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More Money, Less Cure: Why Global Health Assistance Needs Restructuring

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Is more money for global health always good news? In this brief essay I argue that the answer is "No." I suggest that many of the problems that plague decision-making in global health assistance lie not in the global South but in the North, where the monetary flows originate and where most policies are conceived. In sketching several constitutive elements of the political economy of global health finance, I develop a series of arguments that show why the contemporary practice of throwing good money into a dysfunctional global health system makes neither economic nor ethical sense. What emerges is an image of global health as a deeply political arena shaped by local and global interests and incentives. I conclude with three proposals to strengthen global health assistance through the more equitable involvement of critical partners. Only thus can financial investment in global health reasonably be expected to make effective and efficient contributions to human development and global equity.

Financial Resources for Global Health: Progress and Dilemmas

The past decade will likely come to be viewed in the history of international affairs as a period characterized by unprecedented activism for global health by national governments, multilateral agencies, corporations, nongovernmental organizations (NGOs), and private foundations. These activities have been sustained by unparalleled amounts of financial capital. While it is difficult to present accurate figures due to inconsistencies and omissions in reporting and

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categorization, databases recording official development assistance (ODA) from Organization for Economic Cooperation and Development (OECD) member states show that funding allocated in the categories of Health, AIDS, and Population more than doubled between 1993 and 2003.[1] Since then amounts have risen still further,[2] not least because of the entry of private foundations, which have poured billions into the quest to reduce the global disease burden.[3] The increased attention to developing world health issues paid by states as well as nonstate actors in the developed world signals a departure from a more traditional characterization of health policy as a purely domestic issue, or as an item of "low politics" not fundamentally linked to a state's national interest.[4] Today, national governments, large NGOs, and the corporate sector in highly developed countries take a different perspective, and they deserve credit for making health a centerpiece of international development strategies.

These recent changes in the scale of resource mobilization and the scope of financial sources suggest a positive trend. Yet they also create a vital challenge. With increasing monies for health pouring in from the North to the South, and a plethora of players (many of whom are relatively new to this field) trying to influence the global policy agenda, how can the equitable and efficient use of these new resources be ensured? Funding for global health has been and remains concentrated in a few highly visible areas, such as HIV/AIDS and tuberculosis (TB). This skewed portfolio has led to a status quo in which AIDS treatment kits alone—which can necessitate vastly more funding than some other primary-care interventions with comparable overall health effects at the macro level—receive more resources than those available *in total* to treat what one might term the "new neglected diseases," such as chronic and mental illnesses, as well as maternal health care.[5] While the latter categories of ill health are decisive contributors to the overall disease burden of people living in developing countries—especially the poorest of the poor—they have received vastly less attention than HIV, TB, and a handful of other "headline" infectious diseases.

The availability of increasing amounts of financial resources for global health programs during the past decade or so has been complemented by an intensified dialogue between the public and the private sectors. This has been hailed as major progress, which is not surprising in a global capitalist system where governments under budgetary pressure have to rely on multinational companies to conduct critical pharmaceutical research and provide much-needed drugs and jobs. State agencies are understandably excited about the financial possibilities resulting from

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closer cooperation with corporate actors. But this view is informed by a type of thinking more suited to the now bygone era in which resource mobilization was the key challenge hindering progress in global health. In the present day, any continuing fixation on resource maximization risks overlooking that the greatest challenge for alleviating disease burdens in developing countries is not the discovery of new medical solutions (with a few important exceptions, such as vaccines against malaria or HIV). Rather, the crucial task today is to break with the practice of selective funding. This is not merely, or even mainly, a kind of technical challenge to be solved solely with better data, allowing for more appropriate financial allocation. On the contrary, fixing the funding imbalance necessitates a candid assessment of the incentives and discourses that govern global cooperation and, indeed, competition, because it is these structures that determine the possibilities and intervention points for reform. With the aim of developing such an assessment, I look first at how national governments prioritize investments in global health, and then at how some diseases gain more policy traction than others, how different organizations cooperate across national borders, and at how language frames all of these processes.

Global Health Priorities, Partnerships, and Discourse in the Public Realm

Growing concern about the cross-border spread of infectious disease, bioterrorism, and environmental threats have played a major role in bringing global health to international attention and to the forefront of national agendas in the global North. This is not surprising given that more than thirty infectious diseases have emerged during the past two to three decades.[6] An influenza pandemic in the United States would cause economic contraction that in its impact could surpass even the current implosion of the financial sector, affecting production as well as service industries.[7] Further, in an age of global media, no government wants to be seen as unresponsive to health threats originating abroad but potentially affecting its own citizenry. Out of concern for their voting populations, most national donor agencies have therefore responded to the call for greater attention to health issues and, as a result, have readily adopted measures aimed at curbing communicable diseases. The recent outbreak of swine flu in Mexico is a case in point. Fueled by the public's vivid memory of the outbreak of severe acute respiratory syndrome (SARS) in 2002 and 2003 and of avian flu in late 2005 and

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2006, high-level diplomatic efforts led to a global response to swine flu within days, and the World Health Organization (WHO) for the first time in forty years issued a global epidemic alarm.

With the public fixation in the global North on halting contagious diseases, one might expect options for prevention in the countries of pathological origin to be scrutinized with special care. But this has not always been the case. Evidence-based approaches to prevention, including those that challenge reigning paradigms, struggle to gain significant traction in global policy. For instance, following years of fighting for condom use across developing countries and against religious barriers, key donor agencies are slow to accept evidence that HIV in sub-Saharan Africa actually does not spread mainly through casual sex but rather is a result of long-term polygamous relationships.[8] A history of Western colonialism and the officially apolitical nature of international development assistance make donor agencies in the global North tread with caution when it comes to challenging deep-rooted social norms in the global South. But such historical factors are hardly the only explanation for the inertia of misguided global health policies. In the short-lived reality of global communication, being able to "tell" a story with a single, striking picture is crucial. So when colorful condoms are pitted against the much more intangible message of "loving carefully" (a phrase coined by some African governments to engage with the reality of polygamy by instilling critical reflection among their citizenry), it is the former that wins the most financial support. Similarly, remarkable health-related achievements, such as lowering the mortality of a specific disease in a country from 10 percent to 8 percent, rarely capture public attention in the same way as yet another health conference featuring renowned experts and famous civil society representatives. All the while, the chances of elevating the profile of those diseases that kill less visibly (for example, trypanosomiasis and mental health disorders), incapacitate less rapidly (leprosy), or are more confined to tropical latitudes (leishmaniasis) appear perilously slim amid the ongoing battle of images and ideas.

These processes of prioritization and public visualization are complemented by another important dynamic located squarely in the institutional realm. We need to recognize the existence of strong incentives for decision-makers to ensure their own political (that is, financial) survival. Organizational self-preservation is an imperative agenda among multilateral entities (as compared to national donor agencies), as these bodies operate under particularly hard budget constraints. Turf wars between agencies are the rule and not the exception, exemplified by

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the "bickering between leading players in the field of global health," such as the WHO and the Bill and Melinda Gates Foundation.[9] Hampering the prospects of effective cooperation and collaboration, turf wars result directly from the felt need to safeguard organizational mandates and budgets, and so to put one's own organization first. Meanwhile, the post–cold war era language of "human development" tries to put the political emphasis on cooperation and mutual support. Poverty, in this framework, is characterized as an evil that can be overcome if only all relevant players unite against it. This vision is a powerful one in its own terms; yet against a backdrop of overriding incentives for institutional self-preservation, the human development agenda, for one example, looks deeply unrealistic. Commitments by international organizations and corporations for closer partnerships—to ensure cohesion, for instance, or to avoid duplication of efforts—will often materialize on paper (particularly at well-publicized meetings) but rarely find their way into practice.

In the midst of a global economic crisis, the level of institutional entrenchment is likely to intensify. Pecuniary pressures force development agencies to strictly follow their strategic plans, which are primarily concerned with justifying a given organization's mandate. In addition, shortened planning cycles in response to the domestic crises of public finance undermine any declared intentions to give recipient governments not only the resources but also the time to assume a leading role in the prioritization and implementation of health and development policy. Furthermore, effective partnerships between national governments and nonstate organizations (private donors and corporate actors, in particular) require that all factors contributing to higher disease burdens in developing countries be tackled. Yet it has been shown that health donors tend to focus on doing what other donors do, and thus the sum of their efforts often concentrates on narrowly defined problems.[10] This is particularly the case in public health, where causes are complex and outcomes contingent on a range of factors, some of which—such as socioeconomic inequalities and resulting differences in risk and exposure—lie beyond medical interventions. This "bandwagon" phenomenon by which agencies follow a first mover's decision—whether effective or not—further limits the prospects of financial resources flowing toward currently under-resourced causes of ill health.[11]

For those who wish to break away from the bandwagon, the arrival of new sources of funding originating in the private sector marks a decisive juncture in global health finance. Yet, while these funds are more flexible, they are also less

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accountable to the public, which has important implications for evidence-based advocacy and policy-making. And if private resource flows broadly mimic the direction of government-funded assistance—and new findings suggest that they do—then there is even more reason to be concerned.[12] To increase the effectiveness of health investments, global partnerships currently often framed as "cooperation" around similar or even identical issues therefore require a radical recasting toward better "integration" of complementary efforts.

Before I sketch three concrete steps for reform, we need to briefly look at the discursive context in which such reforms would take place. The structural dilemmas outlined above are embedded in a discourse that pays lip service to equality and equity while obfuscating the great power discrepancies among the different stakeholders in global health and development. In a situation in which one side is giving and the other is receiving, true partnership is arguably difficult to achieve. The language of "capacity" is a case in point, since whereas the capacity of health systems in the less politically powerful South are cited regularly by the development industry as a major constraint on progress in global health, the capacities of international agencies in the global North are rarely subject to such scrutiny. David Fidler thus warns of a "global health version of the 'tragedy of the commons' [whereby] critical parts of the global health commons, particularly developing and least-developed countries, cannot adequately support the ongoing proliferation of activities, which tend to fragment already fragile local and national capacities for public health and health care."[13] But health systems, not least in developing countries, naturally require more time to mature than vertical interventions that target only one disease; and even despite this to-be-expected slow rate of change, absorptive capacity in developing countries has in many cases been improving. Meanwhile, the most recent internal assessment of the World Bank's investments in the fight against HIV/AIDS highlights that most of its projects have failed to achieve their designated targets.[14] The report even criticizes Bank staff for designing unjustifiably complex structures and setting overambitious objectives. It is doubly revealing, however, that what even this seemingly self-reflective critique boils down to is again a critique of developing countries' "lack of capacity." Blaming the slow progress in strategic areas of international support primarily on the reality that less developed countries are just that, less developed, will appear cynical as long as we continue to deny the very real political and economic obstacles in donor countries.

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A second limitation of the discursive realm for global health is its remoteness from the "ideal speech situation," as formulated by Jürgen Habermas in his work on discourse ethics.[15] Habermas proposes that those interested in a deliberation should be in a position to co-determine both the content and direction of the communicative process. In international development, however, interorganizational relationships are characterized by hierarchical schemas and not egalitarian participation. A recent investigation of possible correlations between pledged grants for global health from both ODA and private U.S.-based foundations on one side, and local preferences measured by local surveys on the other, shows that when funds are committed, neither multilateral agencies nor foundations seem to take into account what recipients in Africa, Latin America, and the poorer parts of Asia consider the most severe causes of ill health (which include respiratory diseases, complications during childbirth, and the lack of access to primary care more generally).[16] As a result, one question that is gaining prominence in policy circles—how to localize the health dimension of the UN Millennium Development Goals—appears to be much less a technical than a political one.

Toward Better Agency: A Three-Pronged Agenda for Radical Reform

The new players in global health finance—the Global Fund to Fight AIDS, Tuberculosis, and Malaria (an international public-private partnership created in 2002); the Global Alliance for Vaccines and Immunization (GAVI); and numerous, mostly U.S.-based, private foundations—all harness resources from divergent arenas and coordinate them for specific causes. But they alone cannot ensure global coverage of resources for and access to health. Their focus on a number of diseases and countries is likely, at best, to provide an imperfect solution to the multitude and magnitude of global health challenges, and over the long run may even serve to increase inequalities both within and among world regions. Nonetheless, because of their function as financial trendsetters, and also given the fact that they dominate agenda-setting processes, any sketch of a sectoral reform must begin with them.

The first change necessary to increase the effectiveness of global health finance is located in the global North: specifically, I refer to the international organizations whose priority is to safeguard their mandates and thus ensure their survival. In order to remove this powerful obstacle to efficient cooperation, bilateral donors

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need to be called upon not to play organizations off against each other but rather to negotiate for a transparent and reliable division of labor among them. In addition, and mimicking funding conditions that were imposed on developing countries by the Global Fund, agencies should demand that multilateral organizations cooperate with private foundations and NGOs wherever possible. Foundations bring a wealth of resources and managerial skills from the private sector to the table, but they often lack the operational experience in resource-scarce settings. Multilateral organizations, for their part, occupy a strategic niche as international conveners and, in some cases, legislating bodies. Large NGOs that run programs in all major developing regions, meanwhile, are repositories of contextual local knowledge, which multilateral agencies and global corporations commonly lack.

But in order to prevent such reinforced collaboration in the global North from dominating health reform agendas in the South even more than is currently the case, a second, explicitly political reform should aim at correcting the power imbalance between donors and recipients. If global health finance is to avoid becoming the next bursting bubble—in this case the result of political recoil in response to failure to produce discernible positive effects on global poverty and inequality—the steerage of priorities must be transferred to the recipient side. At the moment, the process of national prioritization suffers from two major distortions. First, recipient governments tend to align with the dangling carrots of aid funds rather than setting priorities independently.[17] This is particularly worrisome since the decline of earmarked funding during the early years of the current decade and the return to earlier sector-wide approaches has slowed as a result of the activities of highly selective nonstate donors.[18] Second, in less-than-democratic local political structures, with weak accountability, both effectiveness and efficiency are threatened as resources are at risk of being diverted to special agendas. The occasional donor argument that existing project selection criteria upheld by different global health partnerships already incorporate a mechanism to ensure local deliberation fails to convince. While these catalogs of criteria do demand that proposals submitted for funding be sectorally diverse and include several stakeholder groups, the scope of funding is nonetheless limited to the institutional objectives of the scheme, which commonly target selected rather than holistic aspects of health care. Moreover, the argument that project selection mechanisms are effective in ensuring that projects incorporate the voices and opinions of recipients rests on the erroneous assumption that those civil society "partners" who are invited to participate as cosigners actually represent societal interests.

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Rather than creating perverse incentives for recipient country governments by offering them funding for the donors' favorite dishes of the day, donors must allow national governments in the global South to determine where they see the most urgent needs. True ownership of this process requires that recipient governments identify priorities from the complete range of sectoral components and diseases. Intensified South–South cooperation is one strategy that holds the potential to allow developing countries to amplify their voices in global negotiations and eventually loosen the grip of international financial interests. It is in the best interest of governments of high-income countries to support this process of emancipation. Resource mobilization within developing countries themselves—such as co-financing through fund-matching schemes—is the only way to ensure that recipient governments think about and, where necessary, fight hard for agendas that to them appear worthy of financial support.

Finally, a radical agenda to improve the health status of the most vulnerable obliges its proponents to view these people as active agents of their own destinies. Undeniably, the ability of "beneficiaries" to speak politically varies greatly, especially given the existence of authoritarian regimes. With the latter often coinciding with significant disease burdens (but not always, as the case of Cuba attests), the political dimension of contemporary health interventions is complicated even further. Opportune moments for deliberate changes only arise where actors possess both the resources and knowledge necessary to challenge a status quo. It is imperative, therefore, to merge health policy with other sectors of international development—from primary education to the inclusion of women in the workforce and political life—and to redirect public and private investment toward programs that work holistically by linking health interventions with political mobilization and employment creation. Related evidence-based campaigns need to target current decision-makers as much as taxpayers and intended beneficiaries.

Health system reforms cannot be conducted in a top-down fashion and in isolation from the larger political economy of development. Global health beneficiaries or their representatives must be permitted to play an agenda-setting role and, where political risk permits, they should be encouraged to do so. There is a clear difference between mobilizing beneficiaries around agendas conceived in regional headquarters of aid agencies and supporting the mobilization of aid recipients around issues ranking high on their agenda—or even facilitating the formulation of such an agenda. In the absence of economic escapes from local scarcity and squalor, political mobilization is one of the few channels of progress

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available to the poor. The international community must cease sweet talking about global partnerships while focusing on some diseases and ignoring many others.

Nobody would suggest that the ongoing U.S. health insurance crisis could be overcome by making technical adjustments and revising budgets. The analogous proposition—highly popular these days—that technical fixes and more money are sufficient to lift billions out of ill health and, ultimately, poverty is equally out of sync with reality, and makes little economic or ethical sense. Ultimately, enabling effective local agency for health in developing countries is not primarily a technocratic or a financial challenge, but a political one.

NOTES

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