

International Aid and Access to Health Products

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Inequity of different kinds persists across the globe and there is evidence that it has actually increased in recent years as a consequence of neoliberal policies that inform large parts of the global political and economic architecture. In such a context it is natural to view international flow of aid to resource-poor countries as a means towards correcting existing inequity. However international aid is not value neutral, and while it has the potential to correct the present global imbalance of power and resources; it can also worsen such imbalances and compromise the sovereignty of nations and their ability to promote policies and programmes that are necessary in specific contexts. There has thus been considerable debate on how international aid actually functions, its impact in different contexts, and the role of different agencies in promoting such aid. In this brief paper we look at some of these debates, with special reference to the role of international aid in promoting access to essential health products, including medicines.

Broken Promises Regarding Scaling Up of International Aid

Though international aid forms an integral component of several discussions on policy environments at the global level, it is surprising how relatively small the actual quantum of such flows really is. Global flows of overseas assistance is often just enough or less than what poor countries need to pay back to developed countries to service existing debts. It is important to remember that these debts were incurred, largely, because multilateral agencies such as the World Bank and the International Monetary Fund IMF advised poor developing countries to access loans at high interest rates from capitalist banks in the developed countries. Worldwide, the amount of money returned to high-income countries dwarfs the amount received in development assistance: donor countries receive back many times over in debt repayments what they give in aid (People's Health Movement et al., 2006). Journalist Ken Wiwa, son of Ken Saro-Wiwa, the activist hanged for opposing Shell Oil's destruction of Nigerian homelands, noted: '*You'd need the mathematical dexterity of a forensic accountant to explain why Nigeria borrowed \$5 billion, paid back \$16 billion, and still owes \$32 billion*' (Wiwa, 2004).

Recently, in the aftermath of the devastating earthquake in Haiti, the IMF rescinded an emergency loan of \$100 million to Haiti and re-offered it as a grant. What is, however, not debated adequately, is how did Haiti get into a situation where taking on another loan could put millions of lives in jeopardy. It estimates that by 1999, the country was paying \$38 million in debt service; while the health budget the same year was \$26 million. Between 1995 and 1996 in particular, Haiti paid 900 million gourdes (approx. 25 million US\$) in debt service. During the same period, only 120 million was invested in agriculture. Please note that half the population lives in rural areas. According to the Haitian Central Bank, in 2006

alone, total debt service paid was \$57 million, with 47% going to International American Development Bank (IADB), 30% to the World Bank, and 10% to the IMF.

Moreover, the inflow of international aid in many cases, is much less than the outflow from developing countries as a result of their trade deficit, largely with developed nations. As we see in the following table, of the three regions of developing the world, only in the case of Africa do we see that inflow of aid is higher than the outflow due to trade deficit.

Table: Flow of ODA and Trade Deficit, By Region (World Bank, 2005) (*Figures for (2003) in US \$ Billion*)

Region	Aid	Trade Deficit
Sub-Saharan Africa	24	9
Asia	6	19
Latin America & Caribbean	6	31

However, just prior to the onset of the global financial crisis, export revenues of many developing countries had risen and the burden of servicing external debt for the developing countries had fallen from almost 13 per cent of export earnings in 2000 to below 4 per cent in 2007. This has now been reversed as developing country exports and commodity prices have fallen starkly as a consequence of the crisis.

The quantum of international aid in the form of development assistance has been a cause for considerable debate, and repeated commitments have been made pledging 0.7% of rich-countries' [gross national product](#) (GNP) to [Official Development Assistance](#) (ODA). First pledged 40 years ago in a [1970 General Assembly Resolution](#), the 0.7 target has been affirmed in many international agreements over the years, including the [March 2002 International Conference on Financing for Development in Monterrey, Mexico](#) and at the World Summit on Sustainable Development held in Johannesburg later that year. However, most developed countries are nowhere near reaching the 0.7% target.

Table: Official Development Assistance (ODA) in 2005

(source: [OECD 2005](#)) (*) Indicates countries that have NOT set a timetable for 0.7%.

Country	Aid as % of GNI	Country	Aid as % of GNI
Australia (*)	0.25	Japan (*)	0.28
Austria	0.52	Luxembourg	0.87
Belgium	0.53	Netherlands	0.82
Canada (*)	0.34	New Zealand	0.27
Denmark	0.81	Norway	0.93
Finland	0.47	Portugal	0.21
France	0.47	Spain	0.29
Germany	0.35	Sweden	0.92

Greece	0.24	Switzerland (*)	0.44
Ireland	0.41	United Kingdom	0.48
Italy	0.29	United States (*)	0.22

However, there has been an increase in the absolute quantum of ODA since the 1980s. Total bilateral ODA commitments from OECD members have increased by more than 50% in real terms since 1980-1984, from an annual average of US\$ 70.5 billion in the period 1980-1984 to US\$ 108.7 billion in the period 2002-2006 (Piva & Dodd, 2009).

Donor Priorities Drive Aid Flows

While the meager allocation towards development assistance is a matter of concern, perhaps of even greater importance is the way such assistance is often linked with political and economic interests of the donor countries. Aid has often served the political, strategic or commercial interests of donor nations. Aid is often tied to the purchase of goods and services (in the form of technical cooperation) from donor countries, and similar criticisms are made of debt relief priorities (People's Health Movement et al, 2006). Aid is also accompanied by conditionalities — the 2003 US commitment to increase its annual aid spending to US\$ 15 billion by 2006, by way of its Millennium Challenge Account, made new funds conditional on 'sound economic policies that foster enterprise and entrepreneurship, including more open markets and sustainable budget policies' (UN, 2002) (in other words, greater market and investment opportunities for US-based firms).

Donor duplicity is evident in the case of philanthropic foundations as well. The Bill and Melinda Gates Foundation - arguably the largest donor in the health sector among all foundations - is a major funder of programmes related to HIV-AIDS control and treatment. Ironically the grants that the Gates foundation makes for health care are also funded through investments made in companies that restrict access to HIV-AIDS medicines. The Gates Foundation has huge investments in Pharmaceutical companies such as Abbott, who have been aggressively promoting Intellectual Property Rights and have been responsible for compromising access to HIV-AIDS medicines in resource- poor settings. In 2005 the Gates Foundation held \$169 million in Abbott stock, part of \$1.5 billion worth of stock in drug companies (Pillers et al., 2007).

Trends in Health ODA

Recent trends indicate that health ODA as a percent of total ODA has been rising — OECD/DAC members' total bilateral aid commitments for health in 1980-1984 averaged US\$ 2.8 billion per year (constant 2006 dollars), or 5.3% of all ODA. This figure remained virtually unchanged up to the end of the 1990s, increasing thereafter to an annual average of US\$ 6.4 billion in 2002-2006, equivalent to 7.8% of total ODA (Piva & Dodd, 2009).

However the recent trend of increasing allocations for health care is accompanied by several issues of concern. More often than not, donor or global concerns (rather than national priorities of donor nations) determine aid flows in health. Thus, the funding for Millennium Development Goal 6 (combat HIV/ AIDS, malaria and other diseases) accounts

for much of the recent increase in health ODA, while many other health priorities remain insufficiently funded. Funding for HIV/AIDS accounted for almost one third (32%) of total health ODA for the period 2002–2006.

At the country level, aid is highly fragmented, and often lacking in synergy and coherence between different donors. The multiplicity of instruments and channels of aid is a major challenge for the governance of health, especially in the poorest countries which are critically dependant on such aid to develop health systems and health policies (Kickbusch, 2000). In 2002–2006, global and regional multi-country initiatives accounted for 25% of all health ODA. Global and regional multi-country initiatives are important mechanisms for targeting funding at global health challenges. However, as the overarching operational and programming priorities of such initiatives are set at the regional or global level, they are often not fully aligned with national priorities. This can result in an uneven pattern of investment across the sector (Piva & Dodd, 2009).

While there is more money available for health, through ODA flows, such flows are too commonly channelized in pre-determined areas and leave little room for flexibility. General budget support, wherein donors channel their aid directly into the budget of a recipient country, is arguably one of the most efficient aid modalities: it avoids many of the costs and inefficiencies associated with projects; it is easier to align with the recipient's priorities; and it opens the way to a broader, strategic dialogue on economy-wide issues (Killick & Lawson, 2007). However, overall, general budget support commitments account for a small part of all ODA — in 2002–2006 they were equivalent to 6.4% of total ODA.

International Aid and Access to Medicines

Let us now turn to the specific context of how international aid impacts on access to medicines. Many essential medicines are inaccessible to the poor in developing countries for two main reasons. First, there are large gaps in the availability of medicines in both the public and private sectors; second, the prices of the medicines that are available are high in relation to their international reference prices (UN, 2009). Median prices of essential medicines in developing countries are on average, 2.5 times higher than international reference prices in the public sector, and 6.1 times higher in the private sector (UN, 2009). International aid seldom addresses the generic reasons for the twin maladies. Poor availability of essential medicines is a function of technological backwardness and capabilities in LDCs and poor developing countries. Yet, development assistance rarely attempts to remedy the situation through technology transfer mechanisms that could build manufacturing capabilities for basic medicines in developing countries.

Medicine prices are inordinately high in many poor countries because they are imported, and also because new medicines are protected by IPRs and the monopoly prices charged by pharmaceutical companies for patent-protected medicines are beyond the reach of most patients in these countries. Yet, the large donor countries and multilateral agencies such as the World Bank and the IMF are some of the strongest votaries of a strong IP system. Not just that, the same actors have been responsible for obstructing the use of health safeguards that are available in the TRIPS agreement, and which can be used to break

patents and allow manufacture of cheap generic medicines. A case in point is the immense pressure brought upon by the US Government on Thailand, after the latter issued compulsory licenses for the manufacture of HIV-AIDs medicines and a cardio vascular medicine in 2008.

As a consequence an inordinately large proportion of aid for disease control programmes in developing countries that are supported by development assistance, needs to be allocated for purchase of medicines - the prices of which could have been much lower if the assistance was channelized differently.

Drug Donations

Finally, we turn, to the vexing issue of drug donations. This is often the most visible form of assistance in the health sector, especially in disaster situations. Unfortunately, all drug donations do not necessarily improve access or assist countries in dealing with disaster situations. There are many different situations in which drugs are donated — in acute emergencies or as part of development aid in non-emergency situations. They may be corporate donations (direct or through private voluntary organizations), aid by governments, or donations aimed directly at single health facilities.

Some common, but unfortunately recurring problems with drug donations include the following (WHO, 1999)

- Donated drugs are often not relevant for the emergency situation, for the disease pattern or for the level of care that is available.
- Many donated drugs arrive unsorted and labelled in a language which is not easily understood, viz in an unfamiliar language and/or without an International Nonproprietary Name (INN) or generic name on the label.
- Double standards may be in play, where the donated drugs do not comply with standards in the donor country. They may be near-expiry or expired drugs, or free samples returned to pharmacies health professionals.
- The donor agency sometimes ignores local administrative procedures for receiving and distributing medical supplies. The distribution plan of the donor agencies may conflict with the wishes of national authorities.
- Donated drugs may have a high declared value, e.g. the market value in the donor country rather than the world market price. In such cases import taxes and overheads for storage and distribution may be unnecessarily high, and the (inflated) value of the donation may be deducted from the government drug budget.
- Drugs may be donated in the wrong quantities, and some stocks may have to be destroyed, thus adding to the burden at the receiving end.

Given the widespread nature of problems associated with inappropriate drug donations, it is imperative that all drug donations be scrutinised, using the benchmark set by the WHO's "Guidelines for Drug Donations".

References

Kickbusch I. (2000). The development of international health policies - accountability intact? *Social Science Med* 2, 51, 979-89.

Killick T, Lawson A. (2007) Budget support to Ghana: a risk worth taking? Overseas Development Institute: Briefing Paper 24, London.

People's Health Movement, Medact, Global Equity Gauge Alliance. (2006). *Global health watch 2005-2006*. London/New Yorks: Zed Books Ltd.

Pillers.C, Sanders.E, Dixon.R. Dark cloud over good works of Gates Foundation, *Los Angeles Times*, 7 January 2007.

Piva, P, Dodd.R. (2009) Where did all the aid go? An in-depth analysis of increased health aid flows over the past 10 years. *Bull World Health Organ*, 87, 930-939.

UN Secretary-General (2002). *Outcome of the International Conference on Financing for Development*. New York: United Nations. Available at www.un.org/esa/ffd/a57-344-ffd-outcome.pdf [accessed 1 February 2005].

UN. (2009). *Strengthening the Global Partnership for Development in a Time of Crisis, MDG Gap Task Force Report 2009*. New York: United Nations.

WB Group. (2005). *World Development Indicators*. Washington, DC: World Bank.

Wiwa, K. (2004). Money for nothing - and the debt is for free. *The Globe and Mail*, 22 May, A19.

WHO. (1999). *Guidelines for drug donations*. Geneva: WHO.