False economies
A global health crisis

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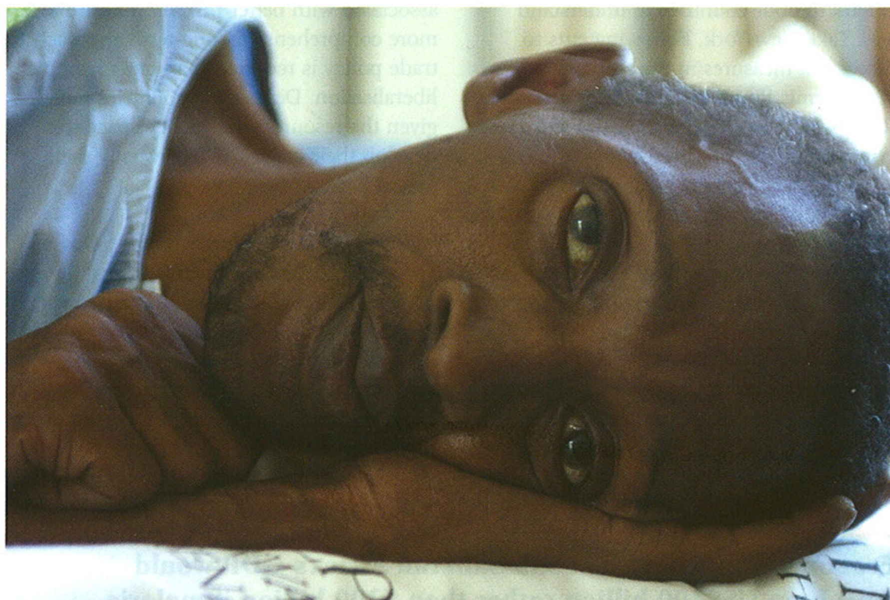
In an age obsessed with economic efficiency and tax cuts, it is ironic that by allowing health systems in developing countries to deteriorate, the industrialised world is engaged in one of the most dangerous experiments in false economy in history.



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The UN Millennium Development Goals, particularly those to reduce under-5 and maternal mortality and to halt the spread of HIV/AIDS, malaria and tuberculosis, are far from being reached.

HIV/AIDS killed some 3 million people in 2003. Around 40 million are infected, including 2.5 million children, and each year there are some 5 million new infections.

Tuberculosis is in a similar league. One third of the world's population is infected. In 2002, there were 8.8 million new cases, and around 2 million deaths from TB. There are cures, yet only around 37% of TB cases receive proper treatment, due to a lack of resources and unreliable supplies of quality drugs. As a result, multi-drug-resistant TB (MDR-TB) incidence is surging, with 300,000 new cases each year. MDR-TB is a hundred times more expensive to treat than normal TB.

Another major killer is malaria – and as with TB, drug resistance is a growing problem. Each year there are 300-500 million cases, with 1-3 million deaths – mostly children. The social and economic burden of such endemic infection is catastrophic. Economists have estimated that sub-Saharan Africa's GDP in 2000 would have been US$400 billion rather than $300 billion if malaria had been eliminated in 1965. Instead, malaria continues to undercut sub-Saharan Africa's GDP per capita growth rates by some 1.3 percentage points per year.

These are just three major diseases. There are many others, caused by poor access to clean water, inadequate sanitation and malnutrition. Over a billion people still do not have access to clean water and 2.4 billion have inadequate sanitation.

Disease and poverty cannot be allowed to win like this. Without a literate and healthy workforce, poor countries have little hope of sustained economic and social development. Malnutrition and illness in childhood can stunt both physical and intellectual growth. We all agree that education is fundamental, but sick and hungry children are often unable to attend school, and cannot learn well. As a result, many countries are finding themselves with large pools of poorly educated, unemployed and alienated young people. This is hardly a recipe for fostering the political stability, social cohesion and investment climate necessary for development.

The 2003 WHO *World Health Report* emphasises the urgency of rebuilding developing country health systems, but this cannot be done without a substantial increase in resources. At a time when new pledges are being made to boost aid (see article by Richard Manning, p. 36), we need concerted action on some focused areas if we are to stave off this global public health disaster.

1 **More aid to health:** The money available for combating global epidemics and collapsing health systems remains meagre. For example, the total funds allocated to TB control in so-called High Burden Countries were a mere

$884 million in 2002. Since its inception in January 2002, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) has received pledges of only $5.4 billion through to 2008 of the $10 billion requested.

This is a false saving and you do not have to look to poor countries to understand why. Take New York. Following cuts to TB control measures in the late 1970s, a TB epidemic flourished, resulting in 20,000 more cases between 1979 and 1994 than would have occurred without the cuts. Around 20% of patients were infected with MDR-TB, which pushed the total costs of the epidemic to well over $1 billion. Stopping the epidemic was a public health triumph, but it took 20 years to get infection rates back below their 1980 level.

Russia faces a far bigger challenge. It has been estimated that of Russia's one million prisoners, around 100,000 have infectious TB and up to 30,000 of those have MDR-TB. Each year 300,000 prisoners are freed, around 30,000 of whom have infectious TB – and of these, 10,000 have MDR-TB. The OECD countries should not delude themselves into thinking they will be unaffected.

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2 **Greater market access:** Developing countries have a legitimate grievance that, despite declining terms of trade for primary commodities, they are still denied fair access to rich country markets, and are undercut in export markets by massive EU and US agricultural subsidies. It is a scandal that around six times more is spent subsidising agriculture in OECD countries than is given in aid.

Just as important as market access, however, is how reliant a country is on a narrow range of exports. A recent World Vision report, *Risky Development*, found that such export concentration is associated with increased terms of trade volatility, higher levels of infant mortality, lower levels of immunisation against measles and diphtheria, pertussis (whooping cough) and tetanus (DPT), lower female life expectancy and higher levels of female illiteracy among both youths and adults. It also matters what types of products countries export. Higher proportions of goods exported are generally associated with better poverty indicators. A more comprehensive, long-term approach to trade policy is required than one of simple liberalisation. Developing countries must be given the resources and policy space to develop their capacities to diversify their export bases appropriately.

3 **Reverse the "brain-drain":** One of the greatest constraints in scaling up public health efforts in the poorest countries is the lack of trained staff. Yet far from supporting developing countries' health systems, some industrialised countries are actively undermining them by recruiting health workers for their own systems, which they have systematically under funded. For example, between a third and a half of South African medical graduates emigrate. A multilateral solution based on ethical recruitment protocols and compensation for countries losing skilled personnel is urgently needed. The UK government's 2001 Code of Practice for the international recruitment of healthcare professionals strongly condemns recruiting in developing countries except under strict conditions. This is encouraging, but a long-term solution must be based on creating incentives for local staff to stay. Again, this requires resources, which many countries simply do not have.

4 **Better drugs and vaccines:** Between 1975 and 1997, only 13 of the 1,223 new medicines commercialised were for tropical diseases and there has been no new class of TB drugs produced since 1966. Diseases of poor countries do not generally incite pharmaceutical companies to develop new drugs. But incentives could be created, by having bodies such as GFATM make pre-commitments to purchase newly developed medicines and vaccines.

5 **Relax conditionality:** Seriously AIDS-affected countries, particularly in Africa, must be treated as special cases, with more relaxed conditionality frameworks for their World Bank/IMF loans. This would enable their governments to focus more effectively on the fight against AIDS.

Failing to respond to the global health funding crisis will cost OECD countries dearly. It will postpone the day when poor countries will be rich enough to form vibrant new export markets; it will boost the flow of asylum seekers; it will require expensive interventions in failed states; and it will allow potentially catastrophic multi-drug-resistant diseases to ferment largely unchecked.

How much would it cost to seriously address these problems? The chair of the WHO's Commission on Macroeconomics and Health, Jeffrey Sachs, reported that it would require an extra $25 billion annually from the rich countries. That's about *one thousandth* of their annual income; ten cents in every hundred dollars. False economy, indeed. How's that tax cut looking now? ■

References

- A fully referenced version of this article is available from the author at: brett_parris@wvi.org
- Currah, K. & Whaites, A. (Eds) (2003), *False Economies: Why AIDS-Affected Countries are a Special Case for Action*, World Vision International, Geneva.
- Gallup, J.L. and Sachs, J.D. (2001), "The Economic Burden of Malaria", *American Journal of Tropical Medicine and Hygiene*, Vol. 64, No. (1,2)S.
- Parris, B.W. (2003), *Risky Development: Export Concentration, Foreign Investment and Policy Conditionality*, World Vision International, Geneva.
- Reichman, L.B. and Tanne, J.H. (2002), *Timebomb: The Global Epidemic of Multi-Drug-Resistant Tuberculosis*, McGraw Hill, New York.
- Sachs, J.D. (2003), "Achieving the Millennium Development Goals: Health in the Developing World", speech at the Second Global Consultation of the Commission on Macroeconomics and Health, Geneva, 29 October.