# 1.4. Can our heroes strengthen health systems?

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*A Lancet report states that:*

"Children and mothers are dying because those who have the power to prevent their deaths choose not to act. This indifference – by politicians, policy makers, donors, research funders, and civil society – is a betrayal of our collective hope for a stronger and more just society, one that values every life no matter how young or hidden from public view that life might be. It signifies an unbalanced world in which only those with money, military strength, and political leverage determine what counts and who counts. As health professionals, we should not accept this pervasive disrespect for human life"[1].

This hard-hitting bitter statement is the conclusion to an article by Lancet editor, Richard Horton. It is the leading editorial in a series of articles about *Countdown*, an independent initiative (sponsored by the United Nations and by other international agencies) led by a team of researchers and experts on mother and child health. *Countdown* aims to monitor periodically the health of women and children up to 2015, the final year of the Millennium Development Goals (MDG). The Millennium Goals, established by the United Nations in 2000, aim to achieve the following results by 2015 (results based on 1990 data): a) a two-third reduction in under-five mortality (MDG 4); b) a three-quarter reduction in maternal mortality (MDG 5).

*Countdown* has recently published its 2008 Report[2]. The report details a battery of indicators measuring the state of health and health trends in women and children in the 68 countries in the world that account for 97% of deaths during pregnancy and birth and in under fives. In the report, each country has its own page containing clear graphs that summarise the following information: a) demographics and epidemiological data (including nutrition); b) health system indicators (health expenditure, human resources, equity, etc.); c) environmental health (access to drinking water, sanitation); d) intervention coverage: including breast-feeding, Vitamin A supplementation, vaccinations, malaria prevention, treatment of diarrhoeal disease and pneumonia, prevention of mother-to-child transmission of HIV, periodic antenatal care, and a skilled attendant at birth.

*Countdown to 2008: the evidence*

Among the 68 countries studied, 16 had made significant improvements and are on their way to achieving MDG 4 in 2015; these countries include Brazil, Egypt, Mexico, Nepal, Bolivia, and China, which has made up much ground over the last three years and is now on track. At the other end of the scale are 26 countries, almost all of them in Sub-Saharan Africa, that fall into the *No progress* category, which

means that no improvement has been made on 1990 figures (e.g.: Sierra Leone, which has gone from 290 children (under five years of age) dying out of 1000 live births to 270 per 1000 in 2006, and Angola which has remained at 206 per 1000). Many of these countries have recorded negative trends: e.g.: Botswana has gone from 58 to 124 per 1000; Congo from 103 to 126 per 1000; Kenya from 97 to 121 per 1000; and Zimbabwe from 76 to 105 per 1000. Between the latter two groups stand the remaining 26 countries, whose progress is considered *Insufficient*, i.e. they have failed to take a significant step towards achieving the objectives of MDG 4.

*Countdown 2008* also states that there is a close link between the under-five mortality indicator (for which most statistics are available) and the maternal mortality indicator. Indeed the 26 countries that have made no progress towards MDG 4 have the highest maternal mortality ratios (e.g.: 2100 maternal deaths per 100,000 live births in Sierra Leone or 1800 per 100,000 in Niger). Regarding intervention coverage for mothers, newborns and children, there is a huge divide among nations and also among intervention types. In this case, trends have been evaluated by comparing figures from 2000 and 2003 (or by comparing two dates after 2000).

On average, only modest improvements were recorded (around 2%) in treating children with diarrhoea and pneumonia and in guaranteeing skilled attendants at birth. The general average of coverage by skilled treatment for diarrhoea (i.e. access to oral rehydration therapy) is 38% (range 7-76%) with figures in a number of countries worsening (Chad – 17%, Ethiopia – 14%, and Malawi – 13%). Similar situations occurred in the administration of antibiotics in cases of suspected pneumonia (average general coverage 32% – range 12-93%) and for skilled attendants at birth (average general coverage 53% – range 6-100%).

The biggest improvements (+4-7%) occurred in intervention coverage for antenatal/neonatal tetanus vaccinations (average general coverage 81% – range 31-94%); measles vaccination (average general coverage 80% – range 23-99%); antenatal care (average general coverage 49% – range 16-99%); and in the supply of insecticide-treated mosquito nets (average general coverage, 7% – range 0-49%). The extent of the range, i.e. the distance between the minimum and maximum values of a certain indicator, highlights the abyssal gap in health care even between countries where the health of both mothers and children is in the same critical condition.

*Countdown* figures reveal that the easier-to-plan and low-tech interventions (e.g.: vaccinations and antenatal care) showed higher coverage levels and better net improvements than "on-request" ones, which require the presence of a skilled attendant twenty-four hours a day (e.g.: care at birth, pneumonia and diarrhoeal disease treatment).

*Countdown* 2008 paints a dramatically serious picture for mothers, newborns and children in terms of both health levels and health care organization for a significant part of the world population, a situation that causes just under 10 million deaths per year in under-fives and more than half a million maternal deaths (about 50% of this burden of mortality is concentrated in Sub-Saharan Africa). **Figures 1** and **2** show the overall figures for Sub-Saharan Africa regarding MDG 4 and 5. For both, but for MDG 5 in particular, the current situation is still a long way from the trend planned in 2000.

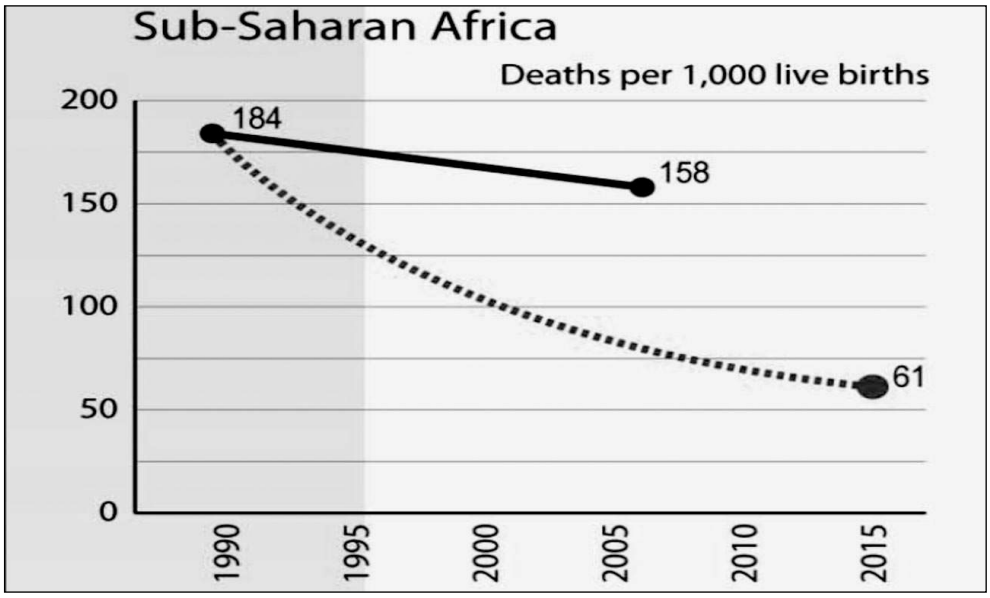


*Figure 1.* Millennium Objective 4 (MDG4). Under 5 mortality rate (per 1,000 live births). Sub-Saharan Africa. Dotted line: Millennium Objective. Continuous line: current situation. Source: WHO.

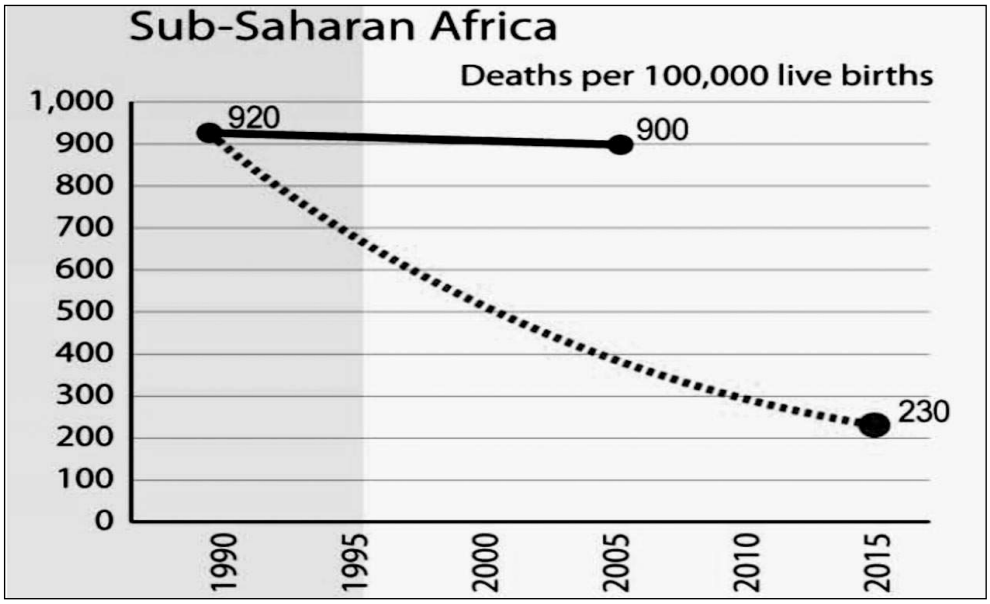


*Figure 2.* Millennium Objective 5 (MDG5). Maternal mortality rate (per 1,000 live births). Sub-Saharan Africa. Dotted line: Millennium Objective. Continuous line: current situation. Source: WHO.

*Reasons behind a catastrophe foretold*

The poor health of the population of Sub-Saharan Africa is clear from both the aforementioned mother, newborn and children indicators and a series of other general (e.g.: life expectancy at birth) and specific indicators (prevalence of/mortality due to a range of pathologies). The reasons for this situation are two-fold: a) the extreme poverty in which the majority of people in this region live; b) the choice of policy and international health cooperation implemented in the last two decades.

**Extreme poverty and under-nutrition**. According to the most recent World Bank figures[3] 315 million people in Sub-Saharan Africa (41% of the population) live below the one-dollar-a-day poverty line. Sub-Saharan Africa is the only region in the world where the number of people living in extreme poverty has not fallen; in fact between 1981 and 2001 the number almost doubled. Among the various aspects of poverty, under-nutrition is a powerful factor affecting a person's health; it is estimated that under-nutrition is responsible for 35% of under-five mortality (i.e. about 3.5 million children die of hunger each year) and at least 20% of maternal mortality[4].

**Choices of international health cooperation and policy**. The principal causes of under-five mortality are newborn disorders (in particular premature birth, asphyxia, serious infection), diarrhoea and pneumonia. These three causes account for almost 80% of mortality in this section of the population. The principal causes of maternal mortality are haemorrhage, infection, eclampsia and obstructed labour. To deal with these pathologies and to meet these, widespread needs, the way forward is clear: strengthen the entire health care system starting with primary care. What is required is an extensive network of facilities and staff that can guarantee a continuum of care at home and in the community to treat diarrhoea and pneumonia, to help birth and to monitor the health of newborns. In addition specific services should also be available for serious and emergency cases, such as carrying out a caesarean section or a transfusion. *Countdown* has established a series of indicators, including a minimum standard, in order to measure the capacity of a health care system to meet the needs of mothers, newborns and children[5]. **Table 1** shows the indicators for service delivery and for staff.

The results of a *Countdown* survey state that the "minimum" standards for most of these indicators are beyond the reach of almost all of the countries in Sub-Saharan Africa, in particular those regarding birth care facilities and healthworkers. Regarding the minimum standard of 2.5 of physicians, nurses and midwives per 1000 population, the majority of African countries are below 1.0 per 1000 population, with some countries recording extremely poor levels (Burundi 0.2 per 1000 and Niger 0.3 per 1000).

None of this is a surprise; various chapters of this report describe in detail the health care policies that the World Bank, G8 and a myriad of Global Health Initiatives (GHI) have adopted and imposed worldwide. These policies are heavily geared towards the privatisation of health care services, razing public health services to the ground, and both local governments and donors giving risible levels of funding; decentralisation, hospital autonomy, user-fees and promotion of private

*Table 1.* Functioning health care system indicators

| | | |
|---|---|---|
| **Service Delivery** | | |
| | | **Standard** |
| 1 | Availability of emergency obstetric care services | Minimum of five emergency obstetric care facilities per 500,000 population including one for comprehensive care |
| 2 | Midwives authorized to deliver life-saving intervention | Policy systematically adopted/implemented |
| 3 | Integrated Management of Childhood Illness* (IMCI) guidelines adapted to cover first week of life | Policy systematically adopted/implemented |
| 4 | Community health workers authorized to identify and treat pneumonia | Policy systematically adopted/implemented |
| 5 | Promotion of low osmolarity ORS and zinc for management of diarrhoea | Policy systematically adopted/implemented |
| **Healthworkers** | | |
| 1 | Density of physicians, nurses and midwives | Minimum of 2.5 of physicians, nurses and midwives per 1000 population to meet adequate coverage levels for primary healthcare interventions |

Source: see bibliography no. 5
* www.who.int/child_adolescent_health/topics/prevention_care/child/imci/en/index.html

insurance; development of monumental programmes for the control and treatment of some illnesses (AIDS, tuberculosis, malaria, heart-surgery illnesses, etc.) and the complete abandonment of basic services (those we have described above and those that are mainly needed to treat mothers and children).

Horton is right when he states: "Children and mothers are dying because those who have the power to prevent their deaths choose not to act."

We could also add that "those who have the power" did choose to act, but they imposed purely ideological recipes that failed to consider the clearly predictable negative consequences that would befall both local health organisations and the health of the local population.

Lancet with its recent series of *Countdown* articles is not the only one to denounce the current situation and to demand a radical change of direction in health policies, putting back at the centre of interest strategies and especially funding of the general health care system (e.g. human resources, infrastructure, governance, accessibility) with particular focus on the sector that lags behind the most: primary health care.

*Strengthening of health care systems*

The International Monetary Fund (IMF), which is twinned with the World Bank, was forced to recognise the dire consequences of these policies:

"Perversely, the large inflows of donor assistance targeted to these diseases (through so called vertical disease programs) have weakened the infrastructure and drained the human resources required for preventing and treating common diseases (such as diarrhea, and upper respiratory infections) that may kill many more people. Furthermore, multiple donors, each with their own priorities, bureaucratic requirements, and supervisory structures, have created waste and confusion with recipient nations. Lastly, an important concern is the sustainability of these vertical programs, since donors' funds may not prove stable or long lasting. For recipient countries, these inflows have created difficult challenges in the management of the health sector"[6].

The World Health Organisation (WHO) recently published a working paper on Aid Effectiveness and Health[7] that provided indepth analysis of the three main distorsions of the current international health cooperation model based on vertical programmes.

1. **Vertical programmes undermine the foundations of national health systems.**
   The current GHI-based health cooperation model directs a mere 20% of resources towards the current management of health care systems. This means that local governments have trouble financing essential aspects such as payment and training of health workers, and the development and maintenance of infrastructure. For example, between 2000 and 2004 funding for AIDS doubled (which is certainly a good thing) but at the same time during the same period, primary health care funding was slashed by half.
2. **Aid can be unpredictable, short-term and volatile.**
   Aid is not only earmarked for certain sectors unrelated to local government priorities, but is also unpredictable, short-term and volatile, making it impossible for local authorities to plan long-term.
3. **The many actors involved are not coordinated and this creates high transaction costs for local governments.**
   Points one and two should be multiplied by 5, 10 or 100 in accordance with the number of GHI in a country. Each one of these initiatives has its own administrative procedures and evaluation systems. As a consequence local health care organisations, already exhausted by a lack of basic resources, are forced to devote a great deal of their time to coordinating the initiatives of others and to meeting the administrative requirements of donors.

In 2007, The United Kingdom's Department For International Development (DFID) published a document that reviewed its health cooperation policy[8]. On presenting it, the Minister stated: "We must do no harm. We must make sure that our well meaning efforts to deal with a single health issue do not damage our wider effort".

*The three priorities of the UK's health cooperation*

**1. Address the major causes of disease.**

In the world each year more than 10 million children under five and more than half a million women still die unnecessarily due to complications during pregnancy and childbirth; almost all of these deaths occur in the world's poorest countries; what is more serious is that very little is needed to prevent them: access to clean water and accessible, functioning primary health care facilities, including the assistance of skilled health workers at birth. A population's health is governed by a country's GDP and by family income, but dramatic improvements in Cuba, Sri Lanka and India's Kerala state show that progress on health does not necessarily depend on high incomes or rapid economic growth.

The mother, newborn and child sector receives very little resources from international donors; however results have also been disappointing in areas where there has been a large injection of aid for illnesses such as AIDS, tuberculosis and malaria. Therefore the problem is not only the amount of aid, but also how it is used. "We must use resources more effectively to support health systems, deliver integrated services and address the underlying reasons why people are vulnerable to such diseases", states the document.

**2. Invest in strengthening health systems so that they can deliver essential health services.**

In many countries health funding falls far short of the US$ 34 per person per year that WHO considers to be the minimum amount needed to deliver an essential package of care.

The majority of African countries fall into this category as do a number of Asian and Latin American countries, as well as some ex-Soviet republics.

In these countries, public health systems are left to their fate with their dilapidated facilities, a dearth of equipment and medication, and few health workers, who are demotivated and poorly paid and often seeking to leave their country. People are also forced to pay for their health care. Consequently patients often turn to the private market, which is unregulated, poor quality and rife with unqualified workers and counterfeit medication.

In these conditions, any intervention risks failure and would be unsustainable once a project had finished.

DFID objectives for this point are:

a. Support selected countries to strengthen their national health systems to deliver basic services, including through investments, management, governance and development of human resources;
b. Provide direct assistance for selected countries to deliver essential health care and to support countries wanting to remove user charges to improve access to essential health care;
c. Develop the next phase of Taking Action, the UK's strategy to tackle HIV and AIDS in the developing world, and to pursue the goal of as near as possible universal access to antiretroviral treatment by 2010;

d. Ensure that investments in other sectors including water and sanitation, food security and nutrition, education, social protection, infrastructure and the environment lead to maximum health gains.

**3. Improve the effectiveness of international health funding.**

In recent years, the world of international health cooperation has been filled with an enormous number of actors: 40 bilateral agencies (namely national agencies that deal with health cooperation; many countries, such as Italy, have also set up regional agencies); 26 UN agencies; 20 regional and global financial institutions; and more than 90 global health initiatives based on public-private partnerships, generally geared towards treating certain illnesses or supporting a particular health sector. To these we also need to add a vast array of non-governmental organisations.

This donor overcrowding not only causes an incredible fragmentation of interventions (with consequent waste and duplications), but also a continual invasion of territory dealt with by the governments of recipient countries, which are thus deprived of any means of control or planning.

DFID objectives for this point are:

a. Give the United Nations the task of coordinating and simplifying funding so that funds destined for recipient countries do not go towards a specific illness, but to the country's health system;
b. Reform the role of the World Bank so that in future it will have to shift its interest from funding individual diseases to funding public health services and to long-term support of national budgets;
c. Explore new paths in order to ensure that all of the major international health institutions are able to take greater responsibility for supporting the growth of essential health services at national level.

## *Unintended victims of generosity*

One episode came to light within the Global Fund to fight against Aids, Tuberculosis and Malaria (GFATM) in 2005. It regarded the situation in Malawi where GFATM funding for AIDS was restricted to supplying medication and laboratory testing, while completely overlooking investments in human resources. Consequently a system that was already severly understaffed suddenly found itself with a huge new workload as well as inadequate facilities. On protests by the government, the GFATM granted Malawi additional funding for 40 million dollars so that the health system could be strengthened. This funding paid for the employment of 5,228 community health workers who were needed to support Malawi's Essential Health Package, a programme that included interventions for HIV/AIDS, malaria, tuberculosis and other diseases.

Since 2005 the GFATM has accepted projects designed to strengthen health systems (and a modest percentage of its budget has been put aside for such projects). This triggered calls to focus more attention, support and funding on strengthening national health systems. It had become clear to all that although vertical pro-

grammes produced some results for a particular disease, they also left the most vulnerable strata of the population defenceless. Furthermore they were destroying countries' entire national health care setup. This destruction ranged from the higher levels where central and peripheral Ministry of Health facilities were stripped of their role and competence (as well as their dignity) to the lower levels where health workers, badly paid and demotivated by the dilapidated facilities in which they had to work, sought the vertical programme that offered the best advantages.

"Well-financed vertical programmes funded by international donors have 'diverted' skilled local health personnel away from the local (primary) health care system. In Ethiopia, for example, to implement the Global Fund proposal, local medical staff were hired on consultancy contracts at triple the public sector salaries. As a result, the health sector became vertically organised, with staff moving from one section to the next, jeopardizing access to overall health services and raising deep concerns regarding equity. This type of internal 'brain drain' has devastating consequences and undermines critical primary health care services"[9].

These distortions, however, are not limited to the poorer countries of Sub-Saharan Africa, more dependent on external aid; resource-rich countries such as South Africa are also affected. The extract below is taken from a lengthy article in the *Los Angeles Times* that covered the work of the *Bill and Melinda Gates Foundation* in South Africa. The article was entitled "The unintended victims of Gates Foundation generosity"[10].

"By pouring most contributions into the fight against such high-profile killers as AIDS, Gates grantees have increased the demand for specially trained, higher-paid clinicians, diverting staff from basic care. The resulting staff shortages have abandoned many children of AIDS survivors to more common killers: birth sepsis, diarrhea and asphyxia. The focus on a few diseases has shortchanged basic needs such as nutrition and transportation, undermining the effectiveness of the foundation's grants. Many AIDS patients have so little food that they vomit their free AIDS pills. For lack of bus fare, others cannot get to clinics that offer lifesaving treatment. Gates-funded vaccination programs have instructed caregivers to ignore – even discourage patients from discussing – ailments that the vaccinations cannot prevent. This is especially harmful in outposts where a visit to a clinic for a shot is the only contact some villagers have with health care providers for years".

## *A vast array of initiatives*

Over the last few years, there has been a host of initiatives and taking of stands in an attempt to reverse a course that was clearly wrong. The most popular buzzwords were "Strengthening Health Systems" and "Maximizing positive synergies", which involved promoting integration between the vertical approach typical of GHIs, and the horizontal approach, which was geared towards strengthening health systems. Below are some of the most important initiatives in this field.

**International Health Partnership**[11]**.** In September 2007, the British government promoted this initiative, involving a range of actors including WHO, European Union, World Bank, African Development Bank, UNAIDS, UNICEF, GFATM,

Bill and Melinda Gates Foundation, and Burundi, Ethiopia, Kenya, Mozambique, Zambia, Cambodia and Nepal as representatives of African and Asian countries. The Partnernship set itself three goals: a) focus on improving health systems and not on individual diseases and sectors; b) promote greater donor coordination; c) support and develop the health plans of individual countries.

**15 by 2015.** This initiative is promoted by Jan De Maeseneer, head of the department of Family Medicine and Primary Health Care at the University of Ghent (Belgium) and president of the European Forum for Primary Care, whose members include a host of academic organisations (as well as others such as WONCA, the world organisation of family doctors) with the support of the British Medical Journal[12]. The aim is to convince international agencies and donors, including WHO, World Bank, Bill and Melinda Gates Foundation, GFATM, US President's Emergency Plan for Aids Relief (PEPFAR), etc. to allocate 15% of the budget of vertical programmes to supporting horizontal programmes for primary care by 2015.

"The majority of the financial support goes towards disease-specific projects (vertical programming), rather than addressing a broader range of illnesses through comprehensive primary health care and preventive measures (horizontal programming). These disease-specific programs have not met the main objective of improving the health of the whole community. Despite the large sums being donated, these projects only focus on small parts of the population. Disease-specific programs underestimate the importance of access to health care services by all people. Furthermore in many countries disease-specific programs lead to increased shortage of human resources in the general health care by employing local health care workers in their own projects for salaries often 2-4 times the normal salaries, creating an internal 'brain-drain'" (www.15by15.org).

**Maximizing positive synergies between health systems and Global Health Initiatives**. In May 2008 the WHO organised a two-day conference in Geneva in which the representatives of about 150 institutions and organisations took part. Participants included governments, international agencies, global health partnerships, non-governmental organisations and universities. Below is an extract from the concluding report[13].

"Global Health Initiatives (GHIs) are characterized by a focus on specific diseases, products or populations and commonly include an element of public-private partnership. Some of the largest and best known of the GHIs include the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund), the Global Alliance for Vaccines and Immunization (GAVI) and the US President's Emergency Plan for AIDS Relief (PEPFAR). In total, over 80 GHIs are now active in the field of public health. These global initiatives have been successful in dramatically raising the level of resources for health, in part because of their specificity and in part through their focus on linking inputs to results".

### The importance of robust health systems

However, through their interventions, the GHIs have exposed critical weaknesses in the broader fabric of resource-constrained health systems. In a vicious circle, diseases such as malaria, tuberculosis, HIV and vaccine preventable diseases have eroded some health sys-

tems so severely that they lack the capacity to successfully implement the programmes that are designed by the GHIs to tackle these very diseases. Furthermore, the selective approach to health services that has been adopted by the GHIs may, in some cases, also have the unintentional effect of further eroding the capacity of health systems to respond to more generalized health needs. In response to these challenges, there has been heightened commitment from all stakeholders to strengthening broader health systems in relation to infrastructure, human resources, supply chain management, health information systems, health financing and integrated health policy".

### The need to ensure maximum gains for global public health

"The WHO consultation on positive synergies was convened in response to a widening recognition of the urgent need to address the challenges that are intrinsic to the relationship between overall health systems strengthening efforts and the selective interventions of the GHIs. There seems little doubt that positive synergies exist between the two. But the consultation faced the question: are these synergies being vigorously exploited by all stakeholders to ensure maximum mutual added value? Or are new opportunities for improving public health in low – and middle-income countries being missed?"

The WHO has recently organised a ministerial conference on health systems (Tallin, 25-27 June 2008) on the theme: **When do vertical (stand-alone) programmes have a place in health systems?**

"Vertical programmes may be desirable as a temporary measure if the health system (and primary care) is weak; if a rapid response is needed; to gain economies of scale; to address the needs of target groups that are difficult to reach; to deliver certain very complex services when a highly skilled workforce is needed. In practice, most health services combine vertical and integrated elements, with varying degrees of balance between them.

When vertical programmes may be desirable, policy-makers could consider two policy options: (1) time-limited vertical programmes with clear strategies to avoid negative spillover effects for the health system and nontargeted populations; and (2) indefinite programmes, with mechanisms at both the strategic and operational levels to enhance links between the vertical and horizontal elements of the health system.

Political economy within a particular context and technical factors related to the health system will influence the extent of integration. As powerful interest groups are likely to oppose the integration of vertical programmes, policy-makers should develop strategies to offset such resistance.

Where vertical governance, funding and service delivery systems exist, integration will be difficult and changes in service delivery must be underpinned by legal and regulatory adjustments aimed at linking the governance, organization and funding of vertical programmes with mainstream health systems"[14].

**Toyako Framework for Action on Global Health – Report of the G8 Health Experts Group**. The G8 held in Japan in July 2008 addressed health issues with a document that had been produced by a group of experts and approved by the heads of state. Here follows an extract from the document.

"It is also clear that health systems strengthening is important for effectively addressing health challenges as a whole. Disease specific approaches and health systems strengthening

should be mutually reinforcing and both must contribute to achieving all of the health-related MDGs. (…). Health systems are multi-dimensional. The international community should tackle various aspects of health systems such as the health workforce and human resources for health; health information; good governance; essential infrastructure; quality assurance; management of medical products and essential drug supply systems; and sustainable and equitable health financing of the health systems. Aiming to work towards universal access to health services, the G8 emphasizes the importance of comprehensive approaches to address the strengthening of health systems including social health protection, and will work with partner countries to promote adequate coverage of recurrent costs in health systems".

## *The heart of the matter*

There is no doubt that the issue of strengthening health systems within a context dominated by GHIs has barged its way onto the agenda of international health policy, and in particular onto the one that deals with international health cooperation.

The idea of solving the problem by transferring some of the resources from the relatively wealthy coffers of the GHIs to the 'poor' health systems in order to finance human resources, infrastructure current expenditure for general activities, may seem realistic and pragmatic, but only on the surface. There are two key reasons behind this: one political and one financial.

**The political reason.** The proliferation of GHIs and the respective vertical prpogrammes do not meet the technical criteria and requirements illustrated by the WHO in the Tallin report. Indeed, events over the last two decades in the global health arena have followed a logic that has very little to do with health organisation strategies (who can deny the usefulness, or necessity, of vertical health approaches when addressing major problems in public health?). What sets the GHIs apart is not only their mission (vertical programmes), but mainly their nature; they are autonomous to the point of anarchy, beyond the control of international institutions (UN, WHO), in fact they are deaf to any requests. They are also beyond the control of governments, institutions and local health organisations, and are often openly at loggerheads with them. The political nature of GHIs is clear: they were born out of the neo-conservative motto "Government is not the solution, government is the problem", with "government" meaning everything that comes within the public sphere. Whilst on one side the public health services of poor countries were being razed to the ground and on the other traditional international health institutions were losing credibility and influence, GHIs, the "magic bullets" of globalized health, roamed free with the blessing of the G8 and the World Bank. If no radical revision of political direction is made (none is on the horizon, but with the new US administration, who knows!), a much-hoped-for redressing in the balance of power between GHIs and national and international institutions seems very unlikely. In the future, we will witness a few symbolic "positive synergies", a few extra dollars will be moved from the GHI budget to that for health systems, but the basic framework will not change; it is also unlikely that there will be any change in the entirely self-referential nature of GHIs.

Let us take a look at PEPFAR, the most powerful GHI (on 16 July 2008 the American Senate approved a 48 billion dollar budget for the next five years). PEPFAR is an extremely centralized organization with a "directive and proscriptive" chain of command governing the agencies (almost all of them American) that operate locally[15]. It is extremely unwilling to discuss intervention policy with local authorities and is "driven by ideologiy rather than science" (namely absolute emphasis on abstinence as a means of reducing the spread of AIDS, a ban on helping prostitutes, opposition to providing safe needles and syringes to drug addicts), as a recent article in the New England Journal of Medicine[16] stated.

**The financial motive.** In 2006 vertical programmes raised a budget of about 7 billion dollars[17]. Although 15% of this amount was transferred immediately to health systems, it amounted to little more than 1 billion dollars. This amount is utterly inadequate in the face of the 22 billion dollars in external contributions needed to achieve a minimum acceptable level for health systems in poor countries, namely the objective of 35 dollars per capita in public health care expenditure (See Chapter 1.2.). When projected to 2015, the same amounts become 31 billion dollars and 40 dollars per capita respectively[18]. Among the great amount of literature that has sprung up around the issue, one original proposal has been suggested by a group of authors who are already known for launching another interesting idea: World Health Insurance[19]. This time, G. Ooms & Co. proposed turning the GFATM into a **Global Health Fund**, an agency with the task of dealing with the health systems of the world's poorest countries rather than a specific sector. The authors have calculated that, to achieve this, 28 billion dollars of external contributions a year will be needed[20]. Strengthening (i.e. rebuilding from the foundations) the health systems of the poorest countries is a daunting challenge; one of epic proportions if we consider that one million health workers are needed in Africa alone. Money is not everything, we known that, but without those 20-30 billion dollars in contributions from the international community, the project will not even get off the ground.

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