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Round table discussion

Impossible to "wean" when more aid is needed

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Kirigia and Diarra-Nama from the WHO Regional Office for Africa say that funding for health in the WHO Africa Region remains inadequate and that, in some countries, is significantly dependent on donor funding. They propose five strategies for these countries to "wean themselves off" donor funding. While each of the proposed strategies might have some value in itself, they will not succeed in the double objective the authors set: to wean countries from depending upon international health aid and to achieve the US$ 34 per person annual health expenditure target suggested by the Commission on Macroeconomics and Health[1] – an amount that must now be adjusted to US$ 40 due to inflation.[2]

Of the five strategies proposed, only the second and third strategy – reprioritizing public expenditure and raising additional domestic revenue – would increase domestic financial resources for health. The other three strategies (reducing inefficiencies and corruption and increasing private sector involvement in health development) might improve efficiency but would not bring countries closer to the US$ 40 per person annual target. It could be argued that with increased efficiency, less money is required. However, the Commission's target is based on need and does not factor in inefficiencies or corruption.

Furthermore, even if countries were to reprioritize public expenditure and raise additional domestic revenue, this is unlikely to generate sufficient additional financial resources, particularly for those countries most dependent on international health aid. To test this, we estimated the impact of these two strategies for the 4 countries where – according to the WHO Statistical Information System – the external contribution to total health expenditure exceeded 40% in 2004 (Madagascar, Malawi, Mozambique and Sao Tome and Principe), plus four other countries where the external contribution to total health expenditure exceeded 40% in 2005 (Liberia, Rwanda, Sierra Leone and Zambia).[3]

Kirigia and Diarra-Nama propose reprioritizing public expenditure by adjusting military expenditure to the average of the countries of the WHO African Region. We estimated military expenditure per inhabitant by using data from the CIA of the United States of America[4] – which are expressed as a percentage of GDP – and multiplied those with GDP per capita estimates of the International Monetary Fund.[5] Using the average annual military expenditure of US$ 16 per person provided by Kirigia and Diarra-Nama, we find that the 8 countries of our selection already spend less than US$ 16 per person per year on the military. The proposed strategy would therefore not make a difference (Table 1).

The other strategy proposed to raise domestic financial resources for health is that all countries should aim for government revenue equivalent to 15% of GDP. Five out of the 8 countries of our selection already have higher government

Table 1. **Impact of strategies proposed to reduce dependency on aid**

Countries	Justification of selection: external contribution to total health expenditure		GDP per capita, 2006[5] (US$)[a]	Impact of second strategy proposed			Impact of third strategy proposed		Current situation
	2004[3] (%)	2005[3] (%)		Military expenditure pp/yr, 2006[4] (% of GDP)	Military expenditure pp/yr, 2005 (US$)[a]	Budget available pp/yr (US$)[a,b]	Government revenue excluding grants, 2005[5] (% of GDP)	Budget available pp/yr (US$)[a,c]	Total health expenditure pp/yr, 2005[3] (US$)[a]
Liberia	33.2	41.2	126.0	1.3	1.6	**0.0**	18.6	**0.0**	**10.0**
Madagascar	42.2	46.1	278.0	1.0	2.8	**0.0**	11.3	**1.5**	**9.0**
Malawi	59.4	61.2	157.0	1.3	2.0	**0.0**	17.5	**0.0**	**19.0**
Mozambique	50.2	66.5	344.0	0.8	2.8	**0.0**	15.9	**0.0**	**14.0**
Rwanda	35.9	43.9	268.0	2.9	7.8	**0.0**	12.9	**0.8**	**19.0**
Sao Tome and Principe	50.8	49.9	698.0	0.8	5.6	**0.0**	21.3	**0.0**	**49.0**
Sierra Leone	31.9	41.0	232.0	2.3	5.3	**0.0**	11.8	**1.1**	**8.0**
Zambia	34.0	40.5	366.0	1.8	6.6	**0.0**	16.9	**0.0**	**36.0**

GDP, gross domestic product; pp/py, per person per year.
[a] US$ amounts use average exchange rate.
[b] If military expenditure were reduced to US$ 16 per person per year and if 15% of the reduced expenditure were allocated to health.
[c] If government revenue increased to 15% of GDP and if 15% of the increase was allocated to health.

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revenue. Three out of 8 countries would indeed increase financial resources if they followed the recommendation, but even if they spent 15% of these additional financial resources on health – in line with the Abuja Declaration[6] – it would merely raise between US$ 0.8 per person per year (Rwanda) and US$ 1.5 per person per year (Madagascar).

Furthermore, 6 out of these 8 countries still face a huge gap between current total health expenditure and the revised target made by the Commission on Macroeconomics and Health: in Liberia, Madagascar, Malawi, Mozambique, Rwanda and Sierra Leone, total health expenditure is still below US$ 20 per person per year, even with 40% coming from international health aid.

Even if some countries of the African region might be able to wean themselves from international health aid, others obviously cannot: they need increased aid, urgently. This can be achieved through sustained international health aid, which should not be seen as an act of charity to be overcome as soon as possible, but as an act of global solidarity, with health recognized as a human right that entails both national and international duties. For these reasons we agree with the position of WHO's Director-General who has called for much greater, and more predictable, international health aid for Africa.[7] We hope that her voice will be heard and understood throughout WHO and the wider international community. ■

Competing interests: None declared.

References

1. Commission on Macroeconomics and Health. *Macroeconomics and health: investing in health for economic development*. Geneva: WHO; 2001.
2. Carrin G, Evans D, Xu K. Designing health financing policy towards universal coverage. *Bull World Health Organ* 2007;85:652. PMID:18026615 doi:10.2471/BLT.07.046664
3. WHO Statistical Information System. Geneva: WHO;2008. Available from: http://www.who.int/whosis/en/index.html [accessed on 30 September 2008].
4. *The world factbook*. Washington, DC: Central Intelligence Agency; 2008. Available from: http://www.cia.gov/library/publications/the-world-factbook/ [accessed on 30 September 2008].
5. *Regional economic outlook: sub-Saharan Africa*. Washington, DC: International Monetary Fund: 2008. Available from: http://www.imf.org/external/pubs/ft/reo/2008/AFR/eng/sreo0408.pdf [accessed on 30 September 2008].
6. *Abuja Declaration: African summit on Roll Back Malaria*. Geneva: WHO/Roll Back Malaria Partnership; 2003. Available from: http://www.rbm.who.int/docs/abuja_declaration.pdf [accessed on 30 September 2008].
7. Chan M. Africa's healthcare needs foreign support. *Business Daily Africa*, September 2008. Available from: http://www.bdafrica.com/index.php?option=com_content&task=view&id=9753&Itemid=5821 [accessed on 30 September 2008].