, French and other European voters have consistently signaled a willingness to pay higher taxes to maintain their health systems.

Canada's public health system is more similar to France's than it is to the one found in the United States. While a few politicians from the Conservative party have argued that the system is too expensive and plagued by bureaucracy, most Canadians have consistently favored their public health system over that of the United States. The Canadian system has been criticized for not integrating the highest-level technologies at the same rate as its neighbors to the south and it is also characterized by long waits, a problem in the United States as well but unheard of in France. Comparisons with the United States are inevitable, and in many respects, the Canadian system offers clear advantages: 9% of GDP is devoted to health care with all citizens covered while the US devotes approximately 16% to health care with at least 45 million citizens not covered; "it takes more people to administer Blue Cross Blue Shield of Massachusetts than it does to administer the entire health system of Canada"²⁵; equity and public financing is ensured because all classes of society use the same health care system in Canada. During this contemporary recession, Canadian medical professionals and policy-makers have considered expanding the role of private health care options within Canada but no major changes have yet been endorsed by the Canadian Medical Association (CMA).²⁶

Developing World Public Health Systems

In many developing countries, government spending on public health is minimal and on average equals only one third of what WHO estimates is necessary to improve life expectancy and overall quality of life.²⁷ Health systems also vary immensely within countries. The delivery of quality health services is often best in the downtown areas of the largest cities and often close to nonexistent in many of the rural areas. In China's rapid transition to capitalism, state financing of health care has plummeted and the results have been disastrous, especially for those in remote rural areas which were previously served by government health workers. "In the countryside, 90% of the population now has no health insurance. In the cities, nearly 60% are uncovered. Out-of-pocket spending on health care is soaring."²⁸ Many developing country health systems integrate some level of government spending, aid from wealthier donor countries, and out-of-pocket expenditures by the citizens of those countries. It is absolutely vital that government expenditures and donor aid increase to bring these countries up to levels where the

²⁵ Bruce Robinson, "Canada's Single Payer Health Care System – It's Worth a Look"

<http://bcn.boulder.co.us/health/healthwatch/canada.html>

For purposes of comparison, Massachusetts's population was estimated at: 6,398,743 for July 2005 – US Census Bureau. Canada's population was estimated at: 33,098,932 for July 2006 – *CIA World Factbook*.

²⁶ *Canadian Broadcasting News (CBC) News*, "Doctors weigh private role in Canadian health care" August 18, 2009.

²⁷ WHO has estimated that per capita government spending on health in the poorest countries needs to reach the level of at least \$35-\$50 per year, whereas in many of the poorest countries, per capita government spending on health is \$10 or less per year.

²⁸ *The Economist*, "Where are the patients?" August 19, 2004.

poorest at least have sustained access to primary health care services. While wealthy countries may claim that their aid is not always spent wisely, their minimal outlays to the developing world are currently far too low to dramatically improve the health and quality of life for billions in the developing world. According to the Commission on Macroeconomics and Health (CMH), “current levels of donor support are extremely low – just \$2.29 per capita in the least developed countries in 1997-1999, and \$.94 per person in the other low-income countries.”²⁹

Zambia may offer a relevant contemporary example of what poor countries’ governments and health providers can expect. After negotiating a significant package of debt relief, Zambia announced that it would provide health care to all of its citizens free of charge. Zambia’s ability to provide basic health services to all of its citizens free of charge may be imperiled by a reduction in foreign aid; the Dutch government recently announced that it will suspend all financial assistance to the Zambian Health Ministry because of its concerns over corruption within the ministry.³⁰ While donor governments often have legitimate concerns about graft and corrupt uses of foreign aid, restricting and/or reducing foreign aid for health and social safety nets is likely to adversely impact the most vulnerable populations. The World Health Organization (WHO) estimates that up to 4 million additional doctors and health workers are needed in developing countries and Zambia would fit that profile perfectly. In the rural district of Kafue located approximately 30 miles south of the capital, Lusaka, “there are only 7 doctors for a population of more than 250,000.”³¹ A discouraging corollary to this lack of doctors and health workers in the developing world is the frequency with which the best and most educated doctors and health workers from the developing world move to the wealthier countries of Europe, North America, and parts of Asia in search of better jobs and working conditions. Reversing this persistent “brain drain” is fundamental to increasing the number of knowledgeable and experienced doctors and health workers in the developing world.

The market doesn’t always deliver: Russia and the former Soviet Union

Public health systems are fundamentally dependent upon political systems and priorities and can be radically altered when those systems and priorities change. The clearest examples of rapid deteriorations of public health systems because of major political changes can be seen in many of the republics of the former Soviet Union. While the vast expansion of civil and political freedoms to the peoples of the former Soviet Union were tremendous achievements, the brisk transition to capitalism removed huge sections of the social safety nets that communism had put in place and public health was an area that was hit very hard. Average life expectancy from birth declined for the first time in decades and epidemics, particularly involving multi-drug resistant tuberculosis (MDRTB), spread rapidly in the poorer communities of the former Soviet Union. Martha Brill Olcott notes that “the Soviet state did a good job of creating a health-care system that reached remote rural areas, eradicating illiteracy and providing access to education,

²⁹ WHO, “Macroeconomics and Health: Investing in Health for Economic Development” 2001 p. 57.

³⁰ *New African*, “Zambia: Dutch Aid Stopped” June 2009 Issue 485.

³¹ Said Penda, “Zambia overwhelmed by free health care” *BBC News* April 7, 2006.

setting up extensive pension, maternity, and child-benefit programs. Whatever the limitations, these state services created a widespread expectation that governments must meet the social needs of the people they rule – an expectation that today’s governments are finding hard to sustain in the transition to a market economy.”³² No comparable system of social provision has been established by market forces and the predictable results have been particularly troubling.

The decline in public health in Russia and other former Soviet republics poses a serious threat to many countries throughout Europe and Asia as epidemics such as MDRTB can ravage whole communities. While the public health systems in the major cities are clearly inadequate, the damage done in the rural areas of the former Soviet Union is astounding. “Alcoholism and poor diet, coupled with diseases like tuberculosis and a crisis in health care, have all meant more and more Russian men dying younger. Average life expectancy for a Russian man is now just 59 years.”³³ The Russian government is predicting that Russia’s population may decline by 50 million people over the next 50 years because of plunging birth rates and skyrocketing mortality rates; Russia’s population is currently declining by 700,000 people annually.³⁴ In August 2009, Russian health officials announced that they were anticipating a massive wave of new drug-resistant tuberculosis (TB) infections, due in part to a lack of resources and correspondingly low standards of hygiene in many Russian hospitals.³⁵ The decimation of the Russian health care system serves as a stark reminder that the free market often does not provide sufficient essential services.

International Institutions, NGO’s, and the Provision of Public Health

The primary international institution that addresses global public health issues is the World Health Organization (WHO), a specialized agency of the United Nations. WHO was established in 1948 and now consists of 192 member states that compose the World Health Assembly which debates major policy questions and allocates WHO’s \$3.3 billion budget for the 2006-07 biennium. WHO works closely with national governments, especially the health ministries, health workers and providers, and non-governmental organizations (NGO’s), many of which are composed of health workers. Former Director-General Gro Harlem Brundtland created the Commission on Macroeconomics and Health (CMH) in 2000 and its major report was published in December 2001. A follow-up report was issued in 2004 as well as a number of national reports from UN and WHO member states. WHO’s *World Health Report 2000* was focused on improving the performance of existing health systems throughout the world, especially in regards to ensuring that all people have adequate access to health services and to overcoming the inequities that plague the financing of particular health systems.

The World Health Organization often divides its work and various programs up amongst its regional components, including multi-year plans for health care financing.

³² Martha Brill Olcott, “The Caspian’s False Promise” *Foreign Policy* Summer 1998 p. 99.

³³ Damian Grammaticas, “Life ebbs away from Russian villages” *BBC News* November 5, 2004.

³⁴ *The Economist*, “The incredible shrinking people” November 27, 2008.

³⁵ Sarah Schafer, “Russia Bracing for Spread of Dangerous TB Strains” *The Washington Post* August 24, 2009.

The six regional groupings of the WHO are: Africa; the Americas; Southeast Asia; Europe; Eastern Mediterranean; and Western Pacific. Within each regional group, the various member countries are devising and implementing programs for cooperating in establishing and financing national and regional health systems. In the Western Pacific regional grouping of the WHO, the emphasis is currently on capacity-building; in early July 2009, the health ministers of the region met in Madang, Papua New Guinea to assess the health threats to the region and to improve the financing of regional health infrastructure.³⁶ At the recent World Fair on Municipalities and Health in Buenos Aires, Argentina, Mirta Roses, Director of the Pan-American Health Organization (PAHO, the WHO's regional grouping for the Americas, urged countries to maintain investments in health systems even during times of crisis.³⁷ Delegates to the World Health Organization/World Health Assembly may wish to examine recent actions and initiatives undertaken by their respective regional groupings.

The World Bank has recently expanded its focus on the financing of health as a vital component of macroeconomic stability and poverty reduction. In its current report, "Health Financing Revisited – a Practitioner's Guide," the World Bank notes that in developing and low-income countries, the overwhelming majority of health spending is out-of-pocket spending by the world's poorest peoples and this trend constitutes "an automatic recipe for poverty."³⁸ The World Bank, while urging more aid to developing countries from wealthy countries, agrees with WHO and many other interested actors that aid alone will not fully solve the inequities and problems associated with contemporary health financing in developing countries.

Non-governmental organizations (NGO's) are playing increasingly important roles in the provision of health care in many parts of the world. WHO recently created its Civil Society Initiative (CSI) to expand its vital work with NGO's and civil society representatives throughout the world. Partners in Health (PIH), the Boston-based NGO headed by Dr. Paul Farmer, operates a large free medical clinic in Haiti, coordinates with Boston-area hospitals, and has established highly successful programs for treating MDRTB in Peru and Russia. Medecins Sans Frontieres (MSF), often called Doctors Without Borders, provides emergency medical care in over 70 countries around the world. MSF works "with the objective of rebuilding health structures to acceptable levels"³⁹ and is vitally important in drawing increasing attention to inadequacies and inequities in the provision of health care. Throughout the world, there are also many domestic NGO's that operate medical clinics, fund emergency medical care, and lobby

³⁶ WHO-Western Pacific Regional Office (WHO-WPRO), "Global economy impact high on agenda for Pacific health leaders" July 3, 2009.

http://www.wpro.who.int/media_centre/press_releases/pr_07032009.htm

³⁷ Pan-American Health Organization (PAHO), "Maintain investment in health in times of crisis" August 18, 2009. http://new.paho.org/hq/index.php?option=com_content&task=view&id=1714&Itemid=1

³⁸ George Scheiber, "Health Financing Revisited – A Practitioner's Guide" May 25, 2006 <http://www.worldbank.org>

³⁹ <http://www.msf.org>

governments for better funding and provision of health care. NGO's are likely to assume increasingly important roles in public health provision throughout much of the developing world, particularly in the Least Developed Countries (LDC's), as often cash-strapped governments confront the difficult choices involved in providing health care to growing populations.

A vexing problem for relying on NGO's and philanthropic organizations and foundations to provide essential health services is that these organizations and foundations are currently confronting difficult economic climates themselves. Many organizations have seen their budgets cut and a great number of foundations have seen their endowments shrink, and in some cases plummet, because of declines in global stock markets. The Bill and Melinda Gates Foundation saw its endowment plunge by 20% in 2008, but it has emerged as a positive counter to the overall trend of reduced giving: in 2009, the Gates Foundation plans to disburse nearly \$4 billion USD, its greatest total in a single year.⁴⁰

The Right Rx: Prescription Pharmaceuticals and Persistent Profits

The most widely publicized aspect of global public health, certainly in terms of cost, has been the struggle to provide affordable drugs to the sick throughout the world, especially in poor developing countries that are experiencing staggering HIV/AIDS crises. While there is no known cure for HIV/AIDS yet, the so-called "AIDS cocktail" of drugs can be used very effectively to prolong an HIV+ person's life and to allow them to maintain a high quality of life for over a decade. These drugs are quite expensive, however, costing well over \$10,000 US a year in the wealthy countries of the world. The pharmaceutical companies argue that the high costs of these drugs stem from high initial research and development (R&D) costs. Dr. Paul Farmer notes that "it is clear enough that biotech and pharmaceutical firms can work miracles. But it is also true that they lean heavily on public funding and end up making a great deal of private profit."⁴¹ Drug companies, however, are having a particularly difficult time proving their arguments that R&D costs are the real reasons why drug are so expensive. "Pharma firms spent a whopping \$14.7 billion on marketing to health-care professionals last year, and at least \$3.6 billion on direct-to-consumer advertising, according to Verispan, a market researcher. Drug firms now spend a third of their sales revenue on marketing and administration, on a par with Coca-Cola and Nestle."⁴²

The most devastating charges that the pharmaceutical companies have faced over the past 10 years have involved their reliance on patent laws to prevent the production of generic versions of their brand name drugs, particularly those drugs used to treat HIV/AIDS. In 2001, the British-based NGO Oxfam International accused major pharmaceutical companies of waging "an undeclared drugs war against the world's poorest countries" by filing lawsuits and complaints with the World Trade Organization

⁴⁰ Stephanie Strom, "Gates Group Plans to Give More in 2009 Despite Losses" *The New York Times* January 26, 2009.

⁴¹ Paul Farmer, *Pathologies of Power* p. 162.

⁴² *The Economist* "An overdose of bad news" March 17, 2005.

(WTO) to halt and/or prevent the production of generic HIV/AIDS drugs.⁴³ After considerable pressure by governments and NGO's in developing countries such as Brazil and South Africa, major pharmaceutical manufacturers rescinded their previous objections to allowing the production and importation of generic AIDS drugs. Brazil provides free universal treatment and drugs for all citizens who are HIV+ or have AIDS and has credited this program as being a major contributing factor in reducing the infection rate by 50% in just a few years.

One crucial factor that convinced some major pharmaceutical companies to lower their objections to generic drugs was the realization that some developing countries, especially India, have already established large pharmaceutical industries of their own. India spurred the development of their pharmaceutical industry in 1970 by introducing a very different form of patent law. In most countries, pharmaceutical patents are based upon the chemical composition of the drugs whereas in India they are based upon the process used to manufacture the drugs. *The Economist* notes that “this spawned thousands of small drug companies that copied drugs by inventing new processes – a perfect breeding ground for creative chemists.”⁴⁴ As India and China continue to develop their domestic pharmaceutical industries, and as legislation reduces the barriers to foreign investment in different sectors of the economy, large Western pharmaceutical companies are seeking to increase their presence in these vast emerging markets.

Pharmaceutical companies have seen the growth in their sales of their newest brand-name drugs slow during this recession but their overall revenues have not declined. Consumers are in some cases buying fewer medicines and many others are seeking to shift their consumption patterns towards generic drugs whenever possible. Ultimately, though, pharmaceuticals demonstrate lower elasticity, or the responsiveness of demand to price changes, than most other goods. In December 2008, Merck announced that it drastically reduced its marketing budget without negatively impacting sales.⁴⁵ Considering the profitability of the pharmaceutical industry and how their sales have been not been as adversely affected by the recession as most other markets, governments may wish to consider new ways of working with pharmaceutical companies to provide low-cost life-saving drugs for poor and vulnerable populations.

Health, the Role of the Government, and Global Public Goods

Market economies are designed to create greater wealth, albeit often highly unequal wealth, through reliance on self-interest and the profit motive. Unfortunately, some vital goods and services will not be provided in sufficient measure by market economies without state assistance and/or intervention because the goods and services are unlikely to generate large and recurring profits. To overcome this under provision of desired and/or necessary goods and services, the government can use its fiscal policies, taxation and public spending, as well as its regulatory powers. One remedy available to governments is the provision, whether direct or indirect, of public goods. Public goods

⁴³ *BBC News* “Drug firms ‘waging war’ on poor” February 12, 2001.

⁴⁴ *The Economist* “The next big thing” June 16, 2005.

⁴⁵ *The Economist*, “Winds of change” December 11, 2008.

are considered to be “characterized by *nonrivalry* and *nonexcludability*” and provided by governments. Nonrivalry means that one person’s consumption of the good or service does not prevent others from also consuming the good or service. Nonexcludability means that consumption of the good is available to all, regardless of ability to pay. Public goods are also often considered *indivisible*, meaning that they are not designed to be provided for only a few individuals. Public goods are often critiqued because they are subject to the “free rider” problem; even those who do not pay for the provision of the good have the ability to enjoy the benefits of consuming it. While the “free rider” problem may be intractable in terms of the provision and consumption of public goods, these goods still often provide such benefits to society that the provision of the goods is still highly desirable.

Complementing the concept of public goods is the crucial concept of externalities. Externalities are additional effects from the production and/or consumption of a good or service that affect third parties that did not produce or consume the goods or services in question. Air and water pollution as well as secondhand smoke are classic examples of *negative* externalities; people downriver and/or downwind from the individuals responsible for the pollution or smoking have their quality of life diminished by the actions of others. In terms of health and health care, vaccinations are considered to provide *positive* externalities because even people who do not receive the vaccines are less likely to contract certain infectious diseases if others around them have been vaccinated. While health is still considered an overall private good because its benefits accrue primarily, if not overwhelmingly, to each individual, healthier societies often provide several health-related public goods that provide positive externalities for their societies and, to a lesser degree, to other countries.

In 1999, the United Nations Development Programme (UNDP) adopted the following definition for global public goods (GPG’s): “a public good with benefits that are largely universal in terms of countries (covering more than one group of countries), people (accruing to several, preferably all, population groups), and generations (extending to both current and future generations, or at least meeting the needs of current generations without foreclosing development options for future generations).” In terms of health, economists and development specialists such as Joseph Stiglitz, Nobel Prize winner in Economics, and Inge Kaul and Michael Faust have pointed to communicable disease control efforts, financing of global health initiatives, and the expansion of knowledge about health and disease as important global public goods (GPG’s).

The Best Investment of All: Investing for Health and Development

The sounds of laughter are amongst the most sublime of human experiences. The sounds of suffering are amongst the most wretched of human experiences, particularly when that suffering can be prevented through increased investments in health and public health systems. What is the cost of saving human lives, though? As crass as the question may seem, the unfortunate truth is that money is an extremely important component in improving the health and well-being of people all over the world, and most especially in the developing world. When the Commission on Macroeconomics and Health (CMH)

issued its first report in December of 2001, the Commission asserted that increased investments in public health by developing and low-income countries of \$35 billion a year along with \$27 billion from high-income donor countries would prevent 8 million early deaths a year and provide global economic growth in the range of \$160-\$180 billion annually. Convincing the wealthy countries of the world of the need to ratchet up their investments in poor countries' public health systems may not be easy, especially during a global recession. At the time the report was issued, the additional \$27 billion annually represented a net 50% increase in the total net aid flows from wealthier to poorer countries.

The deliberations and reports of the CMH have spurred a number of countries to undertake sustained efforts to more effectively address the financing of their public health systems. In 2006, WHO issued a major follow-up report on the national and systemic impacts of the work of the CMH and WHO's member states. One of the key recommendations of the original CMH report released in 2001 was for governments to establish national commissions on macroeconomics and health (NCMH's). According to WHO, "approximately 20 countries established NCMH's or used existing government bodies to strengthen – or, in some instances, to forge – a multisectoral approach to policy-reform and planning."⁴⁶ Improving policy efforts and coordination is essential to creating and strengthening efficient and equitable public health systems.

Increased investment in health systems must also be matched by improved targeting of the vital resources devoted to public health. The inequities in public health systems are often exacerbated by the corruption and graft that plagues so many health systems. In WHO's latest report on macroeconomics and health, the importance of capacity-building is stressed for health systems, particularly in the developing world. "Against the backdrop of the scale-up needed to meet the health MDG's (Millennium Development Goals) and other national targets, together with the growing commitment to increase development aid coupled with debt relief, it is crucial to strengthen the capacity of health systems to absorb these funds effectively. Without a comprehensive strategy, such investments could fail to result in a higher level of health-service delivery to the poor."⁴⁷ Health systems are in turn prone to corruption because the sums involved are often significantly greater than those for many other social programs and the number of actors pursuing narrow versions of their own self-interest can be quite vast. "What marks the health sector out is that there are large sums of money – often public – washing around in complex systems involving a variety of players from doctors and patients to drug firms and government officials, all of whom have competing interests."⁴⁸ The asymmetries of information between parties form central components of graft in the health care industry. Doctors usually know much more about health issues than their patients and health providers and insurers often know far more what procedures actually cost and how they are administered than patients. Any time where health providers collect fees directly from patients, there is the potential for conflicts of interest to arise. The lobbying of government representatives, agencies, doctors, hospitals and the general

⁴⁶ World Health Organization, "Tough Choices: Investing in Health for Development: Experiences from National Follow-up to the Commission on Macroeconomics and Health" Geneva 2006 p. 13.

⁴⁷ WHO, "Tough Choices: Investing in Health for Development" p. 16.

⁴⁸ Nick Triggle, "Why health is so prone to corruption" *BBC News* January 2, 2006.

public by health providers and insurance companies also leads to lucrative arrangements for those doing the lobbying but can result in the failure and/or shutdown of vital segments of public health systems. Combating the corruption in health systems is a critical, and not most importantly, not intractable, element of forging sustainable and equitable public health systems.

Transparency International, the prominent UK-based anti-corruption NGO, is striving to draw more attention to the need to eliminate graft in health systems worldwide. In systems such as Kenya's, where patients pay out-of-pocket for prescription drugs, installing electronic cash registers wiped out many of the instances where hospital and pharmacy staff pocketed the fees paid for medicines rather than report them. In the huge labyrinthine that is the US health system, "a largely-privatized healthcare system means huge expenditure on automated payment systems to process the millions of transactions and control thousands of contracts. But these systems are largely designed to smooth payment, not to detect fraud. Weak audit methods, which tend to focus on individual transactions rather than recognizing patterns of behavior, help loopholes persist."⁴⁹ Ensuring that health resources are used wisely requires persistent enforcement of the laws by governments and sustained engagement by NGO's looking out for the public interest.

Health expenditures by governments have generally been rising over the past 5 years, although often more slowly than is needed to dramatically improve existing public health systems. While the increase in government expenditures is welcome, much of it is due to epidemiological phenomena such as HIV/AIDS, SARS, and avian flu rather than coordinated efforts to strengthen and expand public health systems and train the necessary health workers currently missing from so many societies. Increased investments in health must also be aimed at expanding coverage to all peoples and at addressing the most pressing health problems plaguing the particular society. In the 2006 report titled "Tough Choices: Investing in Health for Development," WHO notes that "Cambodia, China and Mexico are all spending as much as, or more than, the estimated minimum level necessary to provide a set of essential health interventions. However, large numbers of people in those countries lack access to basic care and health indicators remain poor. Thus, an increase in the resources for health may not have a significant impact on health outcomes if not accompanied by reallocation to more effective uses."⁵⁰ Improved tracking of health expenditures as well as targeting and expansion of health services to ensure equity are fundamental to achieving better health outcomes for everyone.

In most instances, scaling up to meet the health needs of a society will be a far more effective strategy than creating new programs, especially in the context of the global financial crisis. Delegates to the World Health Organization/World Health Assembly must strive to effectively prioritize the needs of their various societies while ensuring that no segment of the population is deprived of necessary care.

⁴⁹Jeremy Scott-Joynt, "Hitting back at healthcare graft" *BBC News* January 2, 2006.

⁵⁰ WHO, "Tough Choices: Investing in Health for Development" 2006 p. 28.

Guiding Questions:

How is your country's health system financed? How equitably are basic health services distributed throughout your country?

Has your country enacted any health budget cuts or reductions in services during this contemporary global recession? If your country has reduced or restricted services, what have been the impacts on health?

What major health and epidemiological issues does your country currently face? What solutions have been implemented and how effective have they been?

How can your country most effectively allocate resources for improved health care? How much does your country currently spend on health services? How much of that budget is provided by foreign donors? If your country provides aid to developing countries for health, how much does your country provide and how might it increase that aid? If your country is a donor country, is your government planning to increase its aid for health services?

What successful examples of macroeconomic and health policy coordination can serve as appropriate models for your country and others?

What roles are NGO's, philanthropic foundations, and industry associations playing in your country's public health system? What roles are these civil society actors filling that the state does not? How have these NGO's, philanthropic foundations, and industry associations been affected by the global recession?

Resolutions:

WHA 58.33 Sustainable health financing, universal coverage and social health insurance
May 25, 2005.