Perspectives

Effectiveness of global health partnerships: will the past repeat itself?

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Introduction

It is to be hoped that past mistakes are not going to overshadow the effectiveness of global health partnerships (GHPs), as they provide valuable lessons that should be taken into account. The *Bulletin* publishes a fascinating series of public health classics, consisting of a commentary doing a reality check on what has happened since publication of major public health landmarks. In 2005, Anne Mills commented on a landmark paper on mass campaigns and general health services of 1965.[1] One could get a bit depressed reading her article, because the bottom line is that not much has changed in the past 40 years, which have confronted believers in vertical and horizontal approaches.

The terminology has changed, though. Some 20 years ago the topic shifted from vertical versus horizontal programmes to the dispute over the advantages of comprehensive versus selective primary health care. In the 1990s, this discussion cooled down and a combination of the two approaches was translated into health sector reform efforts, with widespread consensus to integrate health actions at district level. This development has been supported by changes in aid modalities such as the sector-wide approach (SWAp) funding mechanism. This evolution has come under threat, however, with the appearance of global health initiatives at the beginning of this millennium,[2] which have brought back this "old" controversy opposing today's approaches: those that have a more systemic focus or those with a more selective, often disease, orientation. With more than 70 GHPs in existence today, the former selective/vertical party is seemingly gaining the upper hand again.

The difference from before, however, is that aid effectiveness is now receiving more attention. It is noteworthy that in 2005, for the first time, a large group of donor and recipient countries, international organizations and also civil society organizations agreed in the Paris Declaration on Aid Effectiveness to set targets for aid effectiveness and to define a set of indicators to measure progress towards these targets.[3]

The main argument of this paper is that we should avoid the conflicts of the past. We must strive to achieve a balance between the selective approach of many GHPs and the strengthening of health systems, as they are interdependent.

Effectiveness of global health partnerships

Although the evidence is still scarce, there are some indications that individual GHPs have had a positive impact in some settings.[4] In many countries, they have helped – albeit in specific areas – to strengthen planning expertise. The focus of major GHPs on performance-based funding has "forced" countries to improve administrative transparency and strengthen their monitoring capacities. It is also worthy of mention that, through their efforts, awareness of specific health problems has been raised at national and international levels. Last but not least, GHPs have clearly brought to light important health problems, and some headway has been made in fighting AIDS, poliomyelitis and other communicable, otherwise neglected, diseases.

Major challenges and questions remain, however. Even though there are good arguments for almost all GHPs, their large number raises the question whether the priorities thus determined for a given country really do respond to the national problem areas. The magnitude of the resources can put a considerable strain on the capacities of countries to absorb the influx of financial resources, particularly with the major bottleneck in many countries caused by the lack of local professional expertise in both quantity and quality. There is also the potential risk of an impact on the economic stability of a country.

Another important concern about GHPs is sustainability. In poor countries, health systems are seriously underfunded; even if improvements can be achieved with targeted external support, they cannot easily be sustained after the period for which donor agencies are usually ready to commit funding.

GHPs claim to be cost-efficient; many of them have lean structures, with the advantage of reducing transaction costs at least on the donor side. At the same time, however, this approach promotes the tendency to advocate "one size fits all" attitudes, as it does not require large numbers of technical staff. Unfortunately, one size rarely does fit all circumstances. There is also little information on the transaction costs at country level.[5] Furthermore, it is hardly possible to cost alternative approaches, such as fostering synergies with other partnerships or achieving results through a comprehensive strengthening of national health systems. In this context it is perhaps not a coincidence that numerous GHPs have difficulties in channelling resources through SWAp funding mechanisms.

Even though the financial resources made available through GHPs are impressive, they are a far cry from what has been estimated to be needed by the Commission on Macroeconomics and Health.

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In spite of new – though not yet widely accepted – ideas such as the international finance facility or a tax on plane tickets, GHPs might turn out to be inadequate if they do not engage in the necessary efforts to address the complex problems of health systems faced by countries with limited resources.

Lastly, we tend to forget that there are no magic bullets and no quick wins in health development: continuous and long-term efforts are necessary in order not only to make improvements but also to maintain good health status where it exists in a population.

The way forward

The Paris Declaration focuses on almost all of the challenges mentioned above. It stresses ownership of partner countries, alignment with country priorities and systems, harmonization of reporting requirements between donors, managing for results and mutual accountability. The Paris Declaration also has the potential to alleviate the risk of fragmentation of health and should lead inevitably to a stronger consideration of the systemic aspects of health care. It should also be a countermeasure to the proliferation of new GHPs. It provides a basis to motivate all stakeholders to invest in strengthening systems and to work towards solving burning issues such as the human resource crisis.

In a recent meeting on global health initiatives,[6] a partner from the South gave a vivid description of a minister of health from a poor country arriving at an international meeting and being confronted with his fellow colleagues from the North, who are perhaps not as well prepared but come with large groups of advisers who have the time to deal with conceptual issues all year round. This situation reflects that there is a huge need to strengthen partners at this level also, to allow for discussions on an equal footing. In this connection, it remains to be seen if partner countries will have the strength to refuse an offer of GHP funding if it is outside national priorities or beyond their capacity to absorb with available human resources.

It also remains to be seen to what extent donor agencies can overcome the constraint of their usual two- or three-year period of commitment, considering the variations in the parliamentary systems of donor countries.

A major problem – which is unfortunately not new – is the weakness of monitoring mechanisms at all levels; this problem underlines the importance of strengthening health system metrics in partner countries.

Although the Paris Declaration is a good move in the right direction, and follow-up mechanisms in the form of a working group and monitoring tools have been put in place, there is need to strengthen coordination and guidance. WHO is an obvious candidate to play such a coordinating role, though it certainly cannot take on this responsibility without a substantial increase of its funding basis and regaining the leadership that GHPs have started to undermine.

In the past, policy analysis has helped to develop some understanding of the new international environment, but research is still at the descriptive rather than the analytical level. Crucial information, such as details of the transaction costs, is lacking, and further efforts to generate knowledge for improving aid effectiveness is badly needed.

Discussing global health issues bears the risk of being detached from the nuts and bolts of health development. A practical idea stimulated by experience in the airline industry has been introduced with some success in the anaesthesia department of the University Hospital in Basel, Switzerland. The Anaesthesia Critical Incident Reporting System[7] is an international forum where critical incidents of daily anaesthesia practice are collected and made accessible in an anonymous way, so as to provide learning opportunities and to get a grip on quality problems in this field. In the international arena, all of us experience regularly more or less "critical incidents", albeit not as immediately dramatic as in anaesthesia where an individual human life is at stake. Even if we may not be aware of it all the time, however, the consequences of poor aid effectiveness can be much more devastating on human life than one wrong decision by an anaesthetist. Sharing not only the success stories but all practical experience through a critical incident reporting system could be a way forward to deal with the many problems that arise at national and also international level. It would offer a platform to voice concerns, which would otherwise not be heard, and identify problem areas. It might be also a way to avoid the unpleasant experience of realizing in a few years from now that it was not a better effectiveness of international health collaboration that was waiting for us in 2007, but the mistakes of the past come back to haunt us. ■

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