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“Maternal and Child Health, Family Planning, Reproductive Health”

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Senator Leahy, Distinguished Members of the Senate Appropriations Subcommittee on State, Foreign Operations and Related Programs, and Committee Staff;

It is a distinct honor to be invited to address you today on the subject of global health priorities. And I would especially like to thank the Committee for expressing interest in this matter. I recognize that few of you have constituents clamoring for your attention regarding the general health needs of people living far away, in desperately poor countries. These are not electoral make-and-break issues. It is, therefore, all the more laudable that you are devoting time today to their consideration. Again, I thank you.

My esteemed colleagues preceding me today have done an excellent job in describing exactly who is currently under-served by U.S. foreign aid and investment, as well as the generous philanthropic, private support of the American people. I will not reiterate. I will build on their comments, highlighting some critical fault lines in current global health funding and directions, and offering some suggestions for fresh directions for the Committee’s consideration.

Some of the basic principles, and data, I will mention are delineated in a piece I authored for *Foreign Affairs*¹ earlier this year [attached].

Age of Generosity Commences: Still not enough, but rapidly increasing

We are in an age of fantastic generosity. Globalization has brought the plights of the world into every living room, and onto every computer. As the world public’s response to the 2005 Tsunami illustrated this internet-driven sense of the immediacy of catastrophe – even in places as remote as Aceh, Indonesia – spawns remarkable outpourings of finances, donations and goodwill. As little as six years ago global health commitments totaled a few hundred million dollars: Today – combining all government and private sources – we see donations exceeding \$18 billion. This is *not enough*, but it constitutes a dramatic, even astounding, increase in generosity, realized over a short period of time.

But there are dangers in throwing billions of dollars about in emotionally-driven responses to news events, and disease-specific campaigns that capture the collective imagination of the wealthy world citizenry.

First, let's be blunt: most of this generosity reflects *our* interests: causes *we* care about, *our* national security, and *our* moral concerns.

Second, for obvious political and, in the case of the private donor sector, self-promotion reasons, we want bragging rights. We want to be able to say that X amount of money, after two years, saved Y amount of lives. Most of the health-related legislation signed by President Bush and created by the House and Senate is rife with short term, mandatory timelines. In order to achieve measurable health targets in one or two years, we necessarily have to set extremely narrow, pinpointed goals. And on the ground, to achieve such goals, U.S. supported programs must corral all available resources, funneling them into one channel of health.

Treatment, yes: But not without prevention

Let me give you an example. About a year ago I was in a small town in Haiti. The people in this town were overwhelmed with infectious diseases. Their illnesses swamped the beleaguered clinics, where long lines of mothers and children stood in the tropical sun for hours on end, waiting to see a doctor. The children's growth was stunted; mothers couldn't produce enough milk to feed their babies; long-infected teenagers fought to keep their eyes open in class. In the parking lot of the town's main hospital sat two rusted-out, broken USAID jeeps, the American insignias clearly evident. Though American charities were helping to subsidize the medical training and services in the hospital, nobody --- no Haitian government agency and no foreign donor, looked at this town and asked the obvious question: "Why are so many people sick with dysentery, typhoid fever, and intestinal problems? Why are so many children in this town dying before they hit their fifth birthdays?"

The answer: Water. The colonial-era water filtration and pumping system had long ago broken down. For about \$200,000 the system could be fixed, children would drink safe water, and the disease and death rate would plummet. But no donor chose to take on that water problem. Instead, at the cost of far more lives, and dollars, the donors – including USAID – funded treatment of entirely preventable diseases, and supported the operation of a very busy morgue.

The emphasis my colleagues placed on maternal and child health is wise. What is killing babies and toddlers? The lack of essential public health services: clean water, mosquito control, basic nutrition, healthy moms.

What is killing their moms? The lack of medical systems: No safe C-sections, no sterile equipment for episiotomies, no prenatal care.

Public health systems keep babies and children alive. Medical delivery systems keep their moms alive.

Systems: Not individual, disease-specific programs – health *systems* are the key. Those targeted programs, such as PEPFAR (the President’s Emergency Plan for AIDS Relief), are terrific, but without functioning public health and medical systems in place, PEPFAR and its like are just big band-aids that barely cover gaping wounds.

We – Americans and the wealthy world, generally – have given, and given, and given for decades. Yet the gap between longest and shortest lived societies has widened, now a full five decades long. And despite mountains of foreign aid from the OECD nations, basic health markers such as life expectancy and child survival have barely budged over the last 60 years in any sub-Saharan African country – except, thanks to HIV, to go backwards in a few.

Going Backwards, on Half a Trillion Dollars

Senators, your counterparts in the Canadian Senate recently issued a startling report, entitled, “Overcoming 40 Years of Failure: A New Road Map for Sub-Saharan Africa.” The report estimates that over the last 45 years the United States, Canada and the rest of the wealthy world has spent more than half a trillion dollars in aid and investment in sub-Saharan Africa. Yet the World Bank Office in Nairobi estimates, “that in 1948 Africa had a 7.5% share of world trade; in 2004 that share had decreased to 2.6%. A single percentage decrease represents US\$70 billion dollars.”

“Africa is diverging from the rest of the world at the rate of 5% per capita income each year,” The Canadian Senate report concludes.ⁱⁱ

Even in parts of the world we have credited as economic success stories – where the Asian Tiger roars, and the Latin miracle twinkles – health remains a striking challenge. The world nervously watches the spread of H5N1 influenza – “bird flu” – in Asia, largely in the same locations that featured SARS in 2003. Yellow fever, dengue, and malaria have all returned to Latin America. Indeed, Jamaica is at this moment battling the first malaria outbreak on that Caribbean island in more than 60 years, spiraling out of control right in the capital city. That is a public health failure. And as the previous speakers told you, maternal health is going backwards in much of the poor world –women are dying in childbirth in many of these countries at a far greater rate than they were half a century ago. Recent United Nations findings on maternal mortality show that a woman living in sub-Saharan Africa has a 1 in 16 chance of dying in pregnancy or childbirth. This compares with a 1 in 2,800 risk for a woman from a developed region, and a more than 1:28,000 risk for a mother in Scandinavia.

Every effort to battle diseases – from bird flu to HIV – comes up against the same set of problems. Congress has, over the last three years, approved some \$8 billion of spending -- about 5 percent of it overseas -- to make Americans safer in the face of threatened pandemic influenza. But in the big picture the danger has over that time only *increased*, both because of mutations in the evolving H5N1 virus, and because quick-fix approaches to disease surveillance and control won’t work in countries that have no adequate systems of public health and medical care.

Even the Bush Administration’s laudable PEPFAR program, which started out with a fairly minimal mission of providing prevention, care and treatment for a single disease, now finds itself

forced to build medical delivery systems simply to get anti-HIV drugs to the patients who need them.

A just-published critique of the Global Fund to Fight AIDS, Tuberculosis and Malariaⁱⁱⁱ charges that unless the Fund starts to directly underwrite the salaries of healthcare workers, including minimally-educated community providers, the effort will become nothing more than “medicines without doctors,” an unsustainable program for tossing out drugs without providing *any* actual healthcare.

The World Needs Healthcare Workers

The world is desperately short of health professionals, and the severity of that gap promises to increase sharply in coming years. The World Health Organization estimates the shortage breaks down currently as follows^{iv}:

- In 57 countries the deficit is labeled by WHO as “severe”;
- The world needs, immediately, 2.4 million medical service providers;
- 1.9 million laboratory workers, health managers, and administrators;
- A total of 4.3 million healthcare workers are needed at this moment.

Sub-Saharan Africa faces the greatest challenges. While it has 11 percent of the world's population and 24 percent of the global burden of disease, it has only 3 percent of the world's health workers.^v

The World Health Organization says:

*“There is a direct relationship between the ratio of health workers to population and survival of women during childbirth and children in early infancy. As **the number of health workers declines, survival declines proportionately.**”*

This is going to get much worse. Why? Because the wealthy world is aging, therefore requiring more health attention. At the same time, wealthy nations are trying to reduce rapidly inflating health costs by holding down salaries, and increasing work loads, making the practices of nursing and medicine less attractive. Unless radical changes are put in place swiftly in the United States and other wealthy nations the gap will soon become catastrophic. Studies show that the U.S. will in 13 years face a shortage of 800,000 nurses and 200,000 doctors.

How are the United States and other wealthy nations filling that gap? By siphoning off doctors and nurses from the poor world. We are guilty of bolstering our healthcare systems by weakening those of poorer nations.

Here is an example: due to healthcare worker shortages, 43 percent of Ghana’s hospitals and clinics are unable to provide child immunizations and 77 percent cannot provide 24-hour obstetric services for women in labor. So the children die of common diseases, like measles, and the mothers die in childbirth. In all of Ghana there are only 2,500 physicians. Meanwhile, in New York City, alone, there are 600 licensed Ghanaian physicians.^{vi}

There are a number of bills pending in both the House and Senate that seek, in various ways, to increase domestic education and staffing of healthcare workers, and bolster training in poor countries. Though this committee deals with *foreign* operations, it is vital that you concern yourself with the progress of measures that would decrease the drive to drain the health brain power of the poor world by enhancing education and incentives here in the United States. In the House, for example, HR.410, the United States Physician Shortage Elimination Act of 2007, seeks to create incentives for physicians to serve in under-allocated areas of America.

Senate Bill 805, sponsored by Sen. Richard Durbin, is the “African Health Capacity Investment Act of 2007.” It seeks to amend the Foreign Assistance Act of 1961 to provide funding for medical training, and retention of healthcare staff in sub-Saharan African countries. I urge the Senate to pass S.805.

Fund Programs for Systems Development

But let’s be clear: Even if we put the brakes on the brain drain this instant, and the United States of America no longer imported foreign doctors, nurses, and lab technicians, there would still be a crisis. And even if Senator Durbin’s bill passed, fully funded, there would still be a crisis.

We are in an ugly mess. If we want to do the right thing, and get millions more people in poor countries on anti-HIV medications, our U.S. tax dollars have to be put to use skewing health services towards AIDS, and away from general maternal health and child survival. Why: Because there aren’t enough healthcare workers to do both.

If we want to spend U.S. taxpayer dollars – as we should – on campaigns to wipe out malaria-carrying mosquitoes and get children under insect-barrier nets at night, then the public health workers who will implement such programs have to come from somewhere. Perhaps there will be fewer of them trying to clean the children’s drinking water or teaching teenagers how to avoid getting infected with HIV. Why? Because there aren’t enough trained public health experts.

The only way American tax dollars can save lives, across the board – without robbing healthcare workers from one disease area to implement disease combat in another area – is if we start funding systems management. The expertise for disease prevention and treatment is sparse: the talent pool, along with their supplies and patient loads, must be carefully managed. Novel incentive systems to defy corruption and bring quality health to vast constituencies must be put in place.

At the request of Prime Minister Tony Blair, this question of the relationship between wealthy world priorities, and the health – or the lack thereof – in Africa was studied by Lord Nigel Crisp. His recently-released report^{vii} concludes that single-disease-specific programs can damage other health interests. He calls for direct funding of systems development and management, with far longer-term commitments than had been the norm for the UK. The Crisp recommendations are now being implemented.

But what about the U.S.? Well, we do have a health systems management program nested inside USAID. It is working to professionalize health management in poor countries. It's budget? Just over \$3 million.

The FY08 Budget: International Affairs

As you look over the White House FY 2008 budget requests – for a total Foreign Operations request of \$20.3 billion – please pay close attention to the following:

- More than half of all funding for Africa will focus on 8 strategic states.
- Overall health spending in designated African countries would more than double compared to FY06 actual spending.

Of the nearly \$4 billion requested for health in Africa, \$3.4 billion would go for HIV/AIDS in 12 countries (under the Global HIV/AIDS Initiative or GHAI, formerly known as PEPFAR). The remaining \$700 million would be spent on the President's Malaria Initiative, Tuberculosis and a host of modest child survival and health initiatives.

- Nearly all programs are heavily ear-marked, with little or no monies designated for general health threats or health systems management and support. Health management and personnel training is not stipulated clearly in any budget lines, either under disease-specific programs, nor in overall global health budgets.
- Only \$34 million is requested for water systems, sanitation, or general public health threats.
- Under the Global War on Terror 2007 supplemental the President requests \$161 million, in addition to the general budget \$100 million, for pandemic influenza surveillance and control, through USAID. The supplemental request is listed under Child Survival and Health Programs.

I do not believe that we are guilty of *over-spending* in any global health initiative. Rather, we are guilty of *under-valuing* the necessity of building genuine, well-managed public health and medical systems. The paltry \$3 million now spent on USAID's Management Sciences for Health program should increase dramatically, reflecting this gap. Further, current caps^{viii} on human resources development and training that exist for PEPFAR funds should be lifted, for training of indigenous – not American NGO or FBO – personnel.

What is the Goal?

I think the appropriate goals for U.S. foreign aid in support of global health ought to be twofold:

- Build sustainable infrastructures in poor countries that shift the paradigm towards fantastic improvements in maternal health, child survival and overall extension of life expectancy.
- And, second, ensure the safety and security of the American people by lowering the global disease burden, both in terms of infectious threat and detrimental impact on nations' and global GDP and economic growth.

The current channels of spending, though in the billions of dollars, will not accomplish either of these goals.

Systems and infrastructure aren't sexy, cannot be built in short funding cycles, and are tough to brag about to constituents. But without viable systems of medical delivery and public health infrastructures all we will manage to do with our billions of dollars is save some lives, at the expense of others; achieve short term targets without fundamentally leaving anything in place that allows nations ultimate dignity and self-reliance.

Let me close with this final story. During the 1960s, at the height of the Cold War, the global community committed to the astonishing goal of completely eradicating smallpox. The virus had killed more people during the first six decades of the 20th Century than all wars, combined. In order to accomplish this remarkable feat the World Health Organization and our Centers for Disease Control set up an unprecedented worldwide infrastructure of community health workers, public health advocates, disease detectives, laboratories, vaccine manufacturing, specialized infectious diseases clinics and hospitals and international-scale leadership and management. It was a breathtaking scale of effort. And it worked. By the end of the 1970s smallpox was eradicated.

But then a tragic, inconceivable mistake was made: The entire worldwide smallpox infrastructure was simply shut down. Unable to find funding, or international interest, the infrastructure that defeated smallpox was, itself, eradicated at precisely the same time as a new scourge emerged: HIV. Since 1981 AIDS has killed more people, in 25 years, than smallpox did in the 20th Century.

As the late, great Kurt Vonnegut would say "So it goes."

Thank you for your time, attention, and concern.

i Garrett, L., "Do No Harm: The Challenge of Global Health," *Foreign Affairs* Jan/Feb 2007, pp 14-38.

ii Canadian Report by the Standing Senate Committee on Foreign Affairs and International Trade, "Overcoming 40 Years of Failure: A New Roadmap for Sub-Saharan Africa," Feb 2007.

iii Ooms, G., Van Damme, W., and Temmerman, M., "Medicines without Doctors: Why the Global Fund Must Fund Salaries of Health Workers to Expand AIDS Treatment," *PLoS Medicine* 4:0001-0004, 2007.

iv World Health Organization, "The global shortage of health workers and its impact." Fact sheet N° 302, April 2006. <http://www.who.int/mediacentre/factsheets/fs302/en/index.html>

v *ibid.*

vi Kretev, N., "World: Maternal-Mortality Numbers Still Climbing," *Radio Free Europe* July 2006. <http://www.rferl.org/featuresarticle/2006/07/10d24de4-cc8d-459c-9eed-629ee1bcc4c.html>

vii Lord Nigel Crisp, "Global health partnerships: the UK contribution to health in developing countries:" February 2007.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065374

viii Under PEPFAR, spending to train local healthcare workers cannot exceed \$1 million per country per year. That is absurd.