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Reopening a healthy debate about aid
by Peter Browne

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A week before Christmas Gordon Brown, the British Chancellor of the Exchequer, went to Washington and gave a speech that irritated his hosts. Reflecting the widespread feeling that the events since September 11 demand a reassessment of international relationships, he proposed that the total overseas aid budget of western countries be doubled to nearly $A 100 billion a year. In response, the US Treasury Secretary, Paul O’Neill told journalists that the US would only consider a large increase in funding if it could be demonstrated that overseas aid actually “works”.

Not long after Mr Brown’s speech, the World Health Organisation released a major new report called Investing in Health for Economic Development. It shows that, at least some of the time, overseas aid has “worked”. It also provides a plan for increased overseas aid which should satisfy many sceptics, and a guide to an emerging strand of thinking about how the international community might reduce the downside of globalisation.

Investing in Health for Economic Development is the work of the Commission on Macroeconomics and Health, established by the WHO in early 2000 and chaired by the Harvard economist Jeffrey Sachs. It’s pretty clear that the makeup of the commission is designed to maximise the chance that its recommendations will receive a sympathetic hearing among governments which have been scaling back rather increasing their aid programs. Alongside academic economists and health policy analysts, the commission’s members include the director-general designate of the World Trade Organisation, a deputy secretary of the OECD and the deputy director of the International Monetary Fund – not exactly a group of people we’d expect to propose a steep increase in aid.

The encouraging news about aid comes early in the report. Between 1960 and 1995 life expectancy in low-income countries rose by 22 years, compared to a rise of 8 years in the West. The mortality rate of children under five fell from 150 per 1000 in the 1950s to to 40 per thousand in the 1990s. And these gains, says the report, weren’t just “a natural fallout of economic development”. Health initiatives – immunisation, insecticides,
improved case management – made an important contribution to longer and more productive lives.

But despite those gains, the statistics for the 48 “least-developed” countries are still shocking. Infants die at a rate of 100 per 1000, compared with 6 per 1000 in high-income countries. Life expectancy is 51 years, compared with 78 years among the wealthy. In Africa in particular, AIDS-related illness and death is a devastating new burden. Meanwhile, levels of childhood vaccination “stagnated or dropped” in many poor countries in the 1990s, leaving many children to die of diseases routinely treated in wealthier countries.

On the basis of these figures the Commission on Macroeconomics and Health puts forward two separate but related arguments for an increased flow of aid.

First – responding to critics of aid programs who claim that only deregulation and free trade can deliver higher economic growth and better living standards in the third world – the commission calculates the economic benefits of longer, healthier lives. Rather than creating a larger reservoir of underemployed labour, the report shows that reduced ill-health and fewer early deaths will contribute to higher productivity and a better national economic performance. For many families in the poorest countries, an unexpected illness or chronic ill-health can turn a subsistence income into no income at all, or force children to leave school and look for work. For businesses, illness and high rates of job turnover undermine productivity and reduce viability.

In the longer term, the figures show that improved health can lead, seemingly paradoxically, to a fall in the rate of population growth as families become less likely to overcompensate for expected infant deaths. For countries in which population pressures are undermining living standards population growth will begin to ease and economic stability increase.

The commission’s second argument for more aid is based on the potential for direct, measurable improvements in people’s lives once health services are better funded and better organised. The biggest single cause of early deaths in the commission’s “least developed” nations are infectious diseases. In many of these cases, health measures exist which could have averted death. Insecticide-treated mosquito nets, for example, have become a simple
but effective component of anti-malaria strategies in countries like Vietnam and Kenya. They not only directly protect the user of the net but help reduce the infectivity of mosquitoes, lessening the danger for people who do get bitten. Yet in many countries the lack of an effective, decentralised health system, or the simple lack of funds, has prevented such low-cost measures from being adopted.

Obviously there are constraints on the wider use of preventative measures and treatments. Funding is one key problem, but even the largest conceivable increase in donor funds would not cover the costs of new and emerging drugs at first-world prices. Because they were so expensive, HIV/AIDS treatments being sold into Africa by the large, patent-holding drug companies have been a focus of intense debate over the past year, with some significant concessions from the manufacturers. The Commission on Macroeconomics and Health wants to take that process further and formalise guidelines for differential pricing of pharmaceuticals according to local ability-to-pay. The precise arrangements – including safeguards for both government and companies – are complex but deserve serious consideration.

At the core of Investing in Health for Economic Development is a series of recommendations designed to build up and adequately fund healthcare delivery systems. About a quarter of the poorest billion people live in countries which face enormous problems – official corruption, civil war, hostile climate – in creating and managing adequate health services. In each case health programs will need to work around enormous gaps in local capacity. But another three-quarters of those people live in less extreme circumstances, where the basic infrastructure of government is present and has the capacity to work in partnership with international agencies.

In a high proportion of the poorest countries, a relatively low proportion of gross national product is spent on health. The commission wants these countries to increase the share of GNP going to health by 1 per cent as of 2007 and 2 per cent as of 2015 – on the basis, of course, that donor countries make the report’s recommended increases in their contributions.

Interestingly, the report warns against any further privatisation of health care financing. Already, a relatively high proportion of health spending in these countries comes straight out of the pockets of individuals, with most people have no access to government-sponsored insurance schemes. The commission recommends that money currently spent directly by individuals
instead be channeled into community financing schemes to help fund a local, community-based health services to complement restructured national health systems. The central government’s responsibility would be to decentralise health infrastructure so that the techniques and pharmaceuticals funded by donor countries can more effectively be directed to where they are needed.

Better systems and a greater commitment of local funds will provide some health gains, but to make significant inroads into the level of illness and early deaths will require more donor help. According to the commission, an additional $US 22 billion is needed per year by 2007 and an extra $31 billion by 2015 to enable universal coverage of basic health care and to boost research efforts in dealing with diseases like malaria and tuberculosis (see box).

Early signs are that it’s not a plan that will win the whole-hearted support of the US government. Paul O’Neill and his US Treasury colleagues will no doubt argue that such much of the significant boost in health funds would be wasted by inefficient or corrupt governments. But the commission has recommended detailed measures to make sure funds are carefully spent. Countries wishing to gain access to donor funds would need to prepare a detailed plan for using the resources fairly and effectively before any funds changed hands. (It’s worth noting that, as a proportion of GDP, the US’s overseas aid program is the smallest among the 22 OECD countries mentioned by the commission.)

Critics of increased aid also highlight the apparent intractability of poverty and ill-health in specific regions, especially tropical countries. But the commission’s report shows that these regions face much greater health challenges than countries with more temperate climates. Malaria is largely confined to tropical areas, for example, with sub-Saharan Africa further burdened by the most pernicious mosquito vector. Parasitic diseases like onchocerciasis and schistosomiasis make life especially difficult in specific tropical areas. A relatively high level of migrant labour with Africa appears to encourage the spread of HIV/AIDS. The report draws on an econometric study to argue that more than half the shortfall in Africa’s growth compared to East Asia can be explained by disease, demography and geography.

Criticism has also begun to emerge from overseas aid organisations and sympathetic academics. Their concern is with the report’s emphasis on the economic benefits of healthier, longer lives – and sometimes the language of
the report does seem disconcertingly emotionless in the face of great suffering, although the emphasis on economics was obviously part of the WHO’s strategy in commissioning the report. They also fear that the report will divert attention from what they see as the real problem: the brutal impact of a globalised world economy. No doubt the commission would respond by saying that it should be judged on the basis of what it sets out to do, rather than what its critics say it should have done.

In important ways the commission runs counter to the rigid economic orthodoxy of the past two decades. By implicitly arguing against a US-style approach to healthcare financing in poor countries, by proposing redoubled international pressure on drug companies, and by challenging the institutionalised “compassion fatigue” of the West it contributes to the necessary reassessment of global relations.

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