Health development – a global perspective

– secondary publication

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ABSTRACT

Countries like Mozambique and Tanzania have shown that some of the poorest countries in the world can make significant health gains with relatively limited additional financial resources. The global health development efforts are focused on the three health related Millennium Development Goals, which have inspired the launch of important new Global Health Partnerships. The more focused global health development effort, matched with increased investments in health development, raises the prospective of further health gains in the coming years.

Newspaper articles on the health situation in developing countries are often very depressing reading. Few people realise that many developing countries have experienced significant improvements in health over the last couple of decades. Some of the poorest countries in the world e.g. Mozambique and Tanzania have experienced a significant reduction in child mortality during the last 5-10 years as reflected in the Demographic and Health Surveys[1] from the two countries.

HEALTH STATUS AND DISEASE BURDEN IN DEVELOPING COUNTRIES

Low-income countries have experienced an increase in life expectancy of 22 years in the period 1960-1995, as compared to industrialized countries that only experienced an increase in life expectancy of 8 years over the same period of time [1]. Despite the improvements seen in developing countries there are still considerable disparities, both between developing and developed countries and within developing countries. 99% of the recorded child and maternal mortality in the world occur in the developing countries and is closely associated with poverty [1]. There are more than one billion people in the world living on an income below 1 USD per day of which approximately 300 million live in Africa South of the Sahara. They represent approximately half of the population in that part of the world [2].

The positive trend in life expectancy has continued over the last decade in most developing countries, except for the countries in Sub Saharan Africa with a high HIV/AIDS disease burden. The life expectancy has increased by 3.3 years in the period 1990-1999 in the countries with low HIV/AIDS disease burden whereas it decreased by 3.6 years in the countries with high HIV/AIDS disease burden [1]. There were 35 countries in the world with a HIV prevalence of more than 2%, in the age group 15-49 years of age, in 2003 according to UNAIDS. Of the 35 countries 29 were located in Sub Saharan Africa.

Diarrhoea, pneumonia and malaria are the leading causes of the high child mortality in developing countries, which was also the case 20 years ago [3]. Diseases that can all be cured with known cost-effective health interventions, which low-income countries can afford within their present public health budgets. Current estimates indicate that roughly two thirds of the close to ten million children under five years of age dying every year could be saved if standard low-cost health interventions were available in developing countries [3].

WHAT HAVE THE DEVELOPING COUNTRIES DONE TO IMPROVE THE PERFORMANCE OF THE HEALTH SECTOR?

During the last three decades there have been a number of health system reforms in developing countries, which have aimed at securing the whole population better access to basic public health care services and interventions. The first wave of reforms were based on WHO's and Unicef's Primary Health Care Strategy that was launched in 1978 in Alma Ata (now Almaty, Kazakhstan). The strategy was based on previous primary health care reform efforts in countries like China, Cuba, Sri Lanka and Tanzania [4]. The Primary Health Care reforms' efforts had a major influence on the health sector development in most of the developing countries in the 1980's and 1990's, but with varied degrees of success.

Compared with the Primary Health Care reforms, which were predominantly focused on the provision of basic health care services and interventions by paramedic health personnel for poor population groups, the health reforms in the last decade have focused more on the delivery of a package of health interventions (addressing the prevailing disease burden) and making them available to the whole population involving all the levels of the health care system (the primary as well as the secondary and tertiary health care system) [4]. The ongoing reforms also recognize that the public sector has an important role in securing people's access to health services, but that the governments do not necessarily have to provide all the health interventions through the public health care system [4]. Health financing and financial barriers to accessing health care have been at the core of the reform efforts during the last decade. There has also been an increasing recognition that the introduction of user charges for primary health services is a serious barrier for poor people's utilization of basic health services. This has led to a renewed effort in many developing countries of introducing various forms of national health insurance schemes with the aim of securing that population groups who can afford services pay for them whereas the poorer segments of the population are secured access to basic health services free of charge [4].

ENCOURAGING REFORM RESULTS IN TANZANIA

The reforms in Tanzania have shown that significant improvements in the health status of the population can be achieved with even a slight increase in the financing of the public health sector. The health sector in Tanzania has, as in many Sub Saharan African countries, been characterised by poorly performing health systems, and an acute lack of financial as well as human resources. Malaria, HIV/AIDS, tuberculosis, malnutrition and anaemia have been the leading causes of ill health. Poor segments of the population are trapped in a vicious circle of poverty leading to ill health, which then prevent them from increasing their income and being in a position to pay for the needed preventive and curative health services and interventions in the future [5].

The ongoing health reforms in Tanzania were initiated in the mid-1990's focussing on improving the capacity of the district health services. A central feature was to secure that the financial resources were better targeted to the prevailing disease burden at the district level. That was achieved by improving the ability and capacity of the district health teams to plan and prioritize the utilization of the available resources through in-service training and through the introduction of new planning tools that secured a better alignment of the provided services and interventions with the local disease burden.

The first positive results from the reform efforts were recorded in 2004 in the districts where the new tools were developed and tested. An impressive 40% reduction in the child mortality was recorded over the five year period after the new tools were introduced. The adult mortality (15-60 years of age) was reduced by 18% over the

same period of time [5]. The first national results came in 2005 and confirmed the positive trend by documenting a 32% nation wide reduction in the infant mortality and a 28% reduction in the child mortality in children under five years of age [6].

GLOBAL TRENDS IN HEALTH DEVELOPMENT ASSISTANCE

OECD could in 2004 for the first time, after many years with falling development assistance, record a significant increase in health development assistance [7]. From the current level of approximately 3.5 billion USD per year it is expected that the development assistance to health will increase to around 7.5 billion per year in the coming years, if the donor countries live up to their commitments.

Development assistance has for some years been focused on supporting the developing countries in reaching the Millennium Development Goals (MDGs), three of which are related directly to the health: Goal 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate; Goal 5: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio; and Goal 6: Have halted by 2015 and begun to reverse the spread of HIV/AIDS.

NEW GLOBAL HEALTH PARTNERSHIPS

A number of Global Health Partnerships (GHPs) have been established over the last couple of years to address the health MDGs based on the realization that the related global disease burden can be reduced significantly with known effective health services and interventions. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was launched in January 2002 to support public and private sector projects in developing countries aimed at preventing and treating people affected by HIV/AIDS, tuberculosis and malaria. The GFATM had by the end of 2002 approved projects to the tune of 4.4 billion USD in 128 countries and had by the end of 2005 assisted in securing that 7.7 million insecticide treated bed nets were made available to the population in developing countries affected by malaria; that approximately 1 million people were receiving treatment for tuberculosis; and that close to 400,000 people were receiving ARV treatment [8].

The Global Alliance for Vaccines and Immunizations (GAVI Alliance) was established in 2000 with the aim of securing that all children in developing countries have access to the routine child immunizations and new vaccines addressing life threatening infectious diseases in children. The GAVI Alliance had by the end of 2005 approved funding to the tune of 1.6 billion USD for 75 developing countries, and the preliminary results indicate that the Alliance has contributed to preventing close to 1.7 million deaths in children under five years of age [9].

Both the GFATM and the GAVI Alliance have realised, during the course of the last couple of years that it's not enough to secure the financing of health programmes aimed at specific diseases to achieve long-term sustainable health goals, if the health systems that are supposed to deliver the services and interventions lack personnel and the needed logistical systems. Both global health programmes have therefore made it possible for countries to apply for funding aimed at strengthening health services and the capacity to provide basic health care services to population groups in hard to reach areas.

NEED FOR IMPROVED AID EFFECTIVENESS

A consensus around a global strategy for supporting developing countries in reaching the health MDGs has emerged over the last couple of years between recipient countries and the major bilateral and multilateral donors in health. The strategy is based on an assumption of increased financial resources for the health sector and a corresponding increase in development assistance to health; a better utilization of the existing financial resources; increased health personnel; and results based management of the efforts in the recipient countries and of the development assistance [10]. Beside the above measures the actual mix and design of the development assistance in each country will be crucial for a continued successful and sustainable development of the health sector and the health status of the population in low-income countries. In this connection it will be important that the UN organizations, the development banks and the bilateral donors adhere to the best practice principles of development assistance outlined in the Paris Declaration[2] from 2005 and that a more balanced financing of the health sector is secured with increased focus on capacity building of the recipient country health systems. (Box 1)

Main points

Low-income countries have experienced an increase in life expectancy of 22 years in the period 1960-1995.

Some of the poorest countries in the world e.g. Mozambique and Tanzania have experienced a significant reduction in child mortality during the last 5-10 years.

More focused global health development effort, matched with increased investments in health development, raises the prospective of further health gains in the coming years.

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Notes

1. Demographic and Health Surveys (DHS) are nationally representative household surveys with large sample sizes (usually between 5000 and 30,000 households). DHS provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition. Typically, DHS are conducted every five years, to allow comparisons over time.
2. The Paris Declaration, endorsed on 2 March 2005, is an international agreement to which over one hundred Ministers, Heads of Agencies and other Senior Officials adhered and committed their countries and organisations to continue to increase efforts in harmonisation, alignment and managing aid for results with a set of monitorable actions and indicators.

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