stop AIDS campaign

Policy Briefing: Strengthening Health Systems to Achieve Universal Access to HIV & AIDS Services

January 2007

Summary

Strengthening health systems is vital if we are to achieve Universal Access to HIV & AIDS prevention, treatment, care and support by 2010.

The UK Government was instrumental in gaining global commitment to Universal Access. Determined and continuing leadership from the UK is required to deliver on it, working with their partners in national government, other donors and the international community.

This paper makes several recommendations in the following areas:
1. **Ensuring that health systems are financed sustainably over the long-term**
2. **Addressing the health worker shortage by investing in and supporting systems that link public services and the community**

Context: the need to strengthen public health systems

Well-functioning public health systems are essential to achieve the internationally-agreed target of universal access to prevention, treatment, care and support by 2010.[1] A well-functioning public health system is a core social institution, which should have scope to address inequities in health as well as shift the distribution of power and resources. Yet the poorest and most marginalised, especially women and communities most vulnerable to HIV & AIDS, experience the greatest difficulties in accessing good health care. The WHO Commission on Macroeconomics and Health concluded that good health is more than an outcome of development, as it is a crucial means to achieving development. Investments in health must, therefore, form a central part of any comprehensive development strategy.[2]

Over the last several decades development approaches have tended to promote privatisation, impose limits on public-sector spending and encourage the use of fees for public service. These policies have had a deleterious effect on public health systems. At the same time, HIV & AIDS has had a severe impact on the health systems of high prevalence countries, because health workers have become sick and died, and greater numbers of people have needed services.

The global commitment to Universal Access by 2010, spearheaded by UK leadership, will, if realised, alleviate a major burden on health systems. Universal access to antiretroviral therapy (ART) will result in people staying healthier and being able to live socially and economically productive lives as well as keep parents alive to care for their children.

There is growing evidence to show that expanded access to treatment encourages voluntary testing, known to be a crucial

[1] For the rest of this paper, the short form Universal Access should be taken to mean this

[2] For the final report of the WHO Commission on Macroeconomics and Health, see the section on the WHO website at http://www.who.int/cmhreport

intervention that supports HIV prevention.[3] Universal access to HIV prevention will result in fewer people acquiring the virus and this will therefore decrease demand on over-burdened health systems. Universal access to care and support is also critical for effective ART adherence and to realising people's rights to life and dignity.

It will be impossible to roll-out universal access to ART or prevention of parent to child transmission (PPTCT)[4] by 2010 without a well-functioning, integrated, and fully operating public health system at local, regional and national level, staffed by well-trained, well-managed and well-paid workers. This requires predictable and sustainable long-term financing to develop the sector and enhance HIV & AIDS specific initiatives. Only a public health system can provide the scale and coverage necessary to provide universal access to services that are free and geared to the needs of **all** citizens.

In a broader conceptualisation of health care, civil society organisations and community health workers are making vital contributions to delivery, quality and accountability in community settings. These include family-centred treatment adherence services, peer outreach for HIV prevention and interventions to address HIV stigma and discrimination. The integration of these community-based health services into more formalised health care is essential to the task of health system strengthening.

This briefing will consider how the UK's leadership can strengthen public health services through:

- Increasing investment
- Freeing fiscal policy
- Enhancing the role of the Global Fund to Fight AIDS, TB and Malaria
- Addressing the health worker crisis
- Recognising and planning for enhanced community responses

[3] WHO Progress on global access to HIV antiretroviral therapy: a report on "3 by 5" and beyond, March 2006

[4] Global coverage of prevention of parent-to-child transmission of HIV is currently as low as 8.7% according to UNICEF (2005) Unite for Children. Unite against AIDS

1. Financing for strengthening health systems

1.1 Take a long-term predictable approach to funding

> *"In three years, we know that we need . . . to take over ACTs and ART. We can't sustain the expense of all of them. ARVs alone will cost $34 million annually, which is one-third of Tanzania's entire public sector budget" (McKinsey and Co 2005) Ministry of Health official, Tanzania.*

Financial resources available for HIV & AIDS fall far short of what is needed to scale up towards Universal Access. UNAIDS estimates that the amount needed for an expanded response in low- and middle-income countries will increase from $14.9 billion in 2006 to $22.1 billion in 2008[5]. At the same time, the WHO has determined that it will cost between US$ 7.2 billion and US$ 14 billion over the next five years to implement its Treat, Train and Retain strategy to address the health worker shortage in the 60 countries with the highest HIV burden[6].

Health systems in developing countries have been severely under-funded for decades and the need to strengthen and even to rebuild them now is a direct result of structural adjustment programmes which undermined the public sector in many countries. Few governments of low- income countries commit a substantial proportion of their budget to their health system to deliver a basic package of services. Only two member states of the African Union have reached their commitment to devote 15% of national budgets to health.

National health systems clearly need significant investment over the long term to improve and expand provision to meet the Universal Access target. The WHO Commission on Macroeconomics and Health estimated that an additional $27bn per annum in aid is needed to strengthen the capacity of health systems so that they

[5] 'Scaling up HIV prevention, treatment, care and support' Note by the Secretary-General, 24th March 2006

[6] Treat, Train, Retain, WHO, August 2006

can deliver basic health-care packages effectively. Meeting this target would require a five-fold increase in donor spending on health and does not include free access to ART for everyone in clinical need[7]. Aid is about 2-7 times more volatile than revenue from domestic sources[8] and thus the uncertainty of aid commitments undermines long-term planning. It also presents serious clinical and ethical problems in relation to financing scale up of HIV & AIDS services such as ART, which once initiated must be guaranteed over the course of a patient's lifetime.

Most low-income countries with severe HIV & AIDS crises are already dependent upon foreign aid from donor governments. To better absorb and effectively utilize aid, countries will need to: recruit, train and retain more health workers across the entire health system[9] ; build more health facilities, including hospitals and clinics; improve transport infrastructure and enhance drug supply chains. International commitment to making medicines available at the lowest cost instead of aid subsidising high cost drugs will ensure financing is efficient and cost-effective.

At the heart of this, however, is a serious contradiction. In order to keep access to foreign aid, countries must adhere to fiscal policy set by the International Monetary Fund. This sets strict limits on public spending in order to keep inflation low and meet deficit reduction targets. Whilst macroeconomic stability is important and runaway inflation is damaging, it is impossible for countries to vastly increase public spending on HIV & AIDS unless these restrictions are changed[10]. A better balance is needed between meeting these macro-economic goals and the economic and social costs of inadequate spending on HIV & AIDS.

Current proposals envisage that the World Bank takes on leadership and co-ordination of health systems financing and policy advice at a global level. The Bank, however, will often only lend or grant large sums of money to fight HIV & AIDS if borrowing countries first agree to adhere to IMF loan conditionalities, including those that keep inflation low and prevent higher levels of public spending.

The Bank also has a long history of promoting structural adjustment, user fees, and a decreased role of the state in service provision. None of these policies address the needs of poor women, men, and children. While it is commendable that the Bank is placing new emphasis on health system strengthening and on protecting poor people, its political weight and influence at country-level means it must address the needs of the most vulnerable through policies that have been shown to work.

The state should be the main service provider as well as have responsibility for regulating services provided by others and it needs significant funding to do this. WHO has the comparative advantage to provide technical support for health system strengthening in developing countries but is currently under-funded in this key role.

1.2 Abolishing User Fees

Basic health services should be free at the point of delivery, especially given evidence that shows that substantial numbers of people are poor or in debt because of costs related to health care[11]. User fees severely restrict the utilization of health services, particularly by women who are less likely to have access to resources. HIV is a chronic condition requiring life-long treatment regimes, with associated costs, including prescriptions, clinical tests and monitoring. These are a continuous drain on household resources and have greater implications for poor people and especially for women. In addition, charges for intake and admission at health facilities mean that more care

[7] Working Together for Health, The World Health report, WHO, 2006

[8] The Role of Donors in Creating Aid Volatility and How to Reduce It, Save the Children, UK August 2006

[9] This includes doctors, nurses and midwives, and the health assistants and technicians who support them; those who manage the delivery of the service, such as managers, planners, accountants and administrators; as well as community health workers.

[10] Blocking Progress: How the Fight against HIV/AIDS is Being Undermined by the World Bank and International Monetary Fund, ActionAid International USA et al, 2004

[11] Liu et al 2003; Meesen et al 2003

takes place at home, with the burden inevitably falling on women and girls.

The UK supports the abolition of users fees which tends to have very positive effects on the uptake of services, especially amongst the poor, and therefore is a way to build equity within the health system[12]. The impact of abolition of fees on national resources for health needs to be considered by all donors who seek to support the expansion and consolidation of health systems.

1.3 Enhancing the contribution of the Global Fund to health systems

The relative merits of disease-specific financing and whether or not they enhance or detract from national health system development have been debated for many years. Comprehensive planning and a focus on integration can leverage considerable benefits from initiatives such as the Global Fund to Fight AIDS, TB and Malaria to the wider health system and enhance services beyond their main remit.

The Global Fund is regarded as one of the best models of transparency, flexibility and consultation and, in most cases, is efficient and effective in mobilizing and managing significant new resources for HIV & AIDS services. It has played an instrumental role in scaling-up access to ART, by providing an important route for donors without bilateral aid programmes to contribute resources and by catalyzing national commitment to access. Global Fund recipient countries, unlike those of the World Bank, have the power to shape their programming ensuring that funding is responsive to country-led agendas and helps fulfil national plans. Civil society has a role in management alongside national governments, donors and the private sector. The Global Fund is, therefore, a model of the kind of country-level leadership recommended by development aid strategists and others focused on enhancing good governance.

Country-level actors have worked to use funding from the Global Fund very effectively, both to address the three diseases and to integrate programming which has benefited the wider health system. For example, in Mozambique, the Global Fund has aligned its money with the SWAp and in Ethiopia has put its resources into improving the existing drug procurement and distribution system. A variety of countries have seen how Global Fund money spent on ART improves the health of people living with HIV & AIDS, thus freeing up hospital beds and staff, and PPTCT programmes funded by the Global Fund clearly alleviate strain on child health services.

During the creation of the Global Fund there was a focus on the capacity of low-income countries, to spend substantial new resources for health effectively. Independent analysis of grant use in 86 countries has found that, counter to prevailing notions, low-income countries are those most likely to rapidly use grants from the Global Fund[13]. Governments need to increase public health spending in order to be able to realise absorptive capacity, but as previously stressed they cannot do so under current IMF demands to restrict public spending in favour of inflation and deficit reduction.[14]

The Global Fund's Second Partnership Forum recommended that the Board seek a strong, clearly-articulated mandate to invest in a broad range of health system strengthening interventions. These proposals include: establish longer funding cycles for health systems strengthening; prioritise funding for integrated primary health care delivery within Universal Access goals, integrate sexual reproductive health and basic primary health care in funded programmes; and use its influence to bring about the necessary changes in IMF fiscal policies.

Ultimately, all global health partnerships should be aligned with health sector

[12] According to a Save the Children report, when Uganda made all public health services free of charge in 2001 this triggered substantial reforms to the health system, increased public spending on health and resulted in outpatient attendance rising by 117% and the uptake of immunisation services doubled. Killer Bills, Save the Children UK 2005

[13] Lancet, August 2006

[14] ActionAid International USA et al, 2004

financing, including SWAps, in the spirit of the Paris Declaration on Aid Effectiveness. This may mean that funding could be channelled through SWAps, or other nationally-led architecture. Donors should consider providing extra resources for capacity-building for ministries to compensate them for the management of disease-specific programme funding.

It is obvious that an urgent response to HIV & AIDS requires both an increase of domestic resources and substantial external assistance. We believe that the Global Fund can contribute to strengthening health systems and is an essential mechanism to meet the 2010 Universal Access target.

The UK should:

- Lead on delivering funding support for 10 year national health plans in PSA countries
- Champion sustainable funding for evidence-based costed plans for scale up towards Universal Access.
- Increase bilateral budget support to the health sector, particularly through SWAps, in order to resource health system strengthening.
- Implement its publicly-stated opposition to user fees for basic health services and support developing country governments to ensure that the health system is buffered to deal with the abolition of user fees.
- Leverage its position on the IMF board to ensure that macro-fiscal policy allows greater flexibility for countries to undertake expanded investment in the public sector.
- Continue to fulfil a long-term commitment to fund the Global Fund in a sustained manner which incrementally increases in order to allow Fund to grow to optimum operational size.
- Provide £150m to the Global Fund in 2007, increasing to £375m by 2010.
- Support the Global Fund to be able to enhance its role in integration of services to bring wider benefit to health systems.

The UK should continue to show leadership among donors to ensure:

- G8 members and other European donors honour their commitments on Universal Access.
- The WHO is resourced to provide the technical capacity-building needed on health system strengthening

2. The Health Worker Shortage

The magnitude of the health worker shortage in the world's poorest countries cannot be overstated and requires an urgent, sustained and coordinated response from the international community. Donors must facilitate the immediate and longer-term financing of human resources as an investment in public health systems[15].

Inadequate numbers of health workers are a major constraint to the rapid scaling-up of health systems required to effectively meet the challenges of HIV & AIDS. The critical shortage of health workers in regions of the world worst affected by HIV & AIDS has undermined possibilities of scaling-up to ensure comprehensive HIV & AIDS services and has placed additional pressures on already undersized and over-burdened workforces providing all health services.

WHO estimates that there are currently 57 countries with critical shortages equivalent to a global deficit of 4.25 million health workers[16]. The proportional shortfalls are greatest in sub-Saharan Africa, although deficits are very large in South-East Asia because of its population size. There is an urgent need to train more health workers in developing countries which takes time and resources, but is often exacerbated by the lack of sufficient training facilities and health educators in developing countries. For example, WHO's African Region needs a 139% increase in its overall number of

[15] Treat, Train, Retain, WHO, August 2006
[16] Working Together for Health, The World Health Report, 2006

health professionals but currently has only 354 institutions for training them[17]. Expanding labour markets have intensified professional concentration in urban areas as well as accelerated migration within regions and from developing to developed countries. There is, therefore, an urgent need for long-term training plans, alongside provision of condensed shorter courses of training to other cadres of health workers.

In the absence of professional staff and services Community Health Workers (CHWs), especially women workers, are providing front-line health care, particularly home-based care. CHWs represent a significant human resource for health which are seriously undervalued and poorly remunerated. They are not integrated into public health systems and therefore do not have access to proper training, support, or management. Countries need to develop combined short and long-term human resource strategies to improve conditions for current workers, improve and expand training; implement a code to reduce recruitment by the private sector in developed countries, and integrate community workers into the public health system.

2.1 Improving the conditions for health workers to enhance recruitment and retention

There is an exodus of skilled health workers in the face of enormous demand for public health services. Surveys of the reasons that health workers leave public sector jobs to migrate or to work in the private sector show that there are a number of factors which *push* developing country health workers from their jobs, and others which *pull* those workers towards work in urban centres, other sectors or developed countries.

The factors include low pay, poor occupational health and safety, lack of training and prospects of career advancement, poorly supplied medical facilities, too few staff, and poor management and overall health system governance. Despite an extraordinary commitment to providing public health care, many health workers are so undervalued, vulnerable and unable to cover the costs of living that they seek work elsewhere.

Numerous attempts have been made by developed countries to limit recruitment of health professionals from developing countries by the introduction of codes of practice[18]. The UK's Code of Practice even specifies countries that should not be targeted for international recruitment under any circumstances. However, these mandates largely apply to public sector providers and are not mandatory for private sector recruitment agencies, and it is worth noting that not all migrants who leave healthcare jobs in developing countries are employed as health workers in their destination country[19]. What is most important is placing emphasis on increasing the incentives for women and men to work where the need is greatest.

The health worker shortage is particularly complex in countries most affected by HIV. One of the major push factors, according to the WHO, is health workers' perception of risk of HIV infection in the workplace due to the absence of minimum standards of occupational health and safety. This is further compounded by the huge burden of working in a health system serving the needs of communities that are seriously affected by HIV & AIDS and experience high mortality rates. A survey of health workers' reasons to migrate in four African countries (Cameroon, South Africa, Uganda and Zimbabwe) found that 6 out of the full list of 13 reasons were attributable to HIV & AIDS.[20]

As with the rest of the population, risk of HIV infection through, for instance, unsafe sex renders health workers themselves vulnerable to disease and death, and this places further constraints on what the health system can deliver. For example 17% of

[17] Ibid

[18] E.g. the Melbourne Manifesto, 2002, World Rural Health Conference, and the UK Department of Health's code of practice

[19] Department of Health Code of Practice for the international recruitment of healthcare professionals December 2004

[20] p9, Taking Stock, Health Worker Shortages and the Response to AIDS, WHO, 2006

Botswana's health workers died due to AIDS related complications between 1999 and 2005.[21] Alongside a comprehensive programme for recruiting, training and retaining health workers, health workers must be targeted for prevention and treatment programmes to ensure as many health workers as possible can continue to work in the health system and provide much needed care in communities severely affected by HIV & AIDS.

In order for countries to scale up their response to HIV & AIDS, ambitious workforce planning must be aligned with efforts towards broader health systems strengthening. Responses to these challenges have included DfID's health sector support in Malawi, which piloted increased financial and training incentives for some health workers. WHO's 'Treat, Train and Retain' (TTR) plan[22] has been introduced to strengthen human resources for health and to promote comprehensive national strategies across different disease programmes.

One of the advantages of the WHO approach has been the central involvement of health workers and their representatives from trade unions in designing strategies to strengthen the health system. This helps to ensure that plans will work when rolled out on the ground, and addresses the important issue of ensuring health workers are valued by the system they work to serve.

Donors must facilitate the immediate and longer-term financing of human resources as a health systems investment and ensure that low public sector expenditure is not the primary constraint to workforce expansion.

2.2 Enabling community effort to strengthen health systems

Public health planning centres on the management of clinics and hospitals, laboratories and health technologies but in resource-poor communities health care is often provided outside of the formal health system. In Sub-Saharan Africa a significant proportion of health care is provided by community based organisations, national and international non governmental organisations, faith- based organisations and private health providers such as traditional healers, shopkeepers and others[23]. A reconceptualisation of health and health care that recognises, resources and integrates this wider health care effort will be crucial to reaching the Universal Access commitment. It brings in extra capacity for health in community organisations, and has the reach that is vitally important for the delivery of HIV & AIDS services.

The highly-stigmatised nature of HIV & AIDS, alongside the highly stigmatised behaviours associated with AIDS in many countries – sex work, male to male sex and injection drug use – set up many barriers to health care for marginalised and vulnerable populations. Community- based organisations, often created by and for marginalised populations, are an essential link between vulnerable and highly affected populations and the formal health care system. Formal health care services are prominent sites of discrimination for people with HIV, sex workers, men who have sex with men and injecting drug users. To really reach out and access highly affected and highly vulnerable populations, community organisations act as important 'bridges' to services.

Community home-based care (CHBC) is now well-recognised as key factor in the response to HIV & AIDS[24]. However, the work of community health workers (CHWs) tends to be unrecognised, unpaid, and is often exploitative. Between 70 - 90% of care for the sick takes place within the home and is mostly delivered by women and girls[25]. Due to the loss of working-age adults from AIDS-related deaths, older women, who are vulnerable to poverty and illness,

[21] p107, World Health Report 2006, WHO
[22] See Taking Stock, WHO, 2006

[23] Omaswa F, 'Informal health workers – to be encouraged or condemned? *Bulletin of the World Health Organisation,* February 2006:84:83
[24] CHBC is defined as any form of care given to sick people within their homes and it includes physical, psycho-social, palliative and spiritual interventions.
[25] WHO (2002) Community home-based care in resource-limited settings: a framework for action. Geneva: WHO

are playing a major role in community home-based care[26].

Building on existing CHBC initiatives in a way that supports carers rather than burdens them further is vital. Very few programmes exist to build the capacity of individuals, often poor women and community organisations, to take on expanded roles in the provision of health care. Despite low levels of available resources, a wide range of health services for the management of HIV & AIDS is undertaken by communities including:

- HIV testing and counselling
- Treatment preparedness, adherence support & counselling
- HIV prevention education – including positive prevention for people living with HIV
- Referral to health, social and other support services
- Sexual health and reproductive health services for people living with HIV
- Procurement and distribution of ARV and other medicines
- Clinical services
- Palliative and home based care
- Combating stigma and discrimination
- Planning, evaluation and quality assurance
- Nutrition programmes and food baskets
- Micro-finance and employment programmes

Critical to the sustainability of these services is the ability to link them with public health services. Ideally CHWs should be able to refer people to public health systems, including medical and social services and child protection services. Any integration must involve full consultation both with CHWs and health workers in the public health system to ensure that all health workers are consistently trained, managed, compensated and supported.[27]

[26] Mackintosh M, Tibandebage (2006). Gender and health sector reform: analytical perspectives on African experience. In Razavi S, Hassim S, *Gender and Social Policy in a Global Context: Uncovering the Gendered Structure of 'the Social'*. Basingstoke, UN: Palgrave Macmillan

[27] Reducing The Burden Of HIV & AIDS Care On Women And Girls, VSO Policy Brief 2006

We must address the stark reality that there are simply not enough health workers to deliver Universal Access by 2010. National government and international donors need to invest in **long-term** planning for human resources for healthcare as part of their efforts to strengthen health systems in developing countries, in particular those experiencing an HIV & AIDS crisis. In the **short-term** the contribution which can be made by CHWs must be enhanced.

The UK should continue to play a leading role in supporting health workers by:

- Working with developing country governments and civil society organisations to address the fundamental reasons for health worker migration.
- Fully supporting the WHO strategy to *Treat, Train and Retain* health workers.
- Investing in short term plans for increased salaries and improved working conditions for health workers, including 'volunteer' community caregivers, building on the results of the DfID Malawi pilot.
- Promoting full consultation with CHWs and health workers in public health systems to ensure that all health workers are consistently trained, managed, compensated and supported.
- Funding technical and financial support for civil society to play an expanded and expert role in the planning and delivery of HIV & AIDS services at a country-level, through direct funding and through budget support to governments.
- Directly investing in health training institutions in countries with widespread shortages of health workers.
- Reviewing the effectiveness of the DOH Recruitment Code of Practice in the light of the new impetus for HSS, and ensuring policy coherence across Whitehall.

Conclusion

Strengthening health systems demands a systemic approach to the interlinked issues of sustainable and predictable financing, long-term planning to address the factors pushing health workers away from employment in the health sector, and a focus on integration and support of community health providers. Policy approaches that undermine the ability of countries to set public spending at the level needed to provide health care for the poor and vulnerable, still tend to dominate the fiscal policy landscape. User fees impoverish the poor further. IMF loan conditions influence levels of investment in the public sector, and restrict efforts to build properly-resourced integrated systems which can bring the best of private, community and public provision together to address the HIV & AIDS crisis. Community health resources in the form of organisations, community health workers, and home-based carers, shoulder much of the burden of caring for those living with HIV, yet get very little of the necessary support, training and financing.

International donors need to establish an enabling and innovative financing environment to ensure that national governments can deliver on their promises. National Health systems will see rapid benefit from efficient use of available resources, cheap generic drugs, a concerted push on treating, training and retaining health workers, and a proper recognition of the multitude of community-based health care resources currently carrying the weight of the epidemic.