CHATHAM HOUSE

briefing paper

AIDS: Five Neglected Questions for Global Health Strategies

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Summary points

- The recent rise of Health Systems Strengthening as a policy priority suggests that a move away from single-disease approaches to global health may be occurring.
- As the largest attempt by far to tackle one disease, the global AIDS effort has acted as a lightning rod for criticisms of global health initiatives focused on single diseases.
- Global AIDS institutions have sought to respond by broadening their mandates to incorporate some wider systemic interventions into their activities.
- However, as the debate over addressing particular diseases or investing in health systems continues, five important underlying political and ethical questions are being neglected, including whether there is an ideal health system, the time-scales involved, the definition of sustainability, governance/structural capacity and political will.
- If a more sustained and coordinated effort to improve health outcomes is to become a reality, these difficult questions will need to be tackled.

Introduction

It is now a little over 30 years since early reports of unusual clusters of Kaposi's sarcoma cases in New York and San Francisco alerted medics and scientists to the existence of a significant but then unknown threat to human health. Gay-Related Immune Deficiency Syndrome, as it was originally known, was re-named Acquired Immunodeficiency Syndrome (AIDS), and cases rapidly began to be identified across the world. By the time the Human Immunodeficiency Virus was identified in 1983 it was already becoming clear that this was a genuinely global problem.

The international response to AIDS has changed beyond all recognition in the intervening years. New global institutions, most notably UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria, have been created. High-level political commitments from the G8 and others have been made. The level of funding that AIDS now attracts is unprecedented in the history of global health. Although donor funding fell in 2010 for the first time in a decade, the estimated US$6.9 billion that was disbursed was still more than five times higher than the amount donors spent on AIDS in 2002, and far higher than the amount spent on any other single global health issue. The United States remains the biggest contributor, accounting for well over 50% of total donor spending,[1] but it is also perhaps the most striking example of the extent to which AIDS now dominates the global health landscape. In 2010 the President's Emergency Plan for AIDS Relief (PEPFAR) accounted for more than 70% of the overall US global health budget.[2]

Although this funding has resulted in some significant gains, there have been complaints in some quarters that the amount of effort and money that has been devoted to AIDS has distorted the global health agenda, with other health issues losing out. This debate has naturally been a highly sensitive one. Few commentators want to be interpreted as arguing that AIDS is unimportant. But some have questioned whether too much attention has been focused on it.[3] Particularly interesting has been the recent revitalization of an old public health debate over whether 'vertical' programmes aimed at particular diseases should be pursued or whether 'horizontal' programmes, which seek to strengthen health systems more broadly, should be the priority. As a result of the status of AIDS programmes as the contemporary vertical effort *par excellence* they have become a lightning rod for much of the criticism of the vertically oriented nature of contemporary global health governance.

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This ongoing debate, and the ways in which global health policy communities are responding to it, form the background to this briefing paper. It begins by briefly looking at current global efforts to tackle AIDS and the ways in which the major AIDS institutions – in particular UNAIDS, the Global Fund and PEPFAR – have responded to the rise of talk about Health Systems Strengthening (HSS). Each of these initiatives was created with an explicitly vertical mandate, but over time they have all come to recognize the importance of strengthening health systems for their work. Those disease-specific mandates, however, inevitably inform their approach to HSS, raising questions about their commitment to broader systemic improvements, and about the potentially negative effects of 'mission creep' on their core mandates.

1 Jennifer Kates, Adam Wexler, Eric Lief, Carlos Avila and Benjamin Gobet, 'Financing the Response to AIDS in Low- and Middle- Income Countries: International Assistance from Donor Governments in 2010' (2011), http://www.kff.org/hivaids/upload/7347-07.pdf, pp. 5–6.

2 Kaiser Family Foundation, 'Fact Sheet: The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)' (2011), http://www.kff.org/globalhealth/upload/8002-03.pdf.

3 For instance, Daniel Halperin, 'Putting a Plague in Perspective', *New York Times*, 1 January 2008.

Discussions around these issues to date have largely been focused on public health efficacy – do vertical or horizontal programmes deliver the greatest population health benefits, or should some mix of the two be pursued? Although such considerations are undoubtedly important there is a pressing need to broaden the debate and to grapple with some deeper underlying questions. The final section of the paper sets out five such questions. Each of them has too rarely been asked, let alone answered, and each seems to be a prerequisite to real progress. These are questions with no easy answers, and they are political and ethical rather than technical in nature. They cannot be resolved by the public health community alone.

The global response to AIDS, and its critics

The development of antiretroviral therapies (ART) in the late 1990s changed the entire context for the global response to AIDS, and since then a huge amount of international attention has focused upon increasing the availability of these treatments to those who need them. In many ways this has been hugely successful. In 2002 – the year in which the Global Fund was established – only about 300,000 people in low- and middle-income countries were receiving antiretroviral drugs (ARVs). The most recent available figures (which reflect the situation at the end of 2010) show that around 6.6 million people in those countries are now receiving ART.[4]

One of the reasons for this has been the plummeting price of antiretrovirals, especially since generic versions of some drugs became available in the early 2000s, but just as important have been the huge resources poured into ART provision – especially from the developed countries of the G8. The Global Fund is the biggest multilateral funder, disbursing about $3 billion per year. The programmes it has funded since its inception have put 3.2 million people on treatment.[5] The United States' PEPFAR programme has been the other most significant funder; it claims that it directly supports treatment for 2.4 million people.[6] Nevertheless, significant challenges to sustaining and further increasing ART coverage remain, especially in the context of a global financial crisis. Even greater investment will be required in order to achieve further scaling-up, particularly given the ethical obligation on funders to meet a life-long commitment to those individuals who have already commenced ART. Universal access remains a long way off, but the progress in the rollout of AIDS drugs over the past decade has been remarkable.

The effect that this massive investment in AIDS treatment (and, albeit to a lesser extent, in prevention and care) has had on other global health issues is not straightforward to determine.[7] In some cases there is evidence that other diseases have benefited from the prominence of AIDS. Tuberculosis and malaria (which are also addressed by the Global Fund) seem to have received increased investment.[8] Elsewhere, however, the evidence seems to suggest that other health issues have lost out. Roger England, one of the most prominent critics of 'AIDS exceptionalism', has highlighted the fact that although AIDS accounts for 3.7% of global mortality it receives 25% of international healthcare aid.[9] It is not hard to see how such figures could be used to support an argument that current spending on AIDS is disproportionate.[10]

Another significant strand of criticism has centred on the unintended consequences of AIDS-specific funding pouring into developing countries, especially

4 UNAIDS, *How To Get To Zero: Faster, Smarter, Better, World AIDS Day Report 2011* (Geneva: UNAIDS, 2011), p. 19.
5 Kaiser Family Foundation, 'Cumulative Number of People Receiving ARV Treatment from Programs Supported by the Global Fund as of June 2011' (2011), http://www.globalhealthfacts.org/data/topic/map.aspx?ind=64.
6 PEPFAR, 'Treatment' (2011), http://www.pepfar.gov/about/138312.htm.
7 Jeremy Shiffman, 'Has Donor Prioritization of HIV/AIDS Displaced Aid for Other Health Issues?', *Health Policy and Planning* Vol. 23(2) (2008), pp. 95–100.
8 Jeremy Shiffman, David Berlan and Tamara Hafner. 2009. 'Has Aid for AIDS Raised All Health Funding Boats?', *JAIDS: Journal of Acquired Immune Deficiency Syndromes* Vol. 52 (2009), pp. S45–8.
9 Roger England, 'The Writing is On the Wall for UNAIDS', *BMJ* Vol. 336 (2008), p. 1072.
10 Roger England, 'Are We Spending Too Much on HIV?', *BMJ* Vol. 334 (2007), p. 334.

in sub-Saharan Africa. Laurie Garrett of the Council on Foreign Relations notes that:

> A government may receive considerable funds to support, for example, an ARV distribution program for mothers and children living in the nation's capital. But the same government may have no financial capacity to support basic maternal and infant health programs, either in the same capital or in the country as a whole. So HIV-positive mothers are given drugs to hold their infection at bay and prevent passage of the virus to their babies but still cannot obtain even the most rudimentary of obstetric and gynecological care or infant immunizations.[11]

The result can be 'islands of excellence in a sea of under-provision' and importantly – despite the rhetoric about 'country ownership' – the creation of these islands is often driven by the priorities of donors, not by those of recipients.

Some critics have gone further, arguing not only that the massive investment in AIDS fails to strengthen health services, but that it can actually undermine them. One of the most commonly noted ways in which this can happen is through distortion of the labour market for health professionals. The human resources requirements of AIDS-specific programmes in many countries has drawn staff away from other areas of the health system,[12] and it has been argued that AIDS donors have not always put sufficient effort into increasing the overall supply of health professionals.[13]

The rise of Health Systems Strengthening

These criticisms have been accompanied by the reinvigoration of an old public health debate over whether greater priority should be given to 'vertical' disease-specific strategies or to 'horizontal' health-system-oriented ones. This is certainly not a new debate, but it is perhaps even more significant in its current manifestation given the sheer scale of AIDS funding.

History provides examples of both horizontal and vertical strategies being used to good effect. Smallpox eradication is one of the most frequently cited successful vertical programmes. Indeed, the focus of health-related international development work during the 1950s, 1960s and early 1970s was largely a vertical disease-specific one. A notable shift towards horizontal interventions occurred in the 1970s, encapsulated in the 'health for all' approach introduced at the 1978 Alma Ata conference.[14] Although some international agencies, including the World Bank, have indeed pursued sector-wide approaches, the pendulum swung back towards vertical approaches during the 1990s, not least because of a recognition of the exceptional challenge posed by AIDS.

Contemporary advocates of a shift back towards more horizontal approaches have argued that investing in health systems as opposed to specific diseases brings a number of advantages including greater efficiency, improved sustainability and the ability to adapt to the changing nature of health problems. Such arguments have often used the AIDS response as the basis of a comparison with horizontal approaches. Also contributing to the rise in HSS talk has been concern over the lack of progress on some of the health-related Millennium Development Goals (MDGs). The three health goals – MDG4 (child health), MDG5 (maternal mortality) and MDG6 (HIV/AIDS, malaria and other diseases) – are due to be achieved by 2015, although progress is decidedly mixed. The centrality of strong and efficient health systems to achieving the targets on child and maternal health in particular have only added to the calls for greater investments in horizontal activities.

11 Laurie Garrett, 'The Challenge of Global Health', *Foreign Affairs* Vol. 86(1) (2007), pp. 22–3.

12 Christopher H. Herbst, Agnes Soucat and Kate Tulenko, 'HIV/AIDS and Human Resources for Health' in Elizabeth Lule, Richard Seifman, Antonio C. David (eds), *This Changing HIV/AIDS Landscape* (Washington DC: World Bank, 2009), p. 327.

13 Nandini Oomman, David Wendt and Christina Droggitis, *Zeroing In: AIDS Donors and Africa's Health Workforce* (Washington DC: Center for Global Development, 2010), http://www.cgdev.org/files/1424385_file_CGD_Health_Workforce_FINAL.pdf.

14 Lesley Magnussen, John Ehiri and Pauline Jolly, 'Comprehensive Versus Selective Primary Health Care: Lessons for Global Health Policy', *Health Affairs* Vol. 23(3) (2004), pp. 167–76.

It would be wrong, however, to suggest that the rise of HSS as a policy priority has been driven solely by the critics of vertical approaches, and indeed it has frequently been argued that the dichotomy between vertical and horizontal strategies is a false one. There has been a clear shift towards a greater emphasis on health systems within the AIDS policy community as the recognition has grown that an effective and sustainable AIDS response requires an effective and sustainable health system. Many fear that the response is beginning to reach the limits of what can be achieved without improving the health systems that are so vital to the delivery of prevention, treatment and care services.

There have been some clear examples of the major AIDS institutions responding to these ideas and beginning to make HSS part of their work. Box 1 gives examples of recent statements from the Global Fund, UNAIDS and PEPFAR on the need for them to increase their commitment to promoting stronger health systems as part of their core AIDS mandates.

Box 1: Statements on Health Systems Strengthening by major AIDS institutions

The Global Fund and HSS

'An effectively performing health system is key to improving the population's health status, providing protection against health-related financial risks and enhancing the health sector's responsiveness to customers' needs. The Global Fund's major objective in providing support for HSS is to maximize the overall impact of the response to HIV, tuberculosis and malaria and to contribute to achieving the health-related Millennium Development Goals (MDGs). The Global Fund views health systems strengthening as a means to an end, not the objective in itself.'[a]

UNAIDS and HSS

'UNAIDS recognizes that effective AIDS responses require stronger health systems to achieve universal access to prevention, treatment, care and support services. Equally, AIDS resources can deliver returns for HIV outcomes as well as larger health, development and human rights goals. UNAIDS supports the strengthening of health systems. HIV-related health outcomes and progress towards other health Millennium Development Goals (MDGs) are closely interrelated. UNAIDS will therefore pursue synergy between AIDS and other health and development initiatives to achieve AIDS plus MDGs goals.'[b]

PEPFAR and HSS

'PEPFAR has had a positive impact on the capacity of country health systems to address the WHO's six building blocks of health systems functions. However, the program to date has not placed a deliberate focus on the strategic strengthening of health systems. In its next phase, PEPFAR is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. PEPFAR now emphasizes the incorporation of health systems strengthening goals into its prevention, care and treatment portfolios.'[c]

a The Global Fund, 'Global Fund Information Note: The Global Fund's Approach to HSS (July 2011)', available at www.theglobalfund.org/documents/rounds/11/R11_HSS_InfoNote_en/.

b UNAIDS, 'UNAIDS Position Statement – Leveraging the AIDS Response to Strengthen Health Systems' (2011), http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/07/20110721_HSS_Statement.pdf.

c PEPFAR, 'Health Systems Strengthening' (2011), http://www.pepfar.gov/about/138338.htm.

It is clear from these statements that the major AIDS initiatives *are* responding to the rise of HSS. And this is not merely empty rhetoric – there have also been some concrete signs of commitment. The Global Fund, for example, now funds proposals aimed at Health Systems Strengthening and has also joined with the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisation) and the World Bank (as well as the WHO) to launch a joint Health Systems Funding Platform (the 'Joint Platform') in an effort to align and harmonize the organizations' efforts in that area, as well as committing to the Paris Principles on aid effectiveness.[15] The International Health Partnership + initiative (IHP+), which again includes the Global Fund, as well as UNAIDS, has also attempted to foster a more coherent approach to HSS among the partner organizations. PEPFAR, now part of the Obama administration's umbrella 'Global Health Initiative', has also increased its work with countries on health systems, and is implementing HSS indicators in its programme evaluations.

> 'Unless donor contributions increase substantially to pay for these new activities, the gains that have been made in tackling AIDS, not to mention the much-needed future improvements, could come under threat'

Despite these efforts, concerns remain in some quarters about the ability of these initiatives to achieve broad HSS goals, given that HSS is largely treated in these cases as an add-on to core mandates. The statement from the Global Fund in Box 1 makes this most explicit: 'The Global Fund views health systems strengthening as a means to an end, not the objective in itself.' The overall aim is to address the health system bottlenecks that are affecting progress in relation to the three diseases. The resulting HSS efforts are therefore inevitably targeted in specific ways, and in some respects it would be misleading to call them genuinely 'horizontal' activities. Instead, this has sometimes been described as a 'diagonal approach', seen by some as a way out of the polarization between vertical and horizontal interventions, and by others as a partial, belated and inadequate response to the need to build strong health systems. Striking a balance between HSS and core disease-specific mandates is a difficult task, and it is becoming even more difficult for the Global Fund as it partners with organizations with different priorities and mandates through the IHP+ and the Joint Platform.

There have also been concerns over the effects of this 'mission creep' on the existing activities of agencies such as the Global Fund. Unless donor contributions increase substantially to pay for these new activities (and this is not happening), the gains that have been made in tackling AIDS, not to mention the much-needed future improvements, could come under threat.[16]

Five neglected questions

This ongoing debate between vertical and horizontal (and diagonal) approaches has too often been construed in narrow public health terms: which approach delivers better health outcomes? Or is there a choice to be made – can we actually do both? These are, of course, extremely important questions and the evidence is somewhat mixed.

There is, however, a need to broaden the debate and to engage a wider set of stakeholders in it. There are five other important questions that have too rarely been asked, let alone answered within the vertical–horizontal debate. Each of these questions goes to the heart of what it is we are trying to achieve through global health interventions, and without progress being made on some of these issues the prospects for significant improvements to the status quo seem remote.

15 See OECD, *The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action*, http://www.oecd.org/dataoecd/11/41/34428351.pdf.

16 See, for instance, Gorik Ooms, Win Van Damme, Brook K. Baker, Paul Zeitz and Ted Schrecker, 'The "Diagonal" Approach to Global Fund Financing: A Cure for the Broader Malaise of Health Systems?', *Globalization and Health* Vol. 4(6) (2008), doi:10.1186/1744-8603-4-6.

1. Is there an ideal health system?

A fundamental question that rarely seems to be discussed in debates over AIDS and HSS is what kind of health system is the ideal. What we are aiming for? What does a 'good' health system look like?

There is broad agreement on certain fundamental features of a health system – the need for well-trained health professionals, properly equipped medical facilities, functioning health information systems, adequate financing, availability of essential medicines, and so on.[17] Yet this superficial level of agreement obscures some real political differences over how healthcare should be financed and delivered. There is a huge range of available models (Wendt, Frisina and Rothgang, to take one example, classify health systems into 27 different types[18]) but very rarely do discussions of HSS include some of the most fundamental questions. What is the role of the state in the delivery of health services? What is the appropriate mix of public and private provision? Are private health insurance schemes appropriate for the developing world? If so, what kind of a safety net is required for those who cannot pay, and how should it be organized? This uncertainty about what a health system should look like is reflected in practice in the very different ways in which the major global health institutions approach HSS, leading some to fear that HSS 'is in danger of becoming a container concept that is used to label very different interventions'.[19]

The most obvious answer to the question is that there is no 'one-size-fits-all' solution and that health systems must be appropriate to the domestic political, economic and social context. This is of course true, and certainly chimes with the dominant global health and development rhetoric on 'country ownership'. In reality, however, the ability of aid recipients to set their own domestic health priorities and decide on the appropriate health system model for their own countries is heavily circumscribed by the approaches, policies and priorities of international institutions and donor agencies. While the blatant international interventionism witnessed in an earlier generation of Structural Adjustment Policies is no longer evident, countries seeking assistance in strengthening their health systems are still forced to play by the rules of the game, rules that are by and large set by donors. Two features of AIDS institutions' HSS efforts help to illustrate the point.

The first is that the approach to HSS is often highly selective and focused on particular types of healthcare activities. The HSS efforts of the major global AIDS institutions tend to concentrate on removing the obstacles to achieving their own aims and objectives rather than constituting a broader attempt to address the underlying causes of health system weakness.[20] Thus countries seeking HSS funding on those terms are required to construct their plans accordingly (in the Global Fund case, in ways that address the obstacles to tackling HIV, TB and malaria).

The second is that, even where institutions do have a more holistic approach, HSS tends to be narrowly defined, focusing tightly on the health system itself rather than the broader context within which it operates. Although it might be too much to expect AIDS institutions to address some of the many causes of poor population health – from food insecurity to environmental degradation – their current approaches have been criticized for their bias towards technological and biomedical interventions and (in the AIDS case) an emphasis on treatment – some say at the expense of prevention activities, which would entail a broader engagement with the underlying socio-economic factors linked to HIV infection.[21]

17 A commonly utilized approach is the WHO's 'six building blocks' of a health system: WHO, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes. WHO's Framework For Action* (Geneva: WHO, 2007).

18 Claus Wendt, Lorraine Frisina and Heinz Rothgang, 'Healthcare System Types: A Conceptual Framework for Comparison', *Social Policy and Administration* 43(1) (2009), pp. 70–90.

19 Bruno Marchal, Anna Cavalli and Guy Kegels, 'Global Health Actors Claim to Support Health System Strengthening – Is This Reality or Rhetoric?', *PLoS Medicine* Vol. 6(4) (2009), e1000059.

20 Ibid.

21 Kelley Lee, 'Understandings of Global Health Governance: The Contested Landscape' in Adrian Kay and Owain Williams (eds), *Global Health Governance: Crisis, Institutions and Political Economy* (Basingstoke, Palgrave Macmillan, 2009), p. 31.

This lack of clarity on the ideal health system also raises another difficult question: by how much do health systems need to be strengthened? Again this is something that is rarely, if ever, specified by those agencies engaged in HSS. This is perhaps not surprising, as any such discussion very quickly becomes mired in political and ethical concerns. Are the advanced health systems of the developed world – which rely heavily on highly trained staff, expensive technologies and extensive use of pharmaceuticals – the appropriate model? How, and how far, should this model be tailored to the economic and infrastructural realities of different countries? And in doing so, is there a risk of condemning the populations of under-developed countries to a second-class health system?

2. Do we need short-term results or can we take a longer-term view?

It is clearly no accident that the major global health institutions that have been established in recent years have almost all been created with a disease-specific focus. They have been designed that way as the result of political choices, and the reasons for doing so, and for the prioritization of particular diseases, are complex. Nevertheless, one of the reasons commonly put forward (by people working both within these institutions and outside) for donor states preferring these arrangements is that vertical disease-focused programmes tend to be far more amenable to monitoring and evaluation techniques based on quantifiable targets, year-on-year results and value-for-money justifications. Important contemporary policy frameworks – including the MDGs and the Aid Effectiveness Agenda – strongly reflect this emphasis on measurable results.

To take an example from the fight against AIDS, it is relatively easy to demonstrate how many people have received ART as the result of a particular initiative,[22] and thus to demonstrate the 'bang for the buck' that donors are getting. It is true that metrics have been developed by various agencies to allow for the monitoring and evaluation of HSS efforts,[23] but measurement remains difficult and improving a health system is by its nature a long-term process, so it can take many years for the results to become apparent. One of the difficulties with such longer-term efforts is that they do not fit well with policy horizons that are governed by electoral cycles, or with time-bound global initiatives such as the MDGs.

The problems posed by a focus on short-term results have long been recognized in international development, but such problems are arguably exacerbated by the current emphasis on evidence-based policy and results-based financing, both of which privilege interventions that have clear measurable outcomes and can be relatively rapidly assessed. The global economic crisis, which has put overseas development aid budgets under pressure and has led to an increasing emphasis on value for money and rapid results, also seems to be having an impact, refocusing attention on what is 'achievable now' rather than 'building for the future'.

Taken together, these trends seem to militate against a substantial shift from a largely vertically aligned global health effort to a more genuinely horizontal one. A fundamental change in direction will require major donor governments to show a hitherto unseen willingness to commit to longer-term investments.

3. What do we mean by 'sustainable'?

The idea of 'sustainability' is central to international development discourse – few projects are able to attract funding without making some claims about the sustainability of their interventions – yet there is a surprising lack of consensus over what sustainability means, let alone how to achieve it.

If sustainability means that states are able to manage without external assistance, it is extremely difficult to see how many of those countries experiencing the worst health crises can make such a transition to self-reliance in the short or medium term. This is true of both vertical and horizontal programmes. While the extent to which the governments and populations of poor nations already contribute to financing their own health system is often

22 Although even here the numbers are often disputed.

23 See, for instance, 'Monitoring and Evaluation Systems Strengthening Tool' (2007), http://www.pepfar.gov/documents/organization/79624.pdf; WHO, 'Monitoring and Evaluation of Health Systems Strengthening: An Operational Framework' (2010), http://www.who.int/healthinfo/HSS_MandE_framework_Oct_2010.pdf.

overlooked in discussions of international health aid,[24] in many cases it will be decades at least before they are able to finance even basic health systems, let alone major responses to diseases such as AIDS, without international assistance.

> ‘There exists a clear ethical imperative to continue to provide life-long treatment to those who have begun it. Sustaining this level of provision will require a continued and reliable commitment from international donors’

In recent years there has been increasing discussion around a redefined concept of ‘sustainability’ that is based not on the self-sufficiency of domestic health systems but rather on domestic efforts being supplemented by a predictable and reliable level of international support. As Ooms et al. have noted,[25] the global AIDS response was to a great extent responsible for bringing about this new thinking on what sustainability can mean, and Michel Kazatchkine, Executive Director of the Global Fund, has been a high-profile supporter of viewing sustained international support as central to sustainability. The significant scale-up of AIDS treatment has led to millions more people receiving the drugs they need and, as noted above, this has only been possible because of the massive international investment, especially from the G8. There exists a clear (and widely recognized) ethical imperative to continue to provide life-long treatment to those who have begun it. Sustaining this level of provision – even without adding to the numbers receiving treatment – will require a continued and reliable commitment from international donors. The AIDS community has led the way in making this argument, but Ooms et al. argue that such ‘open-ended solidarity’ must be extended to a broader range of health issues, not least because the success of the AIDS response is itself dependent upon broader systemic improvements.

Achieving this, however, would require leaders of industrialized countries to accept the existence of an expanded obligation to populations beyond their borders, and a willingness (not to mention, in the current financial climate, the ability) to meet that obligation through the provision of substantial new resources.[26] Given the consistent failure of the G8 to meet the commitments it has previously made, the prospects do not look promising. Yet without a guaranteed stream of future funding the question may not be whether vertical or horizontal programmes should be prioritized, but rather whether either can be done properly.

4. Is the current global health governance architecture up to the job?

Much of the existing institutional architecture for global health is vertically oriented, and much of it has been created over the last 15 years. In the case of AIDS, the three biggest players – UNAIDS (which began work in 1996), the Global Fund (2002) and PEPFAR (2003) – were all created specifically to address AIDS, and have only latterly added elements of HSS to their activities. At the same time, some of the other most significant funders in

24 A recent estimate is that low-income countries spend US$25 per capita on health, only $6 of which comes from development assistance for health. The remainder is more or less evenly divided between out-of-pocket expenditure and government spending from tax revenues etc. Taskforce on Innovative Financing for Health Systems, *Constraints to Scaling Up and Costs* (2009), http://www.internationalhealthpartnership.net/CMS_files/documents/working_group_1_report:_constraints_to_scaling_up_and_costs_EN.pdf.

25 Gorik Ooms, Peter S. Hill, Rachel Hammonds, Lue Van Leemput, Yibeltal Assefa, Katabaro Miti and Wim Van Damme, ‘Applying the Principles of AIDS ‘Exceptionality’ to Global Health: Challenges for Global Health Governance’, *Global Health Governance* Vol. 4(1) (2010), pp. 1–9.

26 See Jeff Waage, Rukmini Banerji, Oona Campbell, Ephraim Chirwa, Guy Collender, Veerle Dieltiens, Andrew Dorward, Peter Godfrey-Faussett, Piya Hanvoravongchai, Geeta Kingdon, Angela Little, Anne Mills, Kim Mulholland, Alwyn Mwinga, Amy North, Walaiporn Patcharanarumol, Colin Poulton, Viroj Tangcharoensathien and Elaine Unterhalter, ‘The Millennium Development Goals: A Cross-sectoral Analysis and Principles for Goal Setting after 2015’, *The Lancet* Vol. 376/9745 (2010), p. 1015.

global health – the Bill & Melinda Gates Foundation being an obvious example – have also chosen to largely focus their efforts on specific diseases including (but not only) AIDS. Until very recently they have also largely neglected broader systemic issues.[27]

The World Health Organization – the agency that would seem to best lend itself to a broader system-wide approach – has over time been largely sidelined in the AIDS response, now focusing relatively narrowly on issues such as technical standards and guidelines, while UNAIDS leads the UN response to the pandemic. Compounding this marginalization, the WHO currently finds itself under huge funding pressure and serious discussions are ongoing about institutional reform, the organization's future priorities, and 'how WHO positions itself in a landscape crowded with global health initiatives and partnerships'.[28]

If one of the aims in global health is to improve health systems, the institutional architecture available is less than promising. Despite the attempts to 'retro-fit' disease-specific organizations for a broader mission, they are primarily concerned with improving health systems in particular ways and for particular reasons, as the rhetoric from AIDS institutions shows. Furthermore the danger highlighted above remains: their expanded missions risk undermining the success of their core mandates.

There have been attempts to address this architectural problem, the Health Systems Funding Platform being the clearest example. Although there have been a number of problems in the operationalization of the Joint Platform idea,[29] its very existence speaks to the recognition within the Global Fund and GAVI – two organizations that are essentially vertically oriented – that they are not ideally suited to addressing health systems issues on their own. Elsewhere there have been more radical proposals, including for the creation of a 'Global Fund for the Health MDGs' with a far broader mandate than the existing Global Fund.[30] However, in an environment of financial crisis and economic austerity the likelihood of such ambitious proposals coming to fruition seems poor.

5. Is the developed world willing to stop doing the things that are currently weakening health systems in the developing world?

Finally, despite the rhetoric around the importance of adequate and sustainable health systems, the developed world is continuing to pursue practices and policies that have precisely the opposite effect. This is certainly something that is far too rarely part of discussions over Health Systems Strengthening. Three examples illustrate the point.

> 'The uncomfortable truth is that developed states would have to change their current understanding of their political and economic interests in order to remove some of the fundamental obstacles to improving developing-country health systems'

The first is the global market in health professionals. Many developed-country health systems – including the UK's – rely on an influx of health professionals from other countries, often from the developing world. Naturally these individuals cannot be blamed for seeking better wages and opportunities overseas, but the impact on the countries they leave can be severe. Many countries with extremely weak health systems – countries such as Haiti, Sierra Leone and Mozambique – see well in excess of 50%

27 Charles Piller and Doug Smith, 'Unintended victims of Gates Foundation generosity', *LA Times*, 16 December 2007.

28 Margaret Chan, 'Opening Address at the Executive Board Special Session on WHO Reform', Geneva, Switzerland, 1 November 2011. Available at http://www.who.int/dg/speeches/2011/who_reform_01_11/en/index.html.

29 Peter S. Hill, Peter Vermeiren, Katabaro Miti, Gorik Ooms and Wim Van Damme, 'The Health Systems Funding Platform: Is This Where We Thought We Were Going?', *Globalization and Health* Vol. 7(16) (2011), doi:10.1186/1744-8603-7-16.

30 Giorgio Cometto, Gorik Ooms, Ann Starrs and Paul Zeitz, 'Towards a global fund for the health MDGs?', *The Lancet* Vol. 374/9696 (2009), p. 1146.

of their trained health workers emigrate, with obvious implications for the health systems they leave behind.[31] Although the WHO is promoting a code of conduct on the international recruitment of healthcare workers,[32] what is actually happening through the ongoing drain of health workers from the developing to the developed world amounts to systematic health system weakening.

The second example is the availability of and access to medicines, diagnostics and other health products. The heated debates around the impact of the global patent regime on the ability of the poor to access the drugs they need are ongoing. AIDS, in fact, has in many respects been an exceptional case as a result of a determined effort to increase access via large-scale funding of medicines and a range of interventions in the market on both the supply side and the demand side. Similar efforts have not been seen around drugs for all health conditions, and in many cases expensive medicines are unaffordable for developing-world health systems and/or the individuals who need them. Even more fundamentally, many 'diseases of poverty', for which the prospects of a significant financial return on R&D spending are limited, have been neglected by the major multinational pharmaceutical companies in favour of concentrating R&D effort on those treatments for which significant markets exist in industrialized countries.

The third example is the continuing tendency of donors to pursue their own priorities rather than those of host countries. Despite the rhetoric over 'country ownership', alignment and harmonization in aid efforts, in many cases external agencies continue to dictate priorities, and continue to implement systems and policies that fail to exploit the potential to build government capacity and that increase transaction costs for recipient governments. Evaluations of the implementation of the Paris Principles suggest that some improvements have been seen around these issues, but that much more progress needs to be made.[33]

In all of these cases the uncomfortable truth is that developed states would have to change their current understanding of their political and economic interests in order to remove some of the fundamental obstacles to improving developing-country health systems. This is a major political challenge.

Conclusion: the need for a broader debate

While the debate over vertical and horizontal approaches is not a new one, we are entering an important time for the future of the global response to AIDS, global health, and indeed international development more generally. The direction the debate takes could therefore have a dramatic impact.

There have been some recent indications that AIDS' primacy among global health issues may be coming under threat. It was widely noted following the MDG review summit held in New York in September 2010 that attention seemed to be shifting towards a greater emphasis on other health issues such as malaria, child mortality and maternal mortality, potentially undermining political and financial commitment to the fight against AIDS. The UN's September 2011 high-level meeting on Non-Communicable Diseases may represent further evidence of shifting priorities.

Perhaps even more crucially in the longer term, discussions are now taking place on what will follow the MDGs after 2015. Just as the MDGs have crystallized the global health and development agenda for the first 15 years of the millennium, it seems highly likely that the next set of targets (assuming agreement is reached on a next set of targets) will have a similar effect. The way in which such future goals are framed will inevitably be informed by current thinking. When the MDGs were agreed in 2000 vertically oriented global health initiatives were very much in the ascendancy. Since then, there has been a growing body of evidence that weak health systems constitute one of the most difficult obstacles to achieving the health MDGs[34] and the pendulum

31 WHO, 'Migration of health workers: Fact sheet No. 301' (2010), http://www.who.int/mediacentre/factsheets/fs301/en/index.html.

32 WHO, *The WHO Global Code of Practice on the International Recruitment of Health Personnel* (Geneva: WHO, 2010), http://www.who.int/hrh/migration/code/code_en.pdf.

33 See, for instance, Clare Dickinson, *Is Aid Effectiveness Giving Us Better Health Results?* (London: HLSP Institute, 2011), http://www.hlsp.org/LinkClick.aspx?fileticket=EzzFbskQILE%3D&tabid=1570.

34 See, for instance, Phyllida Travis, Sara Bennett, Andy Haines, Tikki Pang, Zulfiqar Bhutta, Adnan A. Hyder, Nancy R. Pielemeier, Anne Mills and Timothy Evans, 'Overcoming Health-systems Constraints to Achieve the Millennium Development Goals', *The Lancet* Vol. 364/9437 (2004), pp. 900–906.

has begun to swing back. As a result it may be that there is a desire to reflect HSS goals to a much greater extent in future development targets.

For a more sustained and coordinated effort at HSS to be meaningful, however, the issues raised in this paper will need to be tackled. There are no easy answers to any of these questions, but at present they are questions that are rarely even being seriously asked. There is a real need for those involved in framing the future of international development assistance to become engaged in a broader discussion of the political and ethical issues raised here. If they fail to do so, the prospects for a significant and sustained improvement on current responses to pressing global health crises will be significantly undermined.

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