CHRISTOPH BENN

Investment in Health as a Prerequisite for Economic and Social Development

There are many good reasons why people care for the health of others, particularly so if it comes to the poorest people in the world. Some care for the needy out of humanitarian considerations. Others would like the human right to life and access to health care become a reality. Some feel the responsibility also to help the remotest of neighbors. In the past few years, however, a new, very good reason has been added to the list: adequate health care as a mere prerequisite for economic and social development.

The *"Commission on Macroeconomics and Health"* (CMH) of the World Health Organization (WHO) carried out background research supporting this argument. In December 2001 the Commission presented its results. For a long time many experts were convinced that the improvement of health indicators are largely a consequence of economic development. The correlation of better living conditions and health is much contested. It can now, however, be proven that investment in health is an essential precondition for reducing poverty and boosting economic activities.

In the Least Developed Countries (LDCs) 16 million people die every year of malaria, tuberculosis and AIDS or because of infectious diseases, alimentary deficiencies and complications during pregnancy, birth or childbed. These are the reasons why the death rate in the poorest countries is so much higher than in the richest countries of the world. Most of these deaths, however, are avoidable.

Tuberculosis, for example, can be treated with a DOTS therapy, applicable under most modest conditions. Malaria can be combat by means of impregnated bednets, insecticides and specific therapies. Awareness-raising campaigns for young people, targeted prevention of sexually transmitted diseases with prostitutes and their clients and the testing of blood transfusions can undoubtedly reduce the incidence of HIV infections. Antiretroviral drugs help to prevent the HI virus to be transmitted from mother to child and prolong the life of AIDS patients. Vaccines and the integrated management of infectious diseases with children – ranging from respiratory tract infections and diarrhea to malaria – can decisively reduce child mortality. Maternal mortality can also be significantly lowered by providing access to essential obstetric services – including the possibility of surgical delivery. In LDCs it is still only a very small percentage of the population that has access to such simple and approved health care services.

If the access to such basic, preventive and clinical services were gradually facilitated, mortality for reasons of infectious diseases and maternal or infantile causes in Sub-Saharan Africa and in countries with a low per-capita income in Asia and Latin America could, according to the Commission, be reduced by half. On the medium term the lives of 8 million people could be saved each year.

The Commission calculates that LDCs would have to spend 30 to 40 US$ per person per year in public health to achieve this goal. This seems to be a rather small amount but for countries with a very low per-capita income it is just not affordable. Industrialized countries would have to raise a total amount of 27 billion US$ per year in order to achieve a major breakthrough in the field of health care. At first sight this seems unrealistically much but considering that the SARS epidemic in 2003 alone cost the South-East Asian economy 30 billion US$ (according to WHO estimates) and that it could have been avoided with a better infrastructure, the invested amount seems reasonable after all.

The economists of the Commission would not live up to their name had they not pointed out the economic advantages of such a global investment in health care in poor countries. According to careful estimates the economic benefit could amount to at least 360 billion US$ per year, which would be due to the enhanced productivity of people and faster economic growth. This is an amount many times higher than the original investment. Plus there is another dividend from investment in health the commission expressly pointed to: in all areas with bad health conditions the danger of coups, civil wars and failed states is especially high. Investment in health care thus not only saves lives in poor countries and, in the long term, strengthens their economic power, but also contributes to the security of us all.

One concrete suggestion of the Commission was to set up a global health fund for the purpose of raising additional financial means to be used effectively for the worldwide battle against infectious diseases. In January 2002 the Global Fund to Fight AIDS, Tuberculosis and Malaria was established. The secretariat in Geneva and the board have meanwhile taken up their work. The Global Fund was promised financial support amounting to 4.6 billion US$ over the next few years (as of June 2003). Up to now 1.5 billion US$ thereof have been allocated to more than 160 programs in 92 countries. Among the first measures funded with this money were programs in Tanzania, where mosquito nets were handed out to protect children in particular from being infected with malaria, an exemplary initiative in Haiti, which gave people with HIV/AIDS access to effective treatment and a comprehensive program to fight tuberculosis in Sri Lanka.

Applications are dealt with in the recipient countries by so-called *Country Coordinating Mechanisms*. These local assessment bodies are composed of government representatives, NGOs and representatives of the private sector. In special cases NGOs can also apply with the Global Fund directly. This applies especially for countries in situations of war, countries with no internationally acknowledged governments or countries actively suppressing certain groups of the civil society. As soon as applications have passed the *Country Coordinating Mechanism* they are referred to a panel of tuberculosis, AIDS and malaria experts, the so-called *Technical Review Panel*. The panel consists of international specialists from both the North and the South.

The procedure from the initial application to its approval is based on close cooperation. Applications are jointly assessed within the recipient country by the government and NGOs, the technical quality is evaluated by a panel in which experts from the North and the South equally work together. Applications are then approved by a board where donor and recipient countries as well as governmental and non-governmental organizations can cast their vote. This is an innovative and unprecedented mechanism.

The Global Fund triggers development in many countries, irrespective of financial promises. It has been reported from many countries that the establishment of the *Country Coordinating Mechanisms* lead to a fresh and improved cooperation between the governments and the civil society.

The developments of the past few years give real hope to those experts in the health sector who are committed to improving health care in poor countries. Politicians, economists and experts of development cooperation realized that investment in health must become a priority in order to enable people around the world to live a life in dignity and security. Eventually we will all benefit from such a world. This objective is a “global public good”, a task that must be financed and supported by the global community as a whole. The Global Fund, however, is a first essential step to making this vision a reality.