

Health Systems Exist for Real People

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Action always leads to reaction, a fundamental law of nature. The recent unprecedented investment in combating the HIV/AIDS pandemic has led to marvel at the effects of antiretroviral therapy, to constructive questioning about impact on health systems and, at one extreme, to frank hostility.^{1,2} Central to the debate has been the question of whether the disease-specific efforts of initiatives such as the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria have strengthened or undermined national health systems in low- and middle-income countries.³ Regrettably, discussions have sometimes become polarized and antagonistic, drawing attention from the specifics of the enormous tasks at hand in global health. This supplement of the *Journal* examines the impact of HIV scale-up on health systems in a diverse array of countries and contexts, building on discussions that took place at a meeting at the Rockefeller Foundation Bellagio Center in September 2008 that focused on these issues.

These discussions are rooted in documents now decades old: the 1978 Declaration of Alma-Ata⁴ and the 1993 World Development Report entitled "Investing in Health."⁵ These important documents illustrate that discussions about health systems have been ongoing at the highest levels for some time but that bringing the necessary financing to bear lagged far behind. In 2001, the Commission on Macroeconomics and Health published its conclusion that better health for the world's poor is not only a right but an important priority for development and poverty reduction.⁶ Influential academics had been speaking out since the 1990s on sub-Saharan Africa's disproportionate burden of infectious and poverty-related diseases, and more specifically on the dominant impact of malaria, tuberculosis, and HIV.⁷

The stage was set for major donor initiatives, their nature and political origins unpredictable and themselves worthy of historical analysis. These global health initiatives reflected the interplay of multilateral and national politics, and involved the faith-based sector, perhaps for the first time. Investment in countries of the south by the Global Fund and PEPFAR began to be felt in 2003, the year that WHO launched its 3 × 5 initiative, which provided normative and policy guidance for scale-up of HIV/AIDS prevention, treatment, and care in low- and middle-income countries.

Ironically, it was the evaluation of the 3 × 5 initiative that first warned that health system constraints, especially the shortage of human resources, was a rate-limiting step to scale-up toward universal access to essential HIV/AIDS services.⁸ Two other themes fueled the emerging debate about prioritization of disease-specific initiatives versus the strengthening of health systems: the growing recognition that other major health challenges, including enhancing maternal and child health, access to safe water and sanitation, and addressing non-communicable diseases, were under-resourced (and, by inference, that HIV/AIDS received "too much" funding); and skepticism around epidemiologic estimates of the severity of the HIV/AIDS pandemic.⁹

Against this background, a variety of studies and programs have recently examined the question of whether health systems have been strengthened or weakened by disease-specific initiatives, and significant review articles have been published this year.^{10,11} That these discussions are not just academic is illustrated by their implications for programmatic funding. The Obama administration is committed to spending US\$63 billion over 6 years

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for global health, 70% devoted to HIV/AIDS, tuberculosis, and malaria. This represents a welcome overall increase but an actual reduction for the 3 major diseases.

Perhaps there has never been a greater need for global health leadership, clarity of thought, pragmatism, and sound understanding of disease epidemiology. The Bellagio discussions aimed to inject practicality into a debate that remains unrealistically academic and sometimes devoid of specificity. Health systems exist to provide services for real people to prevent and treat diseases that have names.¹² Many countries' experiences may not be generalizable, and the key issue is how to leverage specific investments to ensure maximum benefit for all health outcomes.

Inadequate attention has been paid to the components of health systems—the generality of the discussion reminiscent of global HIV/AIDS discourse in the era before scale-up of HIV treatment that was so remote from the lives of people living with HIV. Perhaps most seriously, the debate fails to take account of the lives saved through PEPFAR and the Global Fund, and the implications for countries and systems if those advances are not sustained or extended. We cannot forget that it was the unparalleled impact of untreated HIV/AIDS in Africa that launched these major initiatives and that the prevention of death remains a core public health function. At the same time, criticisms such as that HIV/AIDS programs steal health care workers or are sometimes ivory tower initiatives amidst a sea of misery need to be examined seriously.

There is strength in diversity and debate, yet there is also danger of fragmentation. Instead of harnessing the great global health topics of the day—health systems strengthening, disease-specific interventions, and the Millennium Development Goals—into a unified vision, we have allowed the appearance of competition among these issues, and perhaps this represents the greatest failure of leadership. Global health

needs global financing, and there is enough money in the world to assure it. It is imperative that we ask the right questions and focus on the right objectives.

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