ALTARUM POLICY ROUNDTABLE

Challenges in Global Health
Taking a Systems View
with Laurie Garrett
Council on Foreign Relations

Washington, D.C.
July 17, 2007

ROUNDTABLE REPORT
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I. Roundtable Purpose and Overview

Between 1955 and 2005, life expectancy worldwide rose from 46.6 years to 65.4 years. Yet today, the life expectancy gap between the wealthiest countries and the poorest countries is the largest it has ever been: a 48 year difference. Tuberculosis, malaria, and, particularly, HIV/AIDS, continue to ravage the developing world, with Sub-Saharan Africa hit the hardest. The United Nations Development Programme (UNDP) projects that by 2010, 18.4 million children will have been orphaned as a result of AIDS.

The global health crisis we face is clear. On the other hand, it is not clear if the global community’s efforts to date sufficiently meet the challenges of this crisis, or if we must consider new approaches to address global health needs and strengthen health systems across the developing world.

As a nonprofit health systems research institute, Altarum has a long history of objectively evaluating health systems and providing culturally-appropriate solutions that strengthen health systems, allowing them to deliver higher quality care and promote better health.

On July 17, 2007, Altarum hosted Laurie Garrett at an Altarum Policy Roundtable to initiate and promote further dialogue on key issues of and impediments to establishing effective and sustainable health systems in developing countries. Garrett’s perspective on the need for a more comprehensive “systems view” of global health challenges served as one of the underlying themes to the Roundtable.

Ms. Garrett, who is a senior fellow for global health at the Council on Foreign Relations in New York, has written extensively on global public health systems and the threat of emerging diseases and is the only writer to have ever been awarded all three of the major journalistic awards: the Peabody, the Polk, and the Pulitzer.

Ms. Garrett’s full biography is in Appendix C.

Altarum invited a broad array of global health experts to the Roundtable, including representatives from the U.S. government, the Non-Governmental Organization community, and the private sector. A complete list of attendees is in Appendix B.

Section II of this document provides a summary of Garrett’s presentation and Section III provides a sample of questions and answers that followed her remarks. The following sections do not constitute a complete transcript. A full video of the presentation is available from Altarum upon request.

II. Presentation Summary and Key Observations

A Brief History of Global Health

In July 1944, the Bretton Woods Conference established rules for commercial and financial relations among the world’s major industrial states and set the goal of raising global productivity,
standards of living, and conditions of labor. From this conference, the foundations for the World Bank and the International Monetary Fund (IMF) were established. In 1946 the Bank and the IMF became operational, and in 1948 the United Nations founded the World Health Organization (WHO). From the outset, WHO had to deal with the challenges of the Cold War in addition to the major diseases plaguing the world at the time: smallpox, polio, measles, and a host of other infectious diseases.

In 1976, Robert McNamara shifted the focus of the World Bank to combating, and eventually eradicating, global poverty. Evidence suggests that there has been little progress since McNamara’s directive was implemented. While global life expectancy has increased by more than 40 percent, this increase is primarily a result of improvements in the developed world. Today, in African countries such as Botswana, Swaziland, and Lesotho, life expectancy is 33, 35, and 36 years respectively. When compared with Japan, where life expectancy is 82 years, and Sweden, where life expectancy is 81 years, it is clear that the health gap between rich and poor countries has grown. Other health statistics tell a similar story. Infant mortality in poor countries is almost double that of rich countries, and a host of other health indicators in developing countries have remained stagnant over the last 30 years. These health disparities have broad implications.

Youthful societies are much more difficult to change structurally, and, according to the UN, disease has lowered the median age in developing and underdeveloped countries to 18.9 years compared with 38.6 years in developed countries. Having a young society also negatively affects economic well being and national security. Between 1965 and 2004, Sub-Saharan Africa’s per capita contribution to global GDP has decreased from 17.1 percent to 9.7 percent. Moreover, today the poorest nine countries in the world account for only .004 percent of the world’s GDP, while the wealthiest nine are responsible for 71 percent. What are the reasons for this decrease in productivity and gross inequality? One is HIV and AIDS. Moreover, the global response is to provide charity for specific diseases rather than invest in health systems.

Understanding Global Efforts to Combat HIV/AIDS

Between 1990 and 2006, the prevalence of HIV in Sub-Saharan Africa rose from roughly 2 percent of the population to nearly 6 percent. According to the UNAIDS Program, by 2010, the percentage of orphans who will have lost one or both of their parents to AIDS will be 60 percent in Zambia, 40 percent in Tanzania, and 48 percent in Uganda. The loss of parents due to AIDS also increases child mortality rates. In 2002, AIDS increased infant mortality by 44.8 percent in Botswana, 12.2 percent in Ethiopia, by 18.9 percent in Malawi, and by 20.6 percent in South Africa; and increased child mortality by 76.5 percent in Botswana, 20 percent in Ethiopia, 29.7 percent in Malawi, and 35.9 percent in South Africa.

In 2006, the Council on Foreign Relations held a series of roundtable discussions about the “Best Practices in the Battle against HIV.” The findings of the discussions outline current challenges facing global efforts to combat HIV/AIDS:

- HIV/AIDS programming is very young. Most programs are less than 6 years old and focus on medical training and/or treatment
• The majority of global health funding, the bulk of which is supplied by the Gates Foundation and the Global Fund, focuses on combating HIV/AIDS, while tuberculosis, malaria, and other infectious diseases are secondary
• A great deal of the money earmarked for global health goes unspent as a result of health systems capacities’ inadequacies
• When large drug companies get involved in the battle against AIDS, they tend to get away from their core competencies rather than focusing on their strength: supply chain management, volume forecasting, etc.
• There is a severe shortage of infrastructure needed to deliver health care. As one company said, “Thirty-eight percent of [our company’s] costs in [Africa] was infrastructure development
• The battle against HIV/AIDS is being waged on a small scale by cottage industries that lack the capacity to scale-up, develop financial models that will sustain their involvement, and develop monitoring and evaluation systems that ensure accountability
• Most NGOs are too reliant on a single source of funding such as the President’s Emergency Plan for AIDS Relief (PEPFAR) or another donor agency, putting their funding at risk in the face of political cycles and changes
• NGOs do not have exit strategies, nor are there clear and consistent metrics by which program successes can be measured

Identifying Obstacles to Solving the Global Health Crisis

Today, global health is most often addressed on a disease-by-disease basis rather than using a more comprehensive approach to health systems strengthening. This “silo” approach to meeting global health needs often leads to policy makers, NGOs, and the funding community ignoring two of the leading, systemic impediments in the fight against global disease: (1) scarcity of health care workers and (2) the lack of basic infrastructure.

The vast majority of the 59 million health care workers in the world are concentrated in wealthy countries and urban areas. The world requires approximately 4 million new health care workers to meet identified needs, with Africa needing about one quarter of those workers. Because developed nations regularly siphon off health care workers from developing countries to meet their own demands, there is no reliable supply of qualified health care professionals willing to work in (and remain in) areas where the need is greatest. Within developing countries, national and local health ministries are losing workers to NGOs because these organizations have access to donor funds (PEPFAR dollars, etc) and can afford to pay workers a better wage. Opportunities for local health care workers to earn a “living wage” from local health authorities are few and far between. Community-based programs to train a diverse set of community health workers (including patient peers, midwives, and “barefoot doctors”) prepared to treat such diseases as tuberculosis and malaria, as well as HIV/AIDS) are urgently needed, yet rarely considered a funding priority. Persistent shortages of qualified health care workers also minimizes other efforts to improve local health systems, including attempts to better manage the millions of patients with chronic diseases in the developing world.
Severe deficiencies in local infrastructure are recognized as problematic, but funding to improve infrastructure critical to promoting public health (e.g., roads, electricity, sanitation, reliable supply chains) remains insufficient.

Global Health Funding

Over the past few years, there has been an enormous and welcome increase in the amount of money allocated for global health, with most of the increase due to charitable giving by large foundations and other donors. In 2005 roughly $8 billion was available for global health programs; today $18-$20 billion is available. A great deal of this money goes unspent as a result of sufficient capacity on the recipient end. Funders also are culpable. More often than not, funders tend to focus on specific diseases rather than long-term capacity building (e.g., strengthening the supply chain, increasing the living wage in developing countries). A good example of this is the Global Fund to Fight AIDS. Moreover, there is no globally organized effort to address health issues, which leads to everyone developing and implementing their own interventions.

With a total of $8.8 billion, and accounting for 20 percent of AIDS funding, 65 percent of tuberculosis funding, and 65 percent of malaria funding, the Global Fund is one of the largest health funding sources in the world. However, despite the amount of money it has, the Fund is behind on grant approvals because of recipient countries’ inability to spend the grants; around 20 percent of its grants perform poorly and it does not strategically fund programs to strengthen health systems and address the human resource shortage. Time has shown that the Global Fund cannot serve multiple roles as a donor, auditor, supporter, and evaluator.

Ideological barriers also have severely limited the potential to improve global health. More often than not, NGOs do not want to work with businesses, and businesses are tired of simply providing money when they have valuable skills to share. There also are donor demands, NGO demands, recipient concerns, and religious issues. These ideological agendas have led to roughly 70 percent of health spending remaining urbanized with stakeholders having little to no ownership of programming. Stronger public-private partnerships (PPPs) with an emphasis on profitable enterprise may offer a valuable path to addressing global health issues if these ideological divides can be overcome.

While charitable dollars may be plentiful today, there will come a time when charity fades. When this inevitably happens, will we have sustainable health systems in place? Will recipient nations have a strong sense of ownership, not only of the health challenges they face, but the programs that have been built (with donor funds) to address them? Funding for global health should be considered an investment rather than charity silos where disease-specific dollars are poured.

III. Question and Answer Session

Q: Have venture capitalists brought innovation to global health?
A: While organizations like the Acumen Fund exist, the structural things that are most needed, such as rapid amateur/low cost diagnostics, are not being funded for research and development. Venture capitalists seek potential profit and the majority of people with diseases in developing countries are very poor and cannot pay for health care.

Q: Is Prime Minister Gordon Brown’s plan for issuing bonds a good idea?

A: Yes and no. In February 2007, Brown announced that the fund would provide $1.5 billion for a global pneumococccous vaccine. While Brown’s plan might work for this specific disease, it is unclear whether or not the model can be replicated for other diseases. The pneumococccous vaccine is feasible because all of the research and development had been done. It just needed funding to overcome the lack of profits and distribution costs, and to pull it out of the pipeline and into the real world.

Q: You said that the key to sustainability is local enterprise, but there is a great deal of corruption. How do you combat existing corruption, as well as prevent corruption in new enterprises?

A: Corruption is a very difficult problem to solve, but if we concentrate on health systems themselves, and increasing their transparency and efficiency, then we can make progress. Health care workers often have more than one job due to low or delayed wages, and doctors often see patients through their private practices. Corruption often affects drug supply and delivery the greatest. There are innovative ideas being offered that would allow for largescale, transparent drug purchasing. Dalberg Global Development Advisors, for instance, suggested creating an online resource along the lines of eBay for drug purchasing. There is a need to broker links between the health care systems and the business communities, such as local pharmacies.

Q: Your articles and your presentation suggest that leaders in the funding/philanthropic community need to think differently about what they fund and why. Do you see a growing interest in this community to focus on projects that take more of a systems approach to promoting global health?

A: I was concerned when I first wrote my article (in Foreign Affairs) that it would be very poorly received and that the global health community might be openly hostile. That has not been the case. I have had lots of interest by funders and NGOs alike, so I think everyone is open to looking at these challenges in new ways. But it will take strong leadership and long term investment.

Q: You mentioned that the skill set and experience needed to address some of these issues can be found in the business community. Among those currently working in global health, have you seen any openness to seeking out that skill set from the business community?

A: The paradigm now is that business companies will often enter into a country with a ‘can-do’ mentality but without sensitivity to the efforts and experience of those who have been
working on the issue. What often results is a clash of arrogance. What needs to happen is for a third-party entity to broker a successful relationship.

More generally, there is a need to use both the public health and business models to better understand what elements or aspects of successful interventions can be replicated elsewhere.

Q: PEPFAR (Presidents Emergency Plan for AIDS Relief), while disease specific, does have some preliminary data which shows that other health indicators are improving as a result of such things as prevention of mother to child transmission (PMPCT) care. The dilemma is that it (PEPFAR) is an emergency plan for a specific disease, yet it also must be sustainable and strengthen health systems. Now PEPFAR is scaling up and learning from the beneficiaries. Having said all of this, we must support national ownership of the HIV/AIDS epidemic. One way this is being attempted is developing national plans that are multi-sectoral, prioritized, sustainable, etc. Do you see the emphasis placed on these plans as an important component of creating effective health systems?

A: I do think that national plans are a good idea, but international coordination and participation is missing and the structure of the current system makes it difficult. I believe a superstructure which can address some of these international barriers (such as volume purchasing, supply chain, etc) will help make the national strategic plans relevant and important.

Q: What if we top up the entire supply chain in a country with the WHO essential drug list so all prevention and treatment needs can be met?

A: This may work, but we must remember that we also have to address the logistic and supply issues. To provide the drugs we need the syringes, latex gloves, alcohol swabs, petrol to get to the rural areas, etc.

Q: How do we maintain knowledge gains and define and disburse best practices in the global health field?

A: I think that conferences are too small to handle the task. The responsibility falls on funders. There was an idea to create in New York a center that would be focused on best and best practices, but it never came about, in part because of a concern about how such a center would sustain itself.

IV. Summary and Next Steps

Ms. Garrett’s presentation suggested several fundamental flaws in how the donor, policy, and NGO communities, to date, have addressed global health needs. Two categories of impediments are most apparent in her comments and clearly call for further dialogue and consideration among all interested parties.
Stovepipes or systems?

Garrett repeatedly emphasizes the need for global health policy makers and funders to move away from their past practice of funding remedies to a specific disease and toward an increased emphasis on funding the creation and/or strengthening of sustainable systems that can reliably address disease while simultaneously promoting health.

Garrett’s presentation challenges future conversations and studies to address such questions as:

- What tools and methodologies might be developed to help the funding/philanthropic community better assess whether their funding portfolios are helping to strengthen global health systems?
- What efforts can be taken to build capacity in global health systems? Specifically, how can we address the global shortage of health care workers? What training, pay-incentive, and other measures can be taken to train a pipeline of local health care workers and to retain them in the most underserved of environments?
- Are there new ways to involve the venture capital community and other investors to ensure a more regular flow of much-needed diagnostic and other medical devices into the communities and nations most in need?
- Are there new ways to encourage or assist developing nations to create national health plans (strategic plans) that take a comprehensive approach to health improvement?
- How can we create and sustain a mechanism for identifying, housing, and disseminating those practices determined to be most effective in strengthening global health systems?

The downside to charity

Garrett makes clear that the tremendous increase in charitable giving (by foundations and governments) to global health causes is the proverbial “double-edged sword.” Donors often concentrate on programs to supply much needed medications, and this is welcome. Yet without similar attention to the supply chain, storage, and local health workforce needs required to actually deliver medication to patients, funds can be wasted and donors frustrated. Ms. Garrett also warns of the day when donor largess will cease and cautions that there is little confidence that the programs that have been established to date, and upon which large numbers of people rely, are sustainable without a constant inflow of donor funds.

Garrett encourages the policy, NGO, and funding communities to:

- Identify ways to encourage governing institutions in developing countries to take ownership of the health crises facing their nations and prepare plans to sustain the gains made with donor dollars
- Develop exit strategies where none exist
- As above, donors must develop new methodologies for evaluating whether their funding programs are developing sustainable health systems, capable of surviving the end of international funding
Appendices
Appendix A.  Altarum Institute — An Introduction

Who we are and what we do
Altarum is a nonprofit health systems research institute. We provide objective, rigorous research and practical solutions to clients ranging from the U.S. military health system to local communities seeking to provide better care to vulnerable populations.

Leading in the field of health systems research demands many things of us: a diverse staff with diverse perspectives; a comprehensive set of skills – from complex modeling tools, to hands-on technical assistance methodologies; and the ability to apply those skills across the continuum of health care programs, making complex decisions simpler.

Our work is helping the nation provide better care today and achieve better health tomorrow.

Our history
Altarum traces its history back to 1946 with the founding of the Willow Run Laboratory in Ypsilanti, Michigan. In 1972, the Willow Run Laboratory was renamed the Environmental Research Institute of Michigan (ERIM). In 2001, ERIM acquired Vector Research, Inc., a leading provider of health care forecasting models and decision support tools for federal and state government clients. Later that year, ERIM became Altarum Institute. To advance its strategic growth in health care, Altarum acquired Health Systems Research, Inc. (HSR) in 2006.

For more information, please visit us at www.altarum.org
## Appendix B. Attendee List

### Roundtable Attendee List

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Appendix C. Laurie Garrett Biography

Laurie Garrett is a Senior Fellow for Global Health at the Council on Foreign Relations in New York. Ms. Garrett is the only writer ever to have been awarded all three of the Big “Ps” of journalism: the Peabody, the Polk and the Pulitzer. Her expertise includes global health systems, chronic and infectious diseases and bioterrorism.