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WHO Asian Civil Society Conference on Macroeconomics and Health

COLOMBO, SRI LANKA, 27-28 APRIL 2004

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Production: Valerie Crowell
Writers: Maria Paalman, Myrtle Perera
Editorial Contributors: Silvia Ferazzi
Executive Secretary CMH Support Unit: Sergio Spinaci
Art and Design: Imagic Sàrl
World Health Organization
CMH Support Unit
20 Avenue Appia
CH-1211 Geneva 27
Switzerland
www.who.int/macrohealth

Acronyms and Abbreviations

AIDS	acquired immune deficiency syndrome
CBO	community-based organization
CHCC	catastrophic health care cost
CMH	Commission on Macroeconomics and Health
CSO	civil society organization
GDP	gross domestic product
GNP	gross national product
HIV	human immunodeficiency virus
KIT	Royal Tropical Institute
MDG	Millennium Development Goal
NGO	non-governmental organization
NHA	National Health Account
PRSP	Poverty Reduction Strategy Paper
PHC	primary health care
SAARC	South Asian Association for Regional Cooperation
WHA	World Health Assembly
WHO	World Health Organization

Introduction

Since the official launch of the report of the Commission on Macroeconomics and Health (CMH) in December 2001, WHO has undertaken to facilitate the implementation of its recommendations at the country level. Countries are supported as they analyse the health situation of the poor and produce a strategic framework for priority setting and a long-term Health Investment Plan for scaling up essential interventions that will benefit the poor, thereby improving their health as well as contributing to economic growth and poverty reduction. Apart from a clear focus on the poor, advocacy for more resources for health and assistance to countries in removing non-financial constraints to increasing health investments are also crucial components of the WHO Macroeconomics and Health approach.

It is critical to involve civil society organizations (CSOs) in adapting the findings and recommendations of the Commission, particularly at country level, because their work is central to poverty reduction and the promotion of equity. They can play an important role in the efforts to scale up resources for health and to invest them wisely through advocacy, lobbying, contribution to implementation and analysis. They are therefore important partners in Macroeconomics and Health activities.

On 27-28 April 2004, the World Health Organization (WHO) organized an Asian Civil Society Conference on Macroeconomics and Health in Colombo, Sri Lanka, with the support of the Royal Tropical Institute (KIT) in Amsterdam and the Marga Institute in Colombo. The overall objective of the Conference was to inform CSOs about the Macroeconomics and Health approach and to discuss the challenges and opportunities related to their potential contribution at country level to improving health outcomes for the poor through the Macroeconomics and Health processes in which their governments are engaged. The meeting was intended to contribute to a constructive dialogue between WHO and international and indigenous CSOs, as well as between them and the governments of the countries they work in, on the important issue of promoting better investment for the health of the poor.

Some 60 representatives of indigenous and international CSOs, operating in low and middle-income countries from the WHO South-East Asia and Western Pacific Regions, came together to discuss how CSOs could contribute to improving the health of the poor in their respective countries within the Macroeconomics and Health framework. The following countries were represented: Bangladesh, Cambodia, China, India, Indonesia, Lao People's Democratic Republic, Mongolia, Nepal, the Philippines, Sri Lanka, Thailand and Viet Nam. In order to facilitate dialogue with the governments of these countries, which are already involved in Macroeconomics and Health work, government officials also attended.

Process of the Conference

WHO offices in the 12 countries identified a number of CSOs to be invited for the Conference on the basis of agreed-upon criteria. The final composition of the participants in the Conference was a balance of organizations involved in advocacy and lobbying, in provision and financing of health services, and in research. The complete List of Participants is available as Annex 2. Invited CSOs received a brief overview of the Conference and the brochure Investing in Health: a Summary of the Findings of the Commission on Macroeconomics and Health. They were requested to fill out an NGO profile, prepared by the organizers, indicating their involvement in pro-poor health and other development sectors.

WHO commissioned the following two background papers for the Conference, which were also made available to participants:

1. Rajiv Misra. The CMH Process and Civil Society.
2. Nance Upham. Making Health Care Work for the Poor: a Preview of NGO Experience in Selected Countries.

The plenary presentations by both authors were based on these background papers and are summarised in this report.

During the two-day Conference, participants received further documentation, including the full CMH Report, a CD-Rom with all CMH working group papers and reports, the declaration of the 2nd Consultation on Macroeconomics and Health held in Geneva in October 2003, global and country updates on Macroeconomics and Health, the People's Charter for Health, the Mumbai Declaration of the People's Health Movement, a booklet on Government/NGO Partnership in Health Care in Sri Lanka, and the People's Health Movement Response to the Commission on Macroeconomics and Health.

The Conference programme is attached as Annex 1. On the first day of the Conference, participants were addressed by key note speakers in a plenary session. Brief summaries of the plenary presentations are given in this report.

All of these documents and presentations stimulated discussions in four thematic working groups, for which ample time was reserved. Participants could choose the working group of their preference but were urged to spread their country team over the different groups. All themes were related to the role of CSOs and the potential for partnership between CSOs and government in improving the health of the poor. Participants looked for common ground, discussed the challenges involved, and debated what and how CSOs could contribute to the Macroeconomics and Health work in general and in their respective countries.

The themes for the four working groups were:

1. **How can CSOs contribute to the policy debate and decision-making on poverty, economic development and health?**
2. **How can CSOs contribute to increasing access to essential health services for the rural and urban poor?**
3. **How can CSOs contribute to giving relief to households that experience catastrophic health costs?**
4. **How can CSOs contribute to analysis and strategic planning of Macroeconomics and Health issues through research?**

In order to facilitate discussion, three objectives were formulated for each group and some background thoughts, information, and questions for each group were prepared by the organizers. These were meant to provoke discussion and were not intended to be prescriptive or exhaustive. Each group was encouraged to come up with additional or different questions and issues.

Each group presented their findings and recommendations during the plenary session on the second day, and interesting discussions followed each presentation. Brief summaries of the discussions in the working groups are given in this report.

The outcomes of the plenary and working group sessions were summarized in a consensus statement that was put together during the two days of the Conference and discussed and agreed upon during the closing session. After the meeting, the WHO secretariat finalized the consensus statement on the basis of the discussions and further comments from the participants. The final version is attached at the end of this report.

The summaries of plenary presentations and working groups in this report and on the event website were produced by the organizers. Drafts were sent back to presenters and group chairpersons and rapporteurs for comments. All comments were included so as to make the summaries a true reflection of the Conference proceedings and recommendations.

All information about the Conference, including full background papers, NGO profiles, programme, participant list, presentations, and extensive summaries of plenary presentations and working group discussions, can be found on the Macroeconomics and Health event website (www.who.int/macrohealth/events/civil_society_asia/en/). References to the Conference can also be found in the MacroHealth Newsletter 9, also available on the Macroeconomics and Health website (www.who.int/macrohealth).

Overview of the Plenary Presentations

Inaugural address

The Minister of Health of Sri Lanka, Nimal Siripala de Silva, welcomed the participants on behalf of the Government of Sri Lanka, the host country. He emphasized the need for increased funding of the health sector, but also stressed that poverty reduction and sustainable development are essential for improving health. He went on to say that the efficient use of money in a cost-effective manner is equally important, maximizing benefits with minimum spending and cutting down waste and corruption. The Minister perceived a role for the civil society organizations, in their capacity as representatives of the community, in acting as a pressure group and in raising awareness that spending on health is, in fact, an investment. He also thought that CSOs could play a role in canvassing funds and in the policy debate on health sector reforms. Setting an example for other Asian countries, the Minister was able to announce that the Government of Sri Lanka had recently pledged to increase the current spending of around 1.5% of GNP on the health sector to 2.5 % within a year, an increase equivalent to what the CMH suggested.

Introduction

On behalf of WHO, Sergio Spinaci, the Executive Secretary of the Coordination of Macroeconomics and Health Support Unit, welcomed the participants and praised the invaluable involvement of CSOs in effectively addressing the problems that affect the poor, including assisting displaced populations and those living in underserved areas. Civil society, in his view, also greatly contributes to linking health and poverty reduction by putting critical issues, such as debt, human and gender rights, trade, and the environment, at the centre of national and global agendas. He stressed that equity in health and universal coverage of health services in low-income countries can be better addressed through closer links and partnerships between governments and CSOs and expressed his hope that discussions would push forward a common agenda for better access to health by the poor.

Overview of Macroeconomics and Health work

A review of the follow-up to the CMH work was given in three presentations by WHO representatives: Silvia Ferazzi's presentation focused on the global process, Bhupinder Singh Lamba presented on the activities in South-East Asia, and Anjana Bhushan presented on the situation in the Western Pacific. The presentations highlighted the need for the CMH Report to be adapted to the local contexts through a flexible, lessons learning-oriented approach and noted that the involvement of the civil society is key to that purpose.

At the global level, after the launch of the CMH report in December 2001, two global consultations for countries and development partners were held in Geneva. The first took place in June 2002, and the second in October 2003. As a result of these two meetings, while it was agreed that there is a need for

additional resources to achieve the CMH objectives, it became clear that the use of existing institutional mechanisms was preferred to the designing of new ones; the creation of ad hoc national commissions on Macroeconomics and Health should be promoted only when existing mechanisms that could fulfil the required functions were not in place or were ineffective.

Work with NGOs started with a briefing on the CMH report at the report's launch in December 2001 and with a discussion on its follow-up at the World Health Assembly (WHA) 2003. The NGOs considered the centrality of health as a human right, which links firmly to the Alma Ata principles, to be weak in the CMH Report. They recommended going beyond selective, vertical programmes, referring rather to a broad primary health care approach. A reduction in the dependency on external aid was preferred, in order to strengthen country responsibility and ownership. A wider circle outside the health sector itself, encompassing non-health sector determinants of health and focusing on synergies with other social sectors, was considered the most fruitful way forward. These comments have been taken into consideration in the approach to the country follow-up to the work of the CMH, and should be further strengthened through common action by WHO and CSOs.

In South-East Asia several high-level regional meetings on MH took place, resulting in a strong interest in most countries to pursue a Macroeconomics and Health process. Concrete country initiatives include the setting up of national Macroeconomics and Health mechanisms, stressing the importance of intersectoral cooperation and collaboration with CSOs, organization of advocacy meetings, preparations for production of Health Investment Plans and mobilization of additional domestic resources. Some countries have sought to reposition health in country Poverty Reduction Strategy Papers (PRSPs) and to link up with complementary initiatives such as the Millennium Development Goals (MDGs).

Some Western Pacific countries are adapting CMH findings through country-specific economic analysis to examine the linkages between health, poverty and macroeconomics, through costing of essential services and through analysis of cost-effectiveness of interventions. In health financing, efforts are focused on policies to reduce financial barriers to equitable access and use of basic health services, through the use of targeted subsidies or through social health insurance initiatives. WHO assistance to countries focuses on the development and use of National Health Accounts (NHAs) and capacity building in resource planning and management.

The CMH process and civil society

The former Health Secretary of the Government of India, Rajiv Misra, discussed the CMH report, the background to its constitution, the main findings and recommendations, follow-up activities and the role

he thought civil society could play in the implementation of the action agenda. He stated that follow-up of the CMH recommendations has been slow and uneven. No country has yet developed long-term plans, and external aid is still nowhere near the scale recommended by the CMH. Public interventions still tend to benefit the rich more than the poor. The neglect of the poor can lead to potentially destabilizing imbalances in development and cause social tensions and unrest. Investment in the health of the poor is not only good economics, but good politics as well.

Because civil society is the driving force of public opinion, CSOs can play an important role in advocating for improvement in the health of the poor. Civil society is well-placed to spearhead the effort to give health its due status and priority. CSOs also have an important role in service delivery for the poor, because they are in close contact with the community. Such activities can be expanded by developing public-private partnerships. Misra advised governments to be flexible in their arrangements with CSOs and not to stifle their initiative and freedom. CSOs were advised to overcome their differences of opinion, as they could be more effective if they come together and develop systems of self-regulation.

NGO contributions to health systems for the poor

The President of the Geneva Office of the People's Health Movement, Nance Upham, had a strong message for the Conference: health systems for the poor need not be and should not be poor health systems. While governments often do not manage to serve the poor, or provide low quality services, NGOs are on the record to deliver good primary health care to poor populations, adapted to the local realities of the communities they serve. However, she asserted that NGOs can only work within the framework of strong public health services. Upham also stressed that primary health care is best delivered as part of a broader socio-economic assistance package and backed up by a sustainable secondary and tertiary health system accessible to the poor. NGOs also have valuable experience in this respect, as many NGOs provide health care alongside education, micro-credit, agricultural and nutrition support, and insurance, for example. This kind of synergy between different aspects of a comprehensive development policy is needed to reduce poverty.

Upham also touched upon community health financing schemes, which have to be further developed to increasingly cover the very poor and suggested that we need more flexible, mobile and modern health systems. Rather than expecting people to travel to the health delivery point while they are sick, more attention should be paid to bringing the services to the people. Besides the more classic outreach services and mobile clinics, the possibilities telemedicine offers could bring sophisticated diagnosis to the remotest parts of the world.

The health transition and economic growth in Sri Lanka

Godfrey Gunatilleke, member of the National Commission for Macroeconomics and Health in Sri Lanka and Chairman Emeritus and Fellow of the Marga Institute in Colombo, described how at present Sri Lanka is managing the later stages of the health transition, characterized by the decline in the proportion of infectious diseases and the rise in non-communicable diseases, with a national health care system which by international norms is an unusually low-cost system. The total cost of health care has been maintained at around 3% of GDP over time.

At present, the public health care system in Sri Lanka provides nearly 75% of all outpatient and inpatient health care, while the private sector, mainly serving the needs of the higher income groups, provides about 6% of inpatient and about 19% of outpatient care. For this volume of goods and services the private sector spends approximately four times as much as the public sector. Household expenditure on health care accounts for no more than about 25% of total expenditure. Although poverty persists and child and maternal mortality still pose serious challenges, the health of the population has improved substantially. The example of Sri Lanka shows that it is possible to improve population health at an affordable price. It also shows that remaining ill health is clearly related to poverty and that there is an indivisible link between health, poverty reduction, productivity and economic growth.

According to Gunatilleke, the role of NGOs has changed. During the first phase of the health transition, community-based organizations (CBOs) made the delivery of health care more cost-effective. They were involved in health education and public awareness, humanitarian support and in matemal and child health. The contributions of NGOs in the second phase were characterized by a greater emphasis on research and advocacy on the public issues of health care in Sri Lanka, budgetary allocation for health, the national health care system and privatization.

Overview of the Working Groups

The core of the discussion on the involvement of CSOs in health and poverty reduction activities and in the Macroeconomics and Health processes took place in the working groups. These centred around the potential contribution of NGOs in four areas: the policy debate and decision making; access to essential health services for the rural and urban poor; relief to households that experience catastrophic health costs; and analysis and strategic planning of Macroeconomics and Health issues through research.

The main conclusions and recommendations with direct implications for the Macroeconomics and Health process are summarized below:

Working group 1 - The contribution of CSOs to the policy debate and decision-making on pro-poor strategies to provide and finance health services

Working group 1 discussed the comparative advantages and constraints that CSOs have as partners in the policy debate on pro-poor strategies, and focused on issues such as experience in working with communities, desire to develop innovative approaches, and inter-sectoral scope. Based on the assumption that governments have the main responsibility for the provision of quality primary health care services for all, including the poor, working group 1 agreed with the plenary speakers that CSOs have a complementary role, in particular in providing health services to the poor and the disadvantaged in remote or otherwise underserved areas. They highlighted that CSOs can effectively bring the voices of the poor to the policy table, both through formal and informal dialogue, at the local level but also at higher levels of government, provided they are well organized, have good networks and base their views on solid evidence. By piloting alternative health financing mechanisms, for instance, CSOs can add to the evidence base for policy making. Working group 1 also recognized the importance of involving donors in fostering and harmonizing partnerships between governments and CSOs.

Working group 1 recommended that:

- ***CSOs should advocate for governments to invest more in health, as this will improve economic growth and reduce poverty. CSOs should advocate for simultaneous investment in other sectors, such as education and employment, in order to render investment in health sustainable.***
- ***In order to be more effective counterparts at the policy table, CSOs should develop the evidence on which their policy viewpoints are based, build up their expertise and strategic alliances with other stakeholders, and unify their voice.***

- ***Governments should regularly involve CSOs in policy debates, as they can effectively help in addressing, inter alia, the limitations of sector-based ministerial structures. Good practice participatory mechanisms should be developed. Donors can also be instrumental in fostering and harmonizing partnerships between CSOs and governments, as has been the case with the Country Coordinating Mechanisms of the Global Fund for AIDS, Tuberculosis and Malaria.***

Working group 2 - The contribution of CSOs to increasing access to essential health services for the rural and urban poor

Working group 2 gave an opportunity to explore the relations between CSOs and governments in providing health services and interventions. It was felt that governments have the primary responsibility for quality public health services, including to the poor. However, CSOs can usefully enter in collaborative arrangements with governments to provide complementary, demand-based health services, particularly to the poor in rural and underserved areas, where fewer public health staff are available to work and where, therefore, public services are weak or non-existent. Among other issues, and with reference to the problem of financing CSO activities in provision of health, health-related and relief services, it was concluded that in addition to funding from government and international agencies or charities, sustainable results can be achieved through local income generation programmes, community funds, community health insurance, and links to micro-credit programmes.

Working group 2 recommended that:

- ***Governments should support CSOs in the provision of health services to the poor by creating a conducive environment and providing financial incentives, while ensuring CSOs operational flexibility and autonomy in implementation.***
- ***In order to make health service delivery for the poor locally sustainable, dependence on international agencies should be avoided; local financing of the costs should primarily take the form of income generation, community funds, community health insurance, and microcredit programmes.***
- ***To subsidise the health expenditures of the poor, governments should consider establishing special equity funds. In order to avoid unnecessary use of services and raise the value of the product, users of health services, however poor, would be requested to complement this support with contributions adequate to their means.***

Working group 3 - The contribution of CSOs to giving relief to households that experience catastrophic health care costs (CHCCs)

Working group 3 defined CHCCs and debated the main determinants of households falling into poverty due to high health care costs, categorizing them into health system-related, patient-related and environment-related determinants. The group further debated the role CSOs can play in prevention of CHCCs, as well as in provision of support once households experience CHCCs. Participants noted that efficient delivery of primary and secondary health care to the poor can prevent CHCCs. Besides direct service delivery to the poor, CSOs can encourage the development of risk pooling arrangements and other financing schemes to protect the poor from high health care costs. CSOs can also play an important role in accident prevention and disaster preparedness, as accidents and disasters are important causes of CHCCs. Households that have fallen into poverty can be assisted by reimbursement of their health care costs from private donations, or in case of disaster, by the provision of relief.

Working group 3 recommended that:

- ***Governments should consider setting up special funds, from which prolonged and expensive courses of treatment for the poor can be (co-)funded, and/or empower and assist communities to mobilize resources to this end themselves.***
- ***Government should develop risk pooling arrangements and financing schemes protecting the poorest. CSOs should collaborate by explaining terms and conditions of insurance and other risk pooling arrangements and assist members of poor families with generating more income.***
- ***CSOs should be involved in educating and informing poor communities about accident prevention and disaster preparedness.***
- ***Governments and CSOs should establish grievance address systems to ensure good governance and quality of services, since the best prevention of CHCCs is the timely delivery of quality health care.***

Working group 4 - CSOs can contribute to analysis and strategic planning of Macroeconomics and Health issues through research

Working group 4 agreed that health and economics research is crucial for policy, planning and programme formulation in the area of health and is a strong tool for monitoring the achievements of health goals. Community-based CSOs can identify issues and areas for research, gather data on attainment of the MDGs

at community level, and also be actively involved in operational, action and policy-related research. CSOs have a special responsibility in making research more pro-poor. It was felt that CSOs, when joining forces, have considerable research capacity which can contribute to health policy and strategic planning efforts, for example by identifying reasons for inadequate access to public health services and evaluating the impact of health sector reforms.

Working group 4 recommended that:

- ***National governments should increase investment in health research and encourage collaboration with CSOs.***
- ***CSOs should contribute to building a sound evidence base for policy making by making data collection and documentation of best practices part of their mainstream activities.***
- ***CSOs should establish an International CSO Forum for Research on Economics and Health. In addition, CSOs should link up more closely with the yearly meeting of the Global Forum for Health Research.***
- ***Health research in developing countries should move from being donor-driven to people-driven and contribute to building a country-based empirical evidence for convincing the governments, thus facilitating the advocacy and lobbying role of CSOs.***

Conclusions and Way Forward

While there is wide knowledge and consensus on the value of a primary health care approach, and the technical interventions, public health measures, system requirements, and cost for scaling up are known, the world's poor still lack access to essential health services. Towards addressing this situation, participants considered the findings of the CMH and the ongoing follow-up approaches in countries of the regions and debated the contribution that CSOs could make towards reaching the poor with essential services.

Over the years CSOs have gained very useful experience in health in relation to poverty reduction. The following three points are a clear justification for their official involvement in Macroeconomics and Health work:

- CSOs have supported national efforts in expanding the scale of primary health care, in particular by assisting displaced populations and those living in underserved or remote areas (often the poor).
- On a global level, CSOs greatly contributed to linking health and poverty reduction by putting critical issues, such as debt, human and gender rights, trade, and the environment, at the centre of national and global agendas.
- Many CSOs deal with health not as a separate issue, but as a part of a comprehensive package of services that also includes education, nutrition and micro-credit, for example. This holistic approach is better geared to contribute to poverty reduction than a single-sector approach.

In the unanimous consensus statement, participants committed themselves to participate in national Macroeconomics and Health processes and asked their governments to ensure full involvement of civil society and NGOs. More specifically, CSOs can make the following contributions:

- CSOs can play an important advocacy role by speaking on behalf of the poor, stressing that health care is a basic human right, promoting equity in health care, and lobbying politicians to really commit increased resources for health.
- CSOs can provide many examples of innovative ways to reach the poor with services, of multisectoral approaches, of providing quality services in difficult circumstances, and in providing relief to households. They can document these practices and extract lessons learned, in order to facilitate replication on a larger scale.
- CSOs can assist governments by experimenting with alternative health financing schemes, such as equity funds or community-based health insurance. Specifically, CSOs can look into building safety nets for the very poor, because user fees and insurance premiums, however low, have undesirable consequences for health care-seeking behaviour.

- CSOs can be instrumental in preventing catastrophic health care costs by advocating for a universal health insurance system, by delivery of health care themselves (both regular and emergency care), as well as by organizing disaster preparedness and relief programmes.
- CSOs are in a good position to identify problems, issues, and areas for Macroeconomics and Health-related research and can also conduct research themselves, in particular operational research and applied research.

Participants came up with several recommendations to their respective governments, as well as to their own constituencies, related to improving engagement and collaboration in areas key to health and poverty reduction, such as pro-poor policy development, provision and financing of services for the poor, preventing catastrophic health care costs, and planning and conducting pro-poor research.

Participants concluded that civil society plays a critical role towards strengthening political will by building awareness of the importance of health and of pro-poor health system reform in economic development and poverty reduction. Governments, for their part, should facilitate the participation of civil society in national Macroeconomics and Health mechanisms and involve them in the preparation of Health Investment Plans. CSOs working internationally should also lobby for increased and better donor assistance to developing countries, while urging the acceleration of debt relief and ensuring that a major share of resources so released are used for increased spending on the health of the poor.

The Conference was an important step towards promoting the participation of the civil society and NGOs in the country work on Macroeconomics and Health in Asia. The next challenging steps, emanating from the consensus and from the specific recommendations of the Working Groups, will be to keep high the interest and involvement of CSOs in the Macroeconomics and Health process, to increase collaboration at country level to advocate for increased pro-poor investments in health, and to promote with governments the regular participation of the civil society in the national mechanisms on Macroeconomics and Health. It is now up to the participating CSOs and governments to translate the above conclusions and recommendations into activities that can be implemented locally. WHO is willing to support this effort.

Among immediate follow-up activities, a dedicated Conference webpage has been set up on the WHO Macroeconomics and Health website. A wide circulation of the consensus document and this report will be ensured and a discussion space created for information sharing among CSOs on issues and activities going on in countries.

Colombo Consensus

Asian Civil Society Conference on Macroeconomics and Health

Colombo, Sri Lanka, 27-28 April 2004

Preamble

We, Asian Civil Society Organizations (CSOs)[1] gathered with government representatives in Colombo, Sri Lanka, on 27 and 28 April 2004 on the occasion of the Asian Civil Society Conference on Macroeconomics and Health, acknowledge with appreciation the opportunity and facilitation provided by the World Health Organization to participate and deliberate on issues concerning macroeconomics and health.

Recognizing that CSOs are major, critical and strategic stakeholders in the formulation, implementation and monitoring of macroeconomic policies related to health, and that they help ensure good governance and social accountability of governments by servicing and articulating citizens' demands,

Recognizing and emphasizing the right to health as a social, economic and political issue and a fundamental human right, and that macroeconomics has a critical role in ensuring this right,

We urge that appropriate, equitable and effective macroeconomic policies and increased investments be put in place to ensure the people's right to health,

We commit ourselves to fully participate in the national mechanisms on macroeconomics and health in order to meet the health needs of the poor. We shall share these recommendations with other civil society and non-for profit organizations, at all levels, and with our governments.

By consensus, the following are our conclusions and recommendations:

Theme I. How can CSOs contribute to the policy debate and decision making?

1. We recognize that political will is determined largely by public opinion and that the civil society plays a major role in creating awareness and highlighting the contribution of health in economic development and poverty reduction.
2. CSOs should advocate for increased and more equitable investments in health, reforms in the health systems and a better focus on the poor, vulnerable groups and women. In this context, the civil society should bring out the existing inadequacies and inequities of the health systems before

1. From Bangladesh, Cambodia, the People's Republic of China, India, Indonesia, the Lao People's Democratic Republic, Mongolia, Nepal, the Philippines, Sri Lanka, Thailand, Viet Nam. List of participating organizations is included in this report.

governments, donors, media and people at all levels, and thereby foster an environment for addressing critical deficiencies of the health systems.

3. Governments should facilitate and strengthen the participation of CSOs in the national macroeconomics and health mechanisms. CSOs should make a proactive effort to participate in the preparation of investment plans, in partnership with national health and health-related ministries and commissions, or equivalent macroeconomics and health mechanisms and planning commissions. They are key to contribute suggestions and inputs on appropriate and evidence-based policy changes and systems reforms to improve equity, efficiency, accountability and transparency of the health delivery systems, particularly for the poor, and to achieve the objective of comprehensive primary health care.
4. CSOs working in the international arena should lobby for increased donor assistance to low-income countries for health to promote balanced and sustainable development and human welfare. They should also create an enabling environment for a coordinated approach, harmonization of procedures and stability of financial commitments from the donor community in respect of the health sector development through public-civil society partnerships.
5. CSOs should strengthen their internal networks and urge donor countries to accelerate the process of debt relief and ensure that a major share of the resources so released are used for increasing outlays for the health of the poor.

Theme II. How can CSOs contribute to increasing access to essential health services for the rural and urban poor?

1. We recognize the need for a functioning national health policy in place, based on comprehensive primary health care, as a first priority, which entails the need for strong health systems. We also recognize that CSOs have knowledge of the deficiencies in the functioning of health delivery systems, and several of them have a demonstrated capacity in providing basic health services in remote areas.
2. CSOs, with financial support from public funds, should enter in active partnership with governments to undertake greater responsibilities in collaborating with them in providing health care and health services at the primary and secondary level, both in rural and urban areas, more efficiently and cost effectively. Besides, in remote and backward areas, where public health infrastructure is virtually non-functioning, governments should provide a liberal package of incentives to motivate and strengthen the capacity of CSOs to fill the gaps.
3. Governments should ensure that the CSOs are provided with the required level of operational flexibility and autonomy in the implementation of programme activities, in order for CSOs to fulfil their

commitments and achieve the performance indicators mutually agreed upon and to be able to make contributions towards appropriate remedies.

Theme III. How can CSOs contribute to giving relief to households that experience catastrophic health costs?

1. We recognize that the principal instrument for avoiding catastrophic health costs to the poor is to ensure the efficient delivery of public health care and services at the primary and secondary level. The CSOs can play an important role in monitoring the functioning of the public health care institutions in respect of the services to the poor. However, there would be contingencies where the patients and their family have to bear a major share of the burden, in the case of prolonged and expensive course of treatment.
2. CSO should advocate with governments for the provision of universal health insurance schemes and enter in partnership with governments to ensure the efficient delivery of public health and emergency medical services. CSOs can complement these services by running health services and health care programmes.
3. CSOs should monitor the functioning of health systems in respect of the quality of services for the poor and help establish a grievance system that ensure users' feedback and good governance.
4. CSO should contribute to prevent the occurrence of catastrophic expenses through collaboration with governments in health education, preventive campaigns, disaster preparedness and management.
5. Governments should set up special funds for the purpose of addressing households incurring catastrophic expenditures and empower communities to mobilize resources to make the services affordable to the poor, including mechanisms for reimbursement of treatment expenses from private donations, community health financing and micro-credit schemes.

Theme IV. How can CSOs contribute to analysis and strategic planning of macroeconomics and health issues through research?

1. We recognize that research is imperative for policy planning and programme formulation in the area of health, and a strong tool for advocacy and monitoring the achievement of country health goals by governments and other stakeholders. Several CSOs have participatory research capabilities to contribute to this effort. In the context of the work of the national commissions on macroeconomics and health, or equivalent mechanisms, CSOs can provide an important input to policy and strategic planning through research.
2. Governments should support CSOs' contribution to increase the health research capacity of low and middle-income countries.

3. CSOs should evaluate the impact of health sector reforms on access to health, and identify reasons for inadequate access to public health services.

4. CSOs should organize themselves and use at best mechanisms to contribute to setting international research agenda with a participatory and pro-poor approach, which promote transfer of knowledge and results, assistance to remote areas, pooling of human resources and capacities, grassroots feedback and influence on the process of resource mobilization for health.

Mindful of the challenge ahead and of the need for forceful action, we close this Conference, and look forward to continuing this dialogue and interaction on macroeconomics and health within our countries.

Annex 1
Conference Programme

WORLD HEALTH ORGANIZATION

Sustainable Development and Healthy Environments Cluster
in collaboration with the Royal Tropical Institute Amsterdam and Marga Institute Colombo

Asian Civil Society Conference on Macroeconomics and Health

27-28 April 2004 – Colombo, Sri Lanka

Day 1	**Chairpersons: Mr B.S. Lamba, WHO Regional Office for South-East Asia and Dr Soe Nyunt U, WHO Regional Office for the Western Pacific**
09.00 – 09.15	Welcome by Chairpersons on behalf of WHO Regional Directors
09.15 – 09.30	Inaugural address by Hon. Nimal Siripala de Silva, Minister of Health of Sri Lanka
09.30 – 09.45	Introduction by Dr Sergio Spinaci, WHO CMH Executive Secretary
09.45 – 10.15	The CMH Report, the Macroeconomics and Health process, and civil society Mr Rajiv Misra, Former Health Secretary, Government of India
10.15 – 11.00	Presentation of the Macroeconomics and Health approach: Overview on MH work globally and in the WHO South-East Asian and Western Pacific regions Dr Silvia Ferazzi, Headquarters, Dr B.S. Lamba, Regional Office for South- East Asia, Ms Anjana Bhushan, Regional Office for the Western Pacific
11.30 – 12.00	Review of NGO experiences in health and development in selected Asian countries Ms Garance Upham, President, People's Health Movement, Geneva International
12.30 – 12.30	Health Transition and Economic Growth in Sri Lanka Dr Godfrey Gunatilleke, Member of the National Commission for Macroeconomics and Health, Sri Lanka
12.30 – 13.00	Open stage for discussion and raising of issues/reactions from the floor

14.00 – 18.00	Four thematic working groups: *How can CSOs contribute to the policy debate and decision-making?* *How can CSOs contribute to increasing access to essential health services for the rural and urban poor?* *How can CSOs contribute to giving relief to households that experience catastrophic health costs?* *How can CSOs contribute to analysis and strategic planning of macroeconomic and health issues through research?*

Day 2	**Chairpersons: Mr B.S. Lamba, WHO Regional Office for South-East Asia and Dr Soe Nyunt U, WHO Regional Office for the Western Pacific**
09.00 – 13.00	Working groups, including preparation of recommendations
14.00 – 15.00	Presentation of group work
15.30 – 17.00	Plenary discussion and consensus on recommendations
17.00	Closure

Annex 2
List of Participants

WORLD HEALTH ORGANIZATION

Sustainable Development and Healthy Environments Cluster
in collaboration with the Royal Tropical Institute Amsterdam and Marga Institute Colombo

Asian Civil Society Conference on Macroeconomics and Health

27-28 April 2004 – Colombo, Sri Lanka

COUNTRY	ORGANIZATION	NAME & DESIGNATION OF PARTICIPANT
BANGLADESH	BRAC	Mr Faruque Ahmed Director, Health and Nutrition
	Center for Policy Dialogue	Ms Fatema Yousuf Head of the Dialogue Division
	Gonoshasthya Kendra	Dr Abul Qasem Chowdhury Vice Chancellor GonoBiswabidyalay
	Grameen Bank Head Office	Mr Zamal Uddin Biswas Deputy General Manager
	Save the Children-UK	Dr Selina Amin Programme Manager, Health and Nutrition Programme
	Ministry of Health and Family Welfare	Mr Md. Jahangir Joint Chief, Health Economics Unit
CAMBODIA	Cambodia Association for Assistance to Families and Widows (CAAFW)	Mr Iyong Suor Director
	Cambodia Family Development Service (CFDS)	Mrs Samnan Lov
	HealthNet International	Dr Fred Griffiths Programme Manager

COUNTRY	ORGANIZATION	NAME & DESIGNATION OF PARTICIPANT
	MEDICAM	Dr Sin Somony Executive Director
	Reproductive and Child Health Alliance (RACHA)	Ms Sun Nasy Deputy Director
	Ministry of Health	Dr Lo Veasna Kiry Deputy-Director, Planning and Health Information Department
PEOPLE'S REPUBLIC OF CHINA	China Primary Health Care Foundation	Dr Yan Xiao Zheng Secretary-General
	Health Technology Assessment & Research Center, Fudan University, School of Public Health	Dr Jie Chen Professor and Director
	Think Tank Research Center for Health Development	Prof. Wang Ke-An Director
	Ministry of Health	Ms Zhu Peihui Department of Planning and Finance
INDIA	Gujarat Institute of Development Research	Dr Leela Visara Director and Professor
	Janani	Mr Krishnamurty Gopalakrishnan Programme Director
	Karuna Trust	Dr H. Sudarshan President
	Sanket Development Group	Ms Maheen Mirza Programme Co-ordinator (Projects)
	SEARCH (Society for Education, Action and Research in Community Health)	Dr Pradeep Prabhakar Paranjpe
	National Commission on Macroeconomics and Health	Ms K. Sujatha Rao Secretary-designate

COUNTRY	ORGANIZATION	NAME & DESIGNATION OF PARTICIPANT
INDONESIA	Indonesian Heart Foundation	Dr Sutedjo Coordinator, Research and Data Center
	Yayasan Lembaga Konsumen Indonesia	Ms Sinthia Prideaka Soekarto Staff Member, Research Department
	Ministry of Health	Mr Teguh Budi Santosa Staff Member, Bureau of Planning and Budgeting
LAO PEOPLE'S DEMOCRATIC REPUBLIC	Central Lao Women's Union	Ms Kaysamy Latvilayvong Deputy Head of Planning Division, Development Department
	Macfarlane Burnet Institute for Medical Research and Public Health	Dr Niramonh Chanlivong Country Programme Manager
	Swiss Red Cross	Dr Vannaly Boupha
	Ministry of Health	Dr Bouaphat Phonvisay Ag Director of Health Insurance Division, Planning and Budgeting Department
MONGOLIA	Mongolian Anti-Tuberculosis Association	Dr Naranbat Nymadawa Chair of Executive Board
	Mongolian Association of Family Doctors	Dr Bunijav Orgil President
	Mongolian Public Health Association	Dr Yondon Dungu President
	Mongolian Red Cross Society	Dr Zambalgarav Jadamba Under Secretary General

COUNTRY	ORGANIZATION	NAME & DESIGNATION OF PARTICIPANT
	Mongol Vision	Dr L. Tumurbaatar Executive Director
	Ministry of Health	Mr D. Chimeddagva Director for Strategic Planning
NEPAL	Family Planning Association of Nepal	Mr Hari Khanal Ag. Director General
	Nepal Health Economics Association	Dr Badri Raj Pande President
	Nepal Red Cross	Dr Vijay Kumar Singh Member Central Executive Committee
	New ERA	Dr Bal Gopal Baidya Senior Research Associate
	United Mission Nepal (UMN)	Dr Maureen Dariang Women and Children Health Technical Advisory Team
	Ministry of Health	Dr Mahabir Krishna Malla Chief Specialist, Policy, Planning & International Cooperation Division
	Ministry of Health	Dr Rita Thapa Senior Health Policy Adviser
PHILIPPINES	Gerry Roxas Foundation	Mr Henry Pantaleon Vicente Aguirre Lopez Manager, GRF Center for Local Governance
	Health Alternatives for Total Human Development Institute	Dr Maria Eufemia C. Yap Member, Board of Directors
	Maharlika Charity Foundation	Dr Michelle Marie Aportadera Plastic Surgeon

COUNTRY	ORGANIZATION	NAME & DESIGNATION OF PARTICIPANT
	Philippine Rural Reconstruction Movement	Dr Glenn V. Paraso Social Development Specialist, Health & Family Planning
	Department of Health	Dr Liezl Lagrada Medical Officer VII, Health Policy Development and Planning Bureau
SRI LANKA	Asian Community Health Action Network	Mr Niranjan Udumalagala
	Community Development Services	Ms Nilani Wijeysinghe
	Family Planning Association	Mr P.J. Karunaratne Deputy Director, Youth Reproductive Health
	Health Action International-Asia Pacific	Dr K.Balasubramaniam Advisor and Co-ordinator
	Helpage Sri Lanka	Mr N.W.E. Wijewantha Executive Director
	Management Sciences for Health (MSH)	Mr Vimal Dias
	Marga Institute (co-organizer)	Dr Godfrey Gunatilleke, Member, National Commission on Macroeconomics and Health
	Marga Institute (co-organizer)	Mrs Myrtle Perera Senior Research Fellow
	Marga Institute (co-organizer)	Ms Dineshini Jayawardana
	Sarvodaya Shramadana Movement	Dr Vinya S. Ariyaratne Executive Director

COUNTRY	ORGANIZATION	NAME & DESIGNATION OF PARTICIPANT
	Ministry of Health, Nutrition and Welfare	Dr S. M. Samarage Director, Organization Development Management Development and Planning Unit
THAILAND	Anti-Tuberculosis Association of Thailand	Dr Nadda Sriyabhaya Executive President
	Thai Health Promotion Foundation	Dr Viroj Na-ranong
	Thai Health Promotion Foundation	Dr Chartri Charoensiri
	Ministry of Public Health	Dr Orasa Kovindha Chief, Macrohealth Policy Section, Health Policy Group, Bureau of Policy and Strategy
	Ministry of Public Health	Dr Luecha Wanaratna Chief of Technical Office
VIET NAM	Institute for Social Development Studies	Ms Nguyen Thi Van Anh Head of Soc. Dev. Section
	Research and Training Centre for Community Development (RTCCD)	Dr Tran Tuan Director
	Viet Nam Family Planning Association (VINAFPA)	Prof. Pham Song President
	Viet Nam Women Union	Ms Chu Nhi Ha Department of Family and Society
	Communist Party of Viet Nam	Prof. Pham Manh Hung Vice Chairman,Committee for Education and Sciences

COUNTRY	ORGANIZATION	NAME & DESIGNATION OF PARTICIPANT
OTHER ORGANIZATIONS	People's Health Movement Geneva International	Ms Garance (Nance) Upham President
	Royal Tropical Institute Amsterdam (co-organizer)	Ms Maria Paalman Senior Health Adviser
	World Health Organization	Dr Palitha Abeykoon WHO Office - Sri Lanka
		Dr Lin Aung WHO Health Planner - Nepal
		Ms Anjana Bhushan Technical Officer Poverty and Gender - Western Pacific Regional Office
		Dr Silvia Ferazzi Partnerships Advisor Coordination of Macroeconomics and Health Support Unit
		Mr B.S. Lamba Sustainable Health Policy Officer Southeast Asia Regional Office
		Mr Rajiv Misra WHO Consultant
		Dr Soe Nyunt U Director, Health Sector Development Western Pacific Regional Office

COUNTRY	ORGANIZATION	NAME & DESIGNATION OF PARTICIPANT
		Dr Sergio Spinaci Executive Secretary Coordination of Macroeconomics and Health Support Unit - Geneva Sustainable Development and Healthy Environments Cluster
		Dr Kan Tun WHO Representative – Sri Lanka

Annex 3
Conference materials

All materials listed below are available on http://www.who.int/macrohealth

1. Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health. WHO Geneva, 2001.
2. Investing in Health: A Summary of the Findings of the Commission on Macroeconomics and Health. WHO Geneva, 2003.
3. The Commission on Macroeconomics and Health: Working Group Papers and Reports on CD-Rom. Royal Tropical Institute Amsterdam, 2003.
4. Declaration, The 2nd Consultation on Macroeconomics and Health: Increasing Investments in Health Outcomes for the Poor. WHO Geneva, 28-30 October 2003.
5. Macroeconomics and Health: an Update. WHO Geneva, April 2004
6. Status reports on Macroeconomics and Health. WHO SEARO & WPRO, April 2004. (Profiles from 12 countries)
7. Information on Health Activities by CSOs participating in the Asian Civil Society Conference on Macroeconomics and Health. Amsterdam/Colombo, April 2004.
8. Rajiv Misra. The CMH Process and Civil Society, 2004.
9. Nance Upham. Making Health Care Work for the Poor: a Review of NGO Experience in Selected Countries, 2004.
10. People's Charter for Health. As amended and approved at the People's Health Assembly. Savar Bangladesh, December 2000.
11. The Mumbai Declaration of the People's Health Movement. Mumbai India, 14-15 January 2004.
12. Potential for Government/NGO Partnership in Health Care. WHO Sri Lanka, 2003.
13. People's Health Movement Response to Commission on Macro-economics and Health, April 2004.
14. Sergio Spinaci. Introductory Remarks to the Asian Civil Society Conference on Macroeconomics and Health. Colombo, 27 April 2004.
15. Rajiv Misra. The CMH Process and Civil Society. Powerpoint presentation. Colombo, 27 april 2004.
16. Silvia Ferazzi. The Macroeconomics and Health Country Follow-up and the Civil Society. Powerpoint presentation. Colombo, 27 April 2004.
17. D. Bayarsaikhan. Anjana Bhushan. CMH in WPRO: an Overview. Powerpoint presentation. Colombo, 27 April 2004.
18. B.S. Lamba. Macroeconomics and Health in the South-East Asia Region. Powerpoint presentation. Colombo, 27 April 2004.
19. Nance Upham. NGOs Contributions to Present and future Health Systems for the Poor. Powerpoint presentation. Colombo, 27 April 2004.
20. Dr. Godfrey Gunatilleke. The Health Transition and Economic Growth in Sri Lanka: Lessons of the Past and Emerging Issues. Powerpoint presentation. Colombo, April 2004.

Participating Organizations

Bangladesh
BRAC
Center for Policy Dialogue
Gonoshasthya Kendra
Grameen Bank
Save the Children-UK

Cambodia
Cambodia Association for Assistance to Families and Widows (CAAFW)
Cambodia Family Development Service (CFDS)
HealthNet International
MEDICAM
Reproductive and Child Health Alliance (RACHA)

People's Republic of China
China Primary Health Care Foundation
Health Technology Assessment & Research Center, Fudan University, School of Public Health
Think Tank Research Center for Health Development

India
Gujarat Institute of Development Research
Janani
Karuna Trust
Sanket Development Group
SEARCH (Society for Education, Action and Research in Community Health)

Indonesia
Indonesian Heart Foundation
Yayasan Lembaga Konsumen Indonesia

Lao People's Democratic Republic
Central Lao Women's Union
Macfarlane Burnet Institute for Medical Research and Public Health
Swiss Red Cross

Mongolia
Mongolian Anti-Tuberculosis Association
Mongolian Association of Family Doctors
Mongolian Public Health Association
Mongolian Red Cross Society
Mongol Vision

Nepal
Family Planning Association of Nepal
Nepal Health Economics Association
Nepal Red Cross
New ERA
United Mission Nepal (UMN)

Philippines
Gerry Roxas Foundation
Health Alternatives for Total Human Development Institute
Maharlika Charity Foundation
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Sarvodaya Shramadana Movement

Thailand
Anti-Tuberculosis Association of Thailand
Thai Health Promotion Foundation

Viet Nam
Institute for Social Development Studies
Research and Training Centre for Community Development (RTCCD)
Viet Nam Family Planning Association (VINAFPA)
Viet Nam Women Union

Other Organizations
People's Health Movement Geneva International
Royal Tropical Institute Amsterdam (Conference organizer)

Government Representatives
Bangladesh
Cambodia
People's Republic of China
India
Indonesia
Lao People's Democratic Republic
Mongolia
Nepal
Philippines
Sri Lanka
Thailand
Viet Nam

World Health Organization

INVESTING IN HEALTH

A Summary of the Findings
of the Commission on Macroeconomics
and Health

WORLD HEALTH ORGANIZATION

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INVESTING IN HEALTH

A Summary of the Findings
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and Health

WORLD HEALTH ORGANIZATION
CMH SUPPORT UNIT

INVESTING IN HEALTH

A Summary of the Findings of the Commission on Macroeconomics and Health

Contents Page

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List of Commissioners

Jeffrey D. Sachs, Chair

Isher Judge Ahluwalia: Chair of Working Group 4: Health and the International Economy
K.Y. Amoako: Commissioner
Eduardo Aninat: Commissioner
Daniel Cohen: Commissioner, Co-Chair of Working Group 1: Health, Economic Growth and Poverty Reduction
Zephirin Diabre: Commissioner, Co-Chair of Working Group 6: International Development Assistance and Health
Eduardo Doryan: Commissioner
Richard G.A. Feachem: Commissioner, Co-Chair of Working Group 2: Global Public Goods for Health
Robert W. Fogel: Commissioner
Dean Jamison: Commissioner, Member of Working Group 3: Mobilization of Domestic Resources for Health
Takatoshi Kato: Commissioner
Nora Lustig: Commissioner, Member of Working Group 1: Health, Economic Growth and Poverty Reduction
Anne Mills: Commissioner, Co-Chair of Working Group 5: Improving Health Outcomes of the Poor
Thorvald Moe: Commissioner
Manmohan Singh: Commissioner
Supachai Panitchpakdi: Commissioner, Member of Working Group 4: Health and the International Economy
Laura Tyson: Commissioner
Harold Varmus: Commissioner

Foreword

A year and a half year ago, Professor Jeffrey Sachs presented me with the Report of the Commission on Macroeconomics and Health. The Report shows, quite simply, how disease is a drain on societies, and how investments in health can be a concrete input to economic development. It goes further, stating that improving people's health may be one of the most important determinants of development in low-income countries.

The Commission's Report argues for a comprehensive, global approach to health with concrete goals and specific time frames. It wants to see the forces of globalization harnessed to reduce suffering and to promote well-being. It is the first detailed costing of the resources needed to reach some of the key goals set in the Millennium Declaration: an annual investment of $66 billion by the year 2007. Much of this will come from the developing countries' own resources. But about half must be contributed by the rich countries of the world - in the form of effective, fast and results-oriented development assistance.

The proposed investments fund well-tried interventions that are known to work. Their impact can be measured in terms of reducing the disease burden and improving health system performance. The emphasis throughout is on results; on investing money where it makes a difference. Three diseases - HIV/AIDS, tuberculosis and malaria - are overwhelmingly important. Maternal and child conditions, reproductive ill-health and the health consequences of tobacco, are also global health priorities. Any serious attempt to stimulate global economic and social development, and so to promote human security, must successfully address the burdens caused by this range of diseases and conditions.

Since the launch of the Commission's Report, CMH work has started to bear fruit. Governments have taken action, trying to mobilize funds and develop efficient mechanisms to move funds rapidly to where they are needed. They are increasingly using global standards to report results. More than a dozen countries have set up national commissions or in other ways begun work to assess how to integrate updated health needs into their national development plans. It is hoped that this summary of the CMH Report will act as a spur for yet more work in countries to examine the findings of the Report and its implications for the health and economic challenges that lie ahead.

Dr Gro Harlem Brundtland,
Director-General,
World Health Organization

The Commission on Macroeconomics and Health

The Commission on Macroeconomics and Health was launched by WHO Director-General, Dr Gro Harlem Brundtland in 2000 and was chaired by Professor Jeffrey Sachs. The Commission's mandate was to examine the links between health and macroeconomic issues.

To arrive at its conclusions, the Commission planned its research and analysis within six working groups which in turn engaged a worldwide network of experts in public health, economics, and finance.

Working Group 1: Health, Economic Growth, and Poverty Reduction addressed the impact of health investments on poverty reduction and economic growth. Co-Chairs: Sir George Alleyne and Professor Daniel Cohen.

Working Group 2: Global Public Goods for Health examined multicountry policies, programmes and initiatives having a positive impact on health that extends beyond the borders of any specific country. Co-Chairs: Professors Richard Feachem and Jeffrey Sachs.

Working Group 3: Mobilisation of Domestic Resources for Health assessed the economic consequences of alternative approaches to resource mobilisation for health systems and interventions from domestic resources. Co-Chairs: Professor Alain Tait and Professor Kwesi Botchwey.

Working Group 4: Health and the International Economy examined trade in health services, commodities and insurance; patents and trade-related intellectual property rights; international movements of risk factors; migration of health workers; health finance policies; other ways that trade may be affecting the health sector. Chair: Dr Isher Judge Ahluwalia.

Working Group 5: Improving Health Outcomes of the Poor addressed the technical options, constraints and costs for mounting a major global effort to improve the health of the poor dramatically by 2015. Co-Chairs: Dr Prahbat Jha and Professor Anne Mills.

Working Group 6: International Development Assistance and Health reviewed health implications of development assistance policies. Co-Chairs: Mr Zephirin Diabre and Mr Christopher Lovelace and Ms Carin Norberg.

The Ten Recommendations

The recommendations of the Report are summarised into an agenda for action, providing the conceptual framework for review and open debate. Each country is invited to assess and analyse the CMH recommendations and to adapt them to their own socio-economic situation.

The main recommendations of the CMH Report are:

1. **Developing countries** should begin to map out a path to universal access for essential health services based on epidemiological evidence and the health priorities of the poor. They should also aim to raise domestic budgetary spending on health by an additional 1% of their GNP by 2007, rising to 2% in 2015, and use resources more efficiently.
2. Developing countries could establish a **National Commission on Macroeconomics and Health** or similar mechanism to help identify health priorities and the financing mechanisms, consistent with the national macroeconomic framework, to reach the poor with cost-effective health interventions.
3. **Donor countries** would begin to mobilize annual financial commitments to reach the international recommended standard of 0.7% of OECD countries' GNP, in order to help finance the scaling up of essential interventions and increased investment in health research and development and other "global public goods".
4. The WHO and the World Bank would be charged with coordinating the massive, multi-year scaling up of donor assistance for health and with monitoring donor commitments and funding.
5. The WTO member governments should ensure adequate safeguards for developing countries, in particular the right of countries that do not produce the relevant pharmaceutical products to invoke compulsory licensing for imports from third-country generic suppliers.
6. **The International Community** and agencies such as WHO and the World Bank, should strengthen their operations. The Global Fund to Fight AIDS, TB, and malaria (GFATM) should have adequate funding to support the process of scaling up actions against HIV/AIDS, TB and malaria. A Global Health Research Fund (GHRF) is proposed.
7. The supply of global public goods should be bolstered through additional financing of agencies such as WHO and the World Bank.
8. Private-sector incentives for drug development to combat diseases of the poor must be supported. The GFATM and purchasing entities should establish pre-commitments to purchase new targeted products (such as vaccines for HIV/AIDS, malaria, and TB) as a market-based incentive.
9. The international pharmaceutical industry, in cooperation with WHO and low-income countries, should ensure that people in low-income countries have access to essential medicines. This should be achieved through commitments to provide essential medicines at the lowest viable commercial price in poor countries and to license the production of essential medicines to generic producers.
10. The IMF and the World Bank should work with recipient countries to incorporate the scaling up of health and other poverty reduction programmes into a viable macroeconomics framework.

CMH Report p 18-19 and p 108-111

Poverty and ill-health are closely linked

Ill health undermines economic development and efforts to reduce poverty. Investments in health are essential for economic growth and should be a key component of national development strategies. The greatest achievements can be made by focusing on the health of the poor and on the least developed countries.

The links between ill health and poverty are now well known. Poor and malnourished people are more likely to become sick and are at higher risk of dying from their illness than are better off and healthier individuals. Ill health also contributes to poverty. People who become ill are more likely to fall into poverty and to remain there than are healthier individuals because debilitating illness prevents adults from earning a living. Illness also keeps children away from school, decreasing their chances of a productive adulthood.

Today the epidemics of HIV/AIDS, malaria, and TB are worsening, and developing countries are experiencing a rapid erosion of the social and economic gains of the past 20 years. Childhood diseases, compounded by malnutrition, are responsible for millions of preventable child deaths and there has been little progress in reducing maternal and perinatal mortality.

In 2000, the Commission on Macroeconomics and Health set out to examine the links between health and poverty and to demonstrate that health investment can accelerate economic growth. The Commission focused its work on the world's poorest people in the poorest countries. It demonstrated that impoverished people share a disproportionate burden of avoidable deaths and suffering; the poor are more susceptible to diseases because of malnutrition, inadequate sanitation, and lack of clean water, and are less likely to have access to medical care, even when it is urgently needed. Serious illness can impoverish families for many years as they lose income and sell their assets to meet the cost of treatment and other debts. The Report also signalled that existing, life-saving interventions, including preventive measures and access to essential medicines, do not reach the poor. The Commission states that over the coming decade the world can make sizeable gains against the diseases which have a disproportionate impact on the health and welfare of the poor by investing more money in essential health services and by strengthening health systems.

Until recently, economic growth was seen as a precondition for real improvements in health. But the Commission turned this notion around and provided evidence that improvements in health are important for economic growth. It confirmed that in countries where people have poor health and the level of education is low it is more difficult to achieve sustainable economic growth. High prevelance of diseases such as HIV/AIDS and malaria are associated with persistent and large reductions of economic growth rates. In some areas, for example, high malaria prevalence is associated with reduced economic growth of at least 1% a year.

Health is a cornerstone of economic growth and social development. The Commission showed that increased life expectancy and low infant mortality are linked to economic growth. Healthy people are more productive; healthy infants and children can develop better and become productive adults. And a healthy population can contribute to a country's economic growth. The Commission says that increased investment in health would translate into hundreds of billions of dollars per year of additional income which could be used to improve living conditions and social infrastructure in poorer countries.

Improving people's health and life expectancy is an end in itself and one of the fundamental goals of economic growth. It is also of direct relevance to the achievement of the **MILLENNIUM DEVELOPMENT GOALS (MDGs),** set by world leaders in 2000 for reducing poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women by 2015.

CMH action in countries

During the biennium 2001-2003, the CMH Report was introduced in many countries. The CMH process and follow-up initiatives have been providing opportunities to national groups - from a range of ministries to academic groups, civil society, NGOs, and the private sector - to debate their vision for health and plans for incorporating the promotion of better health into national development strategies.

Health-related Millennium Development Goals

At the Millennium Summit in September 2000 the UN reaffirmed its commitment to working toward a world in which sustaining development and eliminating poverty would have the highest priority.

Goal 1: Eradicate extreme poverty and hunger - Target 1: reduce the proportion of people living on less than US$ 1 a day to half the 1990 level by 2015. **Target 2:** reduce the proportion of people who suffer from hunger by half the 1990 level by 2015.

Goal 2: Achieve universal primary education - Target 3: ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

Goal 3: Promote gender equality and empower women - Target 4: eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.

Goal 4: Reduce child mortality - Target 5: reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

Goal 5: Improve maternal health - Target 6: reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.

Goal 6: Combat HIV/AIDS, malaria and other diseases - Target 7: have halted by 2015 and begun to reverse the spread of HIV/AIDS. **Target 8:** have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

Goal 7: Ensure environmental sustainability - Target 9: integrate the principles of sustainable development into country policies and programmes and reverse the losses of environmental resources.

Goal 8. Build a global partnership for development: to help poor countries eradicate poverty, hunger, and premature death will require a new global partnership for development based on stronger policies and good governance. **Target 17:** provide access to affordable, essential drugs in developing countries, in cooperation with pharmaceutical companies.

Making a difference: Preventing eight million deaths a year by 2010...

A few diseases and conditions account for most of the avoidable deaths in low- and middle-income countries. Efforts to scale up access to existing interventions against infectious diseases, to address reproductive and child health, and to confront malnutrition will prevent millions of deaths in poor countries and considerably improve health.

Only a handful of diseases and conditions are responsible for most for most of the world's health deficit: HIV/AIDS; malaria; TB; diseases that kill mothers and their infants; tobacco-related illness; and childhood diseases such as pneumonia, diarrhoea, measles, and other vaccine-preventable diseases — all of which are aggravated by malnutrition. Together, they account for around 14 million deaths a year in people under 60 and for 16 million deaths a year among all age groups. Most of these deaths occur in developing countries, which spend the least on health care, and where the poorest people are worst affected.

CMH Report p 104-105, Working Group 5 Report p 161-170

However, the high death toll from major diseases (often linked to malnutrition) is only part of the story. The scale of individual suffering and pain inflicted by illness is tremendous. At any one time, hundreds of millions of people — mainly in developing countries — are sick. As a result, children are kept away from school and adults prevented from working or caring for their children.

Most deaths and disability can be prevented. Effective health interventions already exist to either prevent or cure the diseases which take the greatest toll on human lives. But the fact remains that these interventions do not reach the billions of the world's poor. The Commission argues that by taking essential interventions to scale and making them available worldwide, eight million lives could be saved each year by 2010. A scaled-up response would alleviate countless suffering, dramatically reduce illness and deaths, and provide a concrete and measurable way of reducing poverty and ensuring economic growth and security.

CMH Report p 31-53, Working Group 5 Report p 20-54 and p 55-76

A scaled-up response will require not only a major increase in funding for health but also strong commitment by governments to specific actions for reducing health inequality and inequity, together with broad support from the international community and partners from all levels of society.

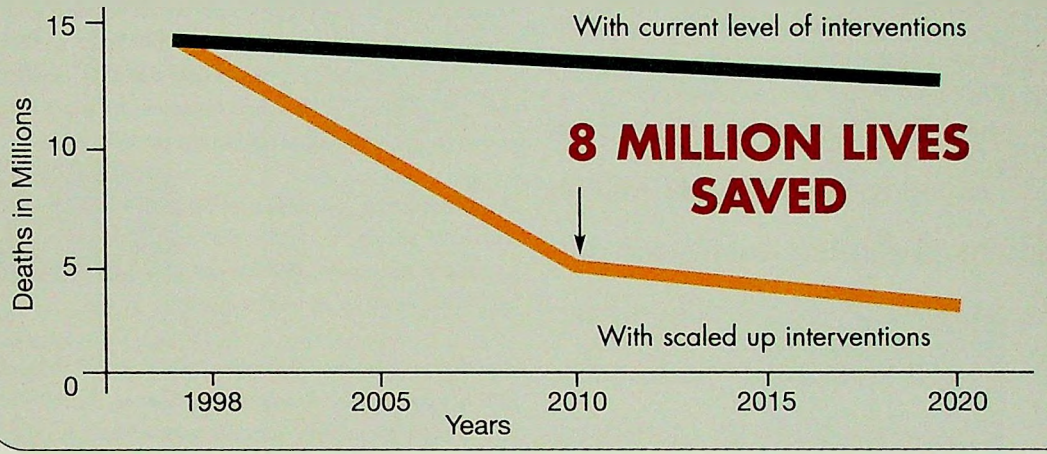
CMH Report p 91-101, Working Group 3 Report p 57-100, Working Group 6 Report p 35-43

Avoidable deaths (all ages) and suffering from infectious diseases, maternal and perinatal conditions, childhood diseases, and nutritional deficiencies.

1. In 1998 there were:
   - 1.6 million deaths from measles, tetanus, and diphtheria, all vaccine-preventable diseases
   - 500 000 deaths among women during pregnancy and childbirth, most of them in developing countries
   - One million deaths from malaria and 2.4 billion people living at risk of malaria
   - 1.5 million deaths from TB and eight million new cases of the disease.
2. In 1999, 5.3 million people died of acute lower respiratory infections and diarrhoeal diseases, in low- and middle-income countries, most of them children under five.
3. In 2002 over 40 million people had died from HIV/AIDS-related illnesses and 42 million were living with HIV/AIDS.
4. Unless smoking patterns change, about 500 million people are expected to die from tobacco-related diseases over the next 50 years.

Scaling up interventions will save 8 million lives a year by 2010

Under-60 deaths from infectious diseases and nutritional disorders, respiratory infections, and maternal and perinatal conditions.



WHO/WHR 2000 and CMH Report 2001 p 103-105, Working Group 5 Report p 55-76

Examples of essential interventions to combat major infectious diseases and malnutrition

TB	MALARIA	HIV/AIDS	CHILDHOOD DISEASES	MATERNAL/PERINATAL	SMOKING
DOTS: Directly Observed Treatment Short-course	• Treatment of uncomplicated/ complicated malaria • Intermittent treatment for pregnant women • Indoor residual spraying • Epidemic planning and response • Social marketing of insecticide-treated bednets.	• Safe blood transfusion for HIV/AIDS • Prevention and clinical management of opportunistic illnesses • Palliative care • Antiretrovirals and breast-milk substitute for preventing mother-to child-transmission (MTCT) • HAART: Highly-Active Antiretroviral Therapy • Peer education for vulnerable groups • Needle exchange programmes for injecting drug users • Social marketing of condoms • School and youth programmes for HIV/AIDS.	• Integrated Management of Childhood Illness (IMCI) • Immunization • Specific immunization campaigns • Treatment of severe anaemia • IMCI for home management of fever • Micronutrients and de-worming • Policies to reduce indoor air pollution • Food fortification with iodine, iron, folate, zinc.	• Family planning • Emergency obstetric care • Skilled birth attendance • Antenatal and postnatal care.	• Cessation advice • Pharmacological therapies to prevent smoking.

CMH Report p 66-67, and Working Group 5 Report p 19-54

...and generating at least US$ 360 billion annually by 2015-2020

330 million DALYs* worth around US$ 180 billion in direct economic benefits, would be saved for every eight million deaths prevented each year and another US$ 180 billion from indirect economic benefits resulting from increased investment in health.

*The term Disability Adjusted Life Years is a measure of both the number of years of healthy life lost to premature death and the years lived with varying degrees of disability. One DALY represents one year of healthy life lost.

The eight million lives that would be saved each year represent a far larger number of cumulative years of life saved (so called Disability Adjusted Life Years or DALYs) as well as a higher quality of life for those involved. One DALY is therefore a health gap measure, equating to one year of healthy life lost. The CMH Report argues that 330 million DALYs would be saved for eight million deaths prevented each year — thereby accelerating economic growth and breaking the poverty cycle.

The Commission estimates that 330 million DALYs will be worth around US$ 180 billion per year in direct economic savings by 2015; the world's poorest people would live longer, healthier lives and, as a result, would be able to earn more. But the actual economic returns could be much higher than this if the benefits of improved health help to spur economic growth.

Improvements in life expectancy and reduced disease burden would tend to stimulate growth through: lower fertility rates, higher investments in human capital, increased household savings, increased foreign investment, and greater social and macroeconomic stability. The correlation between better health and higher economic growth is derived from macroeconomic analyses suggesting that another US$ 180 billion per year by 2020 will be generated as a consequence of indirect economic benefits. Taking into account the valuation of lives saved and faster economic growth, the Commission estimates that the economic benefits would be around US$ 360 billion per year during 2015-2020, and possibly much more.

CMH Report p 12-13, p 23-24 and p 103-108

To achieve these huge gains in health and economic development, the Commission calls for a major increase in the resources allocated to the health sector over the next few years. About half of the total increase would come from international development assistance, with developing countries providing the other half by reprioritizing their budgets. A few middle-income countries will also require assistance to meet the high costs of HIV/AIDS control.

The total investment in health should focus on scaling up the specific interventions needed to control the major life-threatening and disabling diseases and to strengthen health delivery systems to ensure they can reach all people, particularly the poor. Interventions would be scaled up to target diseases and conditions including:

HIV/AIDS; malaria; TB; measles, tetanus, diphtheria, and other vaccine-preventable diseases; acute respiratory infections; diarrhoeal diseases; maternal and perinatal conditions; malnutrition; and tobacco-related diseases.

CMH Report p 35-38, and Working Group 5 Report p 19-76

In addition, investment is needed in reproductive health, including family planning and access to contraceptives, to complement investments in disease prevention and control. The combination of disease control and reproductive health is likely to translate into reduced fertility, greater investment in the health and education of each child, and reduced population growth.

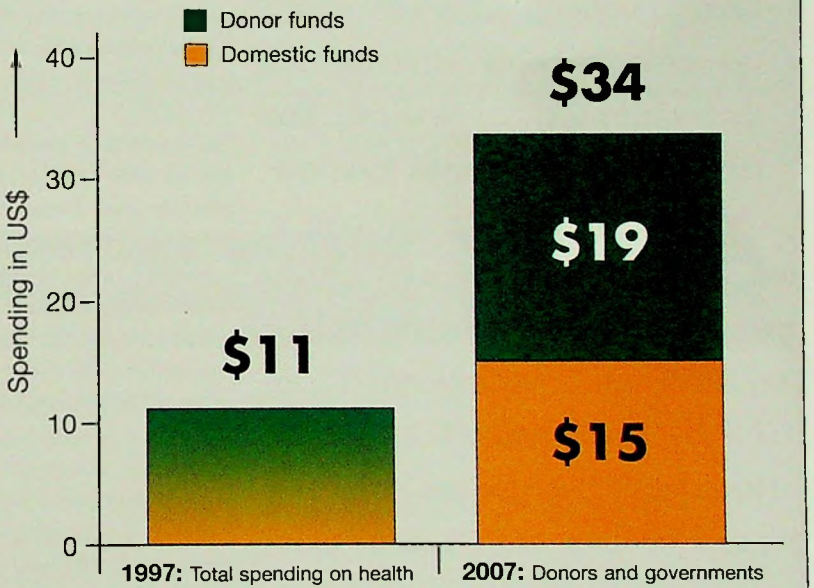
Domestic Spending and Donor Assistance on Health (1997-1999)

	Public Spending on Health (per person, 1997, US$)	Total Spending on Health (per person, 1997, US$)	Donor Assistance for Health (per person, average annual 1997-1999)	Donor Assistance for Health Annual Average (US$ millions 1997-1999)
Least-Developed Countries	**6**	**11**	**2.29**	**1,473**
Other Low-Income Countries	**13**	**23**	**0.94**	**1,666**
Lower-Middle- Income Developing Countries	**51**	**93**	**0.61**	**1,300**
Upper-Middle- Income Developing Countries	**125**	**241**	**1.08**	**610**
High-Income Countries	**1,356**	**1,907**	**0.00**	**2**
All Countries			**0.85**	**5,052**

CMH Report p 56, and Working Group 6 Report p 9-23

The Cost of Essential Interventions

The CMH Report estimates that the minimum expenditure for scaling up a set of essential interventions is on average **US$ 34** (current US$) per person/year, including those needed to fight the AIDS pandemic. Among the 48 least-developed countries, average total spending for health is about **US$ 11** per person/year of which US$ 6 comes from budgetary resources (including donor assistance) and the rest from out-of-pocket expenditures (1997). Current levels of donor support are very low, estimated at **US$ 2.29** per person in the least developed countries in 1997-1999.



1997: Total spending on health per person in least-developed countries (of the $11, $6 are from budget and the rest from out-of-pocket. The sum includes donor assistance).

2007: Donors and governments in low-income countries must mobilize additional funds.

CMH Report p 11, p 56-57, and Working Group 5 Report p 166-168

The extra funding required is unaffordable for poor countries

Current levels of investment by developing countries are far less than needed to address the health challenges they face and to scale up health interventions and essential services. The Commission envisages that low-income countries would aim to use their resources more efficiently and increase budgetary spending on health by an additional 1% of GNP by 2007 and 2% by 2015. However, it recognizes that even these measures will be insufficient to generate the level of funding needed in many poor countries — especially those affected by the HIV/AIDS epidemic.

A major increase in financial resources for health is needed to scale up health interventions and strengthen health delivery systems to ensure that these interventions are accessible, particularly for the poor. But the current low level of health spending in poor countries — due mainly to lack of resources and political commitment — is insufficient to address the health challenges they face. The Commission argues that most countries can mobilize extra domestic resources for health and make cost-effective use of these resources. It says that public spending should be targeted to the poor and used to support community financing schemes that protect households against catastrophic health expenditures — pointing out that in some areas, up to 40% of household revenues may be spent on health care.

The Commission estimated the costs involved in expanding health coverage in sub-Saharan African countries and all low-income developing countries. The Report states that national governments should be at the centre of efforts to raise domestic budgetary spending on health to US$ 35 billion per year for 2007 (an additional 1% of their GNP) and to US$ 63 billion per year by 2015 (an additional 2% of GNP), though for some countries a smaller amount would be sufficient to expand coverage.

CMH Report p 57-63 and Working Group 3 Report p 57-74

These efforts will also require concerted actions to remove structural constraints and strengthen the capacity of national health systems: to deliver essential interventions; to set priorities in response to health needs; to ensure equity; and to work in partnership with other sectors. Ensuring government commitment, transparency, effective governance, donor partnerships, and, above all, good stewardship in health and other sectors are key recommendations of the Commission. Strengthening the delivery of essential services would require a properly structured health delivery system that can reach the poor. The Commission states that creating a **close-to-client (CTC) system** at health centres, health posts or through outreach facilities is one of the highest priorities for scaling up essential interventions. The CTC system would operate locally, supported by nationwide programmes for major infectious diseases and could involve a mix of state and non-state health services providers with financing guaranteed by the state.

CMH Report p 64-73, and Working Group 5 Report p 50-54

In addition, efforts will be needed to increase community involvement and people's control of their own health — through ensuring that people are aware of and seek access to readily available health interventions and services. Donors and external partners need to work closely with governments to empower, assist, and enhance their capacity to lead on macroeconomic and health priorities.

To achieve these goals, poor countries will need to increase domestic resources available for health if they are to convince donors of their commitment to face the challenge. But even with more efficient allocation of resources and greater resource mobilization, the levels of funding necessary to cover essential services are far beyond the financial means of many poor countries — particularly those for the control of HIV/AIDS.

CMH Report p 57-91, and Working Group 3 Report p 75-100

Mobilising greater resources for health in low-income countries

As a basic strategy for health-finance reform the Commission recommends six steps:

1. Increase mobilization of general tax revenues for health — in the order of 1% of GNP by 2007 and 2% of GNP by 2015.
2. Increase donor support to finance the provision of public goods. Ensure access for the poor to essential services.
3. Convert out-of-pocket expenditures into prepayment schemes — including community finance programmes.
4. A deepening of the HIPC initiative, in country coverage and extent of debt relief.
5. Address inefficiencies in the way government resources are allocated and used.
6. Reallocate public outlays from unproductive expenditures to social sector programmes focused on the poor.

CMH Report p 61-62

Mobilising greater resources for health in middle-income countries

As part of an economic development strategy the Commission recommends:

1. Ensure universal access to essential interventions through public finance, with fiscal transfers to poorer regions.
2. Provide incentives for informal sector workers to participate in risk-pooling insurance schemes.
3. Improve equity and efficiency through budgeting, payment contracting and cost-containment measures (following the experience of OECD countries).

CMH Report p 63

Increased investment in health is urgently needed

Donor finance will be needed to close the financing gap. Assistance from developed nations should increase from the current levels of about **US$ 6 billion** per year to **US$ 27 billion** by 2007 and **US$ 38 billion** by 2015. Increased aid for health must be additional to current aid flows.

More **donor investment** is urgently needed to close the financing gap in health in the poorest countries of the world. Overall aid budgets have actually decreased over recent years and fall far short of even conservative estimates of what is currently needed to scale up action. In response, the donor community should not only reverse the decline in overall development assistance but also increase it from present levels to sustain the expanded coverage of essential health services and interventions. Further, they must support the scaling up of research and development and other interventions which have global public health benefits (so-called "global public goods"). Although the level of donor funding required is high in absolute terms (US$ 27 billion per year in 2007 and US$ 38 billion per year by 2015), the Commission maintains that additional assistance can be mobilized. If all donors raised their Official Development Assistance (ODA) to reach the international recommended standard of 0.7 % of OECD countries' GNP, the total 2007 ODA of US$ 200 billion would be sufficient to accommodate health assistance (US$ 27 billion) as well as other significant increases in areas related to poverty reduction and growth.

The Commission argues that a few middle-income countries will also require grant assistance, particularly to meet the financial costs of expanded HIV/AIDS control. It also recommends that the World Bank and regional development banks should increase loans (non-concessional) to these countries for upgrading their health systems; this should be balanced against the macroeconomic consequences of a debt increase.

Despite the apparent deficit in resources, the Commission reasoned that scaling up is feasible. Donor assistance for health has increased over recent years (even though overall ODA has decreased) as donor governments have become increasingly aware of the threat of infectious diseases to global security and of the spread of infectious diseases and their vectors through international travel, trade, and migration. Another encouraging development is that innovative ideas and resources are entering the health sector from private and corporate philanthropy.

CMH Report p 91-97, and Working Group 6 Report p 9-23

The Commission proposes that WHO and the World Bank, backed by a steering group of donor and recipient countries, could be charged with the coordination of the massive, multi-year scaling up of donor assistance in health and the monitoring of donor commitments and disbursements. Implementing this vision of greater expanded support for health requires donor support for build up of implementation capacity and for addressing governance or other constraints.

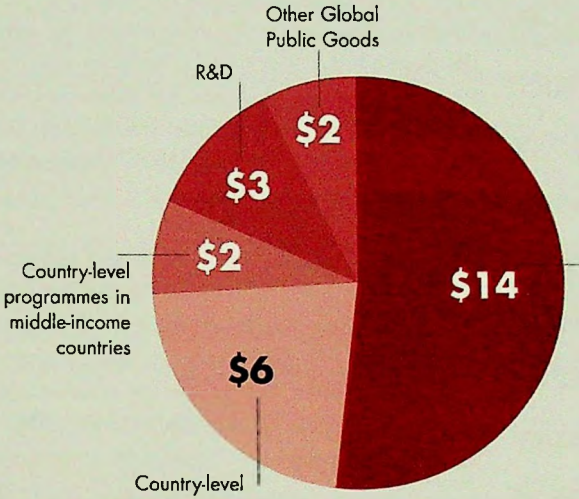
Key international forums (such as the IMF/World Bank meetings, the World Health Assembly, and the UN Conference on Development Finance) should provide venues for specific commitments to scaling up of donor assistance for health.

Recommended donor commitments

A major increase in the current low level of Official Development Assistance for health of around US$ 6 billion must be mobilized. Donor countries can assist by contributing around 0.1% of their GNP— one cent for every US$ 10 of income. The CMH argues that total needs for donor grants for country level programmes are **US$ 22 billion** per year by 2007 and **US$ 31 billion** by 2015 for the least-developed, low- and middle-income countries. Efforts will be needed to improve donor administrative commitments, and support should be readily forthcoming to help overcome country constraints.

Breakdown of recommended donor commitment (incremental) US$ billions

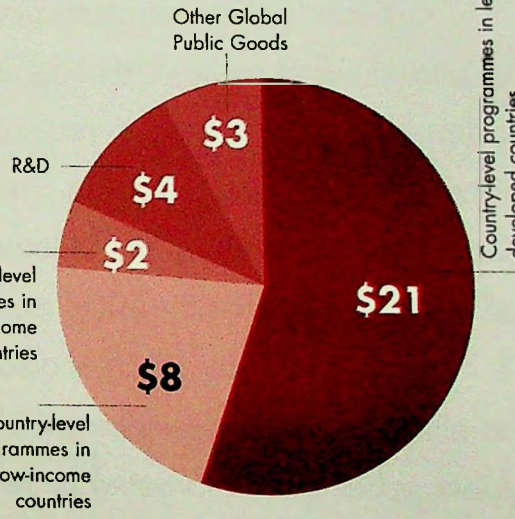
For the least-developed, low- and middle-income countries



US$ in billions (constant 2002 US$)

2007 Estimates:

Country-level programmes :	$22
R&D:	$3
Other Global Public Goods:	$2
Total:	$27



US$ in billions (constant 2002 US$)

2015 Estimates:

Country-level programmes :	$31
R&D:	$4
Other Global Public Goods:	$3
Total:	$38

CMH Report p 91-103, and Working Group 5 Synthesis Paper

CMH Report p 20, p 168

The supply of global public goods in poor countries

The impact of some health interventions and activities — such as the eradication of a disease or health research and development — extends beyond a country's borders to benefit the whole of mankind. These so-called global public goods are generally underfunded by governments in developing countries and require global provision and financing. The Commission maintains that at least US$ 5 billion a year by 2007 and US$ 7 billion a year by 2015 should be allocated to the development of global public goods targeted to the health needs of the poor.

The impact of some health interventions and activities, such as the eradication of a disease or research and development (R&D) in health extends beyond the country's borders to benefit the whole of mankind. These so-called global public goods are generally underfunded by governments in developing countries and require global provision and financing. The Commission maintains that at least US$ 5 billion a year by 2007 and US$ 7 billion a year by 2015 should be allocated to the development of global public goods targeted to the health needs of the poor.

A war against diseases requires not only cost-effective interventions, stronger health systems, political commitment and resources, but also substantial investments in global public goods. One of the most important global public goods is research and development that is focused on the health needs of the poor. The Commission states that new affordable and effective drugs and vaccines are required for HIV/AIDS, TB, malaria, childhood diseases, and reproductive health. Also needed are effective microbicides, new pesticides to control vector-borne diseases, and new drugs to tackle the increasing threat of drug resistance. However, rich country markets offer little incentive for the R&D of new products to combat diseases that occur mainly in developing countries.

In addition to R&D targeted to specific diseases and conditions, the collection and analysis of epidemiological data and surveillance of infectious diseases at the international level must be improved. More support is needed for data collection and analysis of global health trends, analysis and dissemination of best practices in disease control and health systems management, and for technical assistance and training. These global public goods are key forces in the scaling up process; their implementation and international diffusion is a central responsibility of the World Health Organization, the World Bank, and other international institutions.

To help channel the increased R&D investment, the Commission proposes the establishment of a new Global Health Research Fund (GHRF) in addition to the existing major R&D channels (WHO, several public-private partnerships for AIDS, TB and malaria, and the Global Forum for Health Research). A key goal of the GHRF would be to support basic and applied biomedical and applied sciences research on the health problems affecting the poor and on the health systems and policies needed to address them. The GHRF would build long-term research capacity in the developing countries themselves.

Finally, since the public sector does not have the means to improve the supply of some global public goods, the Commission says that incentives are needed to encourage the private sector pharmaceutical industry to develop new and improved drugs, vaccines, and other interventions for low-income countries. These include extending 'orphan drug' legislation (drugs that treat diseases which only affect a very small percentage of the population) to diseases that occur mainly in developing countries, as well as pre-commitments to purchase priority new drugs and vaccines.

CMH Report p 8-9, p 76 –86, and Working Group 2 Report p 26-45

The Commission calls for an increase in research and development:

- **US$ 1.5 billion** per year for existing institutions involved in the research and development of new vaccines and drugs. These include the Special Programme for Research and Training in Tropical Diseases (TDR), the WHO Initiative for Vaccine Research (IVR), the UNDP/UNFPA/WHO/World Bank Human Reproduction Programme (HRP), and the public-private partnerships for HIV/AIDS, TB, and malaria.
- **US$ 1.5 billion** per year through the proposed Global Fund for Health Research (GFHR) that would support basic scientific research in health (including epidemiology, health economics, health systems, and health policy) and would help build long-term research capacity in developing countries.
- **Increased outlays for operational research** at country level in conjunction with the scaling up of health interventions equal to at least 5 % of national programme funding.
- **Expanded availability of scientific information on the internet** with efforts to increase connectivity of universities and research sites in poor countries.
- **Modification of the orphan drug legislation** in the high-income countries to include diseases of the poor.
- **Pre-commitments** to purchase targeted technologies such as vaccines for HIV/AIDS, TB, and malaria as a market-based incentive.

CMH Report p 85, and Working Group 2 Report p 26-45

The 10/90 Gap

Many new technologies, such as genomics and advances in diagnostics have been targeted to the health needs of the industrialized countries rather than the needs of developing countries. This imbalance in research between the health problems of the poor and those of the rich is known as the 10/90 Gap. Less than 10% of global health research funding is targeted at the health problems that are of greatest concern to people in developing countries and which account for 90% of global disease burden.

CMH Report p 79, and Working Group 6 Report p 42

Access to essential medicines

The international pharmaceutical industry, together with low-income countries and WHO, should ensure that poor countries have access to essential medicines through commitments to provide these at the lowest viable commercial price in the poorest settings.

Many people in low-income countries lack access to essential medicines — mainly because neither the poor nor their governments can afford to purchase them. Meanwhile, shortages of doctors and health workers to select, prescribe, and advise on the appropriate use of available medicines — aggravated by weak health systems and poor community outreach services — have prevented a demand-led approach, and diverted benefits from the poor. In many countries, access to essential medicines is held back through burdensome procurement systems, domestic regulatory procedures, and high import duties and taxes.

At the same time, pharmaceutical manufacturers tend to maintain high profit margins — especially in their rich country markets — as a means of recouping their research and development costs. Yet access to drugs in poor countries requires prices at or close to production costs since the poor cannot afford patent-protected prices. Moreover, it is anticipated that in the near future an increasing number of essential medicines will be patented. The Commission considers differential pricing in low-income markets the best solution to this. Under differential pricing, rich countries would bear the costs of research and development, through paying a relatively higher price for patented products, while poor countries would pay close to production costs. The Report also recommends the licensing of the industry's technologies to producers of high-quality generics for use in low-income markets whenever the industry chooses not to supply these markets, or whenever the generic producers can demonstrate that they can produce the drugs at high quality but at a markedly lower cost.

The Commission calls for a new global framework for access to life-saving medicines that includes differential pricing schemes in poorer markets as the operational norm, broader licensing of products to generics producers, and bulk purchase agreements. It also recommends that WHO, low-income countries, and the pharmaceutical industry should join forces and agree on guidelines for pricing and licensing the production of key technologies in developing countries to ensure the uninterrupted supply of essential medicines. The guidelines would identify a designated set of essential medicines for low-income countries, at markedly reduced prices.

Throughout these efforts, the pharmaceutical industry must remain a key partner and adhere to the rules of international trade involving access to essential medicines. At the same time, strong protection of intellectual property rights to preserve the pharmaceutical industry's incentives for the R&D of new medicines could prove a workable and effective solution.

Finally, the corporate sector operating in developing countries also has a critical role to play in ensuring that their own labour force has access to essential medicines and services. For example, the mining companies of southern Africa, that are at the epicentre of the HIV/AIDS epidemic, have a special responsibility to help prevent transmission of the disease and to ensure that their workforce has access to essential medicines and care.

CMH Report p 86-91

Responsibilities of low-income countries

Low-income countries would undertake to meet their own obligations including:

- Prevention of the re-exportation of low-priced drugs to developed countries, either legally or via the black market.
- Removal of obstacles to market access such as tariffs and quotas on the importation of essential medicines.
- Regulation and cooperation with the donor community to ensure the effective use of medicines in order to limit the onset of drug resistance and other adverse effects that can accompany poor administration of medicines.
- Ensure competitive tendering, bulk purchasing, and transparency in pricing.

CMH Report p 89-90, and Working Group 4 Report p 33-35

Responsibilities of the international community

- The donor community would guarantee adequate financing for the purchase, monitoring, and safe use of drugs.
- The WHO, pharmaceutical industry, and low-income countries would agree jointly to guidelines for pricing and licensing of production in low-income countries. This would be backed up by strong protection of intellectual property rights in the higher-income markets to provide incentives for R&D of new drugs.
- The World Trade Organization member governments would ensure adequate safeguards for the developing countries and, in particular, the right of countries that do not produce key essential medicines to invoke compulsory licensing for imports from developing country generic suppliers.

CMH Report p 88-91, and Working Group2 Report p 25-45

Responsibilities of the pharmaceutical industry

- The pharmaceutical industry would cooperate with WHO and low-income countries to agree jointly to guidelines. These guidelines would provide a transparent mechanism of differential pricing that would target poor countries, and would identify a designated list of essential medicines for HIV/AIDS, TB, malaria, respiratory infections, diarrhoeal diseases, and vaccine-preventable diseases, at the lowest viable commercial prices.
- The industry would agree to license their technologies to producers of high quality generic pharmaceuticals for supply to low-income countries when:
  - they choose not to supply these markets themselves
  - the generic producers can demonstrate that they can produce high quality medicines at markedly lower costs.

CMH Report p 89, and Working Group 4 Report p 25-45, and Working Group 2 Report p 39-44

New ways of investing in health for development

To improve the health of the poor, a global partnership involving both rich and poor nations is needed to scale up access to essential health services. Efforts to build on innovative funding mechanisms and new frameworks and to develop strong intersectoral coalitions around common goals would improve health in low-income countries. Creating a close-to-client system would help expand coverage and access to essential services.

Finding new ways of tapping into additional resources is critical to improving health, reducing poverty, and making significant progress towards the Millennium Development Goals. Since scaling up will require a major increase in international financing, an effective **partnership** of donors and recipient countries, based on mutual trust and performance, is essential. This partnership between rich and poor countries will help mobilize investment in health, and scale up access to essential health services with a focus on specific interventions to combat major diseases. Under the new partnership, financing of health would evolve in parallel with necessary country reforms and improved mobilization of tax revenues for health. The mechanisms of donor financing would evolve to include increased debt relief.

Efforts to deliver increased donor financing will require **innovative funding mechanisms** such as the Global Fund to fight AIDS, TB and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI), and the establishment of a new Global Health Research Fund (GHRF) to help channel the increased R&D expenditure. To support country-led poverty reduction initiatives, **effective frameworks** such as the Poverty Reduction Strategy Papers (PRSP) are promising approaches for addressing donor-recipient country relations. And new modalities for delivering additional funding and health sector scaling up, such as the Sector-Wide Approach (SWAp), can serve as a useful tool for donors and recipient countries for coordinating plans and action.
CMH Report p 97- 101

Evidence presented by the Commission also suggests that poverty reduction will be more effective if investment in other sectors is increased as well. Complementary investments and **intersectoral** collaborations with education, water, sanitation, and other sectors will have an impact on health. In addition, private sector involvement and cooperation, particularly of the pharmaceutical industry, is key to ensuring access to the medicines that are critically needed in low-income countries.

One of the Commission's highest priorities for scaling up efforts is the use of an innovative, well structured **close-to-client (CTC) system** to help increase health coverage for the poor. However, the establishment of an effective CTC system is no small task. It requires strong national leadership, coupled with local capacity and accountability. This will require renewed political commitment, increased organizational capacity, and greater

transparency in public services and budgeting — backed up by an increase in funding and transparency, including regular monitoring and evaluation. In addition, the full and equal participation of the community is critical. Without this, it will be impossible to scale up preventive care and treatment for the major life-threatening and disabling diseases.

CMH Report p 97- 101, and Working Group 5 Report p 50-54

Facilitating investment in health

- **The Poverty Reduction Strategy Paper (PRSP)** framework facilitates donor financing mechanisms and provides 1) deeper debt cancellation, 2) state leadership in the preparation of national strategies, 3) involvement of civil society at each step of the process, 4) a comprehensive approach to poverty reduction, and 5) donor coordination in support of country goals.
- A **National Commission on Macroeconomics and Health (NCMH)** can lead the task of scaling up through: 1) assessing health priorities, 2) establishing a scaling up strategy, 3) working together with other health-related sectors, 4) ensuring a sound macroeconomics framework, and 5) preparing an epidemiological baseline, operational targets, and a financing plan, together with WHO and the World Bank.
- **Sector Wide Approaches (SWAps)** can facilitate scaling up by providing donors and recipients with an innovative coordination mechanism for delivering additional funding through: 1) joint planning between country donors and national authorities, 2) agreeing on strategies for support, and 3) pooling assistance for country-designed and country-led strategies.
- **The Global Fund to fight AIDS, TB and Malaria (GFATM)** can support the scaling up process by providing funds to country-level programmes. The Commission has proposed that **US$ 8 billion** per year reach the GFATM by 2007 from the proposed overall US$ 22 billion donor assistance. The GFATM should primarily:1) target financial assistance to the poorest countries, 2) provide funding to countries with viable strategies, 3) provide grants for proposal preparation, 4) encourage proposals to reflect a pan-national dialogue on health, and 5) support demonstrated fiscal efforts.

  CMH Report p 79-81 and Working Group 6 Report, p 36-43
- A potential **Global Health Research Fund (GHRF)** suggested by the Commission can support basic, biomedical, and applied sciences research on the health problems of the poor and on health policies and systems required to address them. The Commission proposes that **US$ 1.5 billion** be dedicated to GHRF work as part of the US$ 3 billion R & D donor commitment.

  CMH Report p 81-86

Initiating macroeconomics and health work at country level

The Report proposes a way forward which, if vigorously pursued at national and international levels, would have a major impact on the health and wealth of nations and their people.

Because of the wide diversity of infrastructure and conditions in different countries, the CMH Report does not provide a road map for transforming its recommendations into actions at the country level. Its aim is to invite each country to examine its health priorities and infrastructural and budgetary constraints. Countries are encouraged to assess the current epidemiological situation, health status, and poverty determinants, in an effort to develop a sound strategy for scaling up health interventions within a macroeconomics and health agenda.

Many countries have endorsed the findings and recommendations of the CMH Report as they review it in relation to their country's health and economic needs. CMH follow-up work is intended to help governments examine issues relating to health and macroeconomics and establish options for scaling up investment and actions, while at the same time addressing the reforms needed to achieve more equitable and better health for all. The CMH follow-up process in countries aims to :

- Support politicians, health and finance ministers, academic groups, senior figures from the private sector, donor partners, and representatives of civil society as they examine the findings of the Report and its implications for the economic and health challenges that lie ahead.
- Endorse sound macroeconomics and health analyses designed to re-evaluate policies for investing in health and re-invigorate national plans for achieving the Millennium Development Goals.
- Help create channels for financial and technical assistance to governments and their partners, and lay the groundwork for building stronger alliances within countries. This will catalyze the ability of governments to plan and implement investment in order to improve the health of the poor more rapidly and in a sustainable way.

Many countries have expressed interest in linking macroeconomics and health work to existing national structures, policies, and capacities. This work begins through an interactive process that can involve health working groups of the PRSP process, national steering committees or the National Health Council, where appropriate. Countries can also set up a National Commission on Macroeconomics and Health (NCMH) or work through subregional groups such as the Economic and Social Commission for Asia and the Pacific (ESCAP). Implementation of a plan of action for increasing investment in health calls for strong political leadership and commitment at the highest level, consistency with the overall macroeconomics framework, and powerful intersectoral alliances.

A national body on macroeconomics and health or its equivalent is expected to organize and lead the task of scaling up national investment in health. This includes working with WHO, the World Bank, and others to analyse the national health situation and identify priority areas for health interventions as well as the financing strategies needed to address those priorities. Other tasks include: designating a set of essential interventions to be made universally available to the population through public financing; initiating a multi-year programme on health system strengthening focused on service delivery at the local level; and establishing targets for reductions in the burden of disease. The use of integrated community development approaches, currently being developed by WHO Regional Offices and other agencies, can amplify efforts to improve health and reduce poverty.

Important Macroeconomics and Health Activities

Each country supporting Macroeconomics and Health work should develop a specific plan of action appropriate to its situation, keeping in view the broad parameters of action outlined in the CMH Report. Development of an action plan requires a number of key activities including :

1. Advocacy on CMH findings and mobilization of additional political support
   - communicate the CMH concept and messages and encourage debates on the Report's findings
   - define the appropriate country-level response to CMH recommendations
2. Data analysis, development of strategies, and setting out a framework of macroeconomics and health action
   - review relevance of CMH findings within a country context
   - investigate system constraints to scaling up
   - ensure that information on coverage, equity, and cost effectiveness of priority services is available
   - develop national health investment plans on how to reach people effectively
   - consider approaches to retaining and training health care professionals across all levels of the health system
   - investigate how to incorporate health in the PRSP process
   - incorporate increased health spending within national Medium-Term Expenditure frameworks
3. Addressing the national burden of HIV/AIDS
   - address the impact of HIV on poverty, economic growth, and health status
   - establish policies and resources for increased access to prevention and care
4. Estimating funding needs and mobilization of additional financial support from domestic and international sources
   - improve information on the costs of health inaction
   - ensure links between relevant ministries and insert health in HIPC
   - build effective links with global funding initiatives
5. Managing implementation of plans and monitoring achievements
   - build country capacity for stewardship, intersectoral action, and monitoring performance
   - assess results, relate them to expenditure and track financial flows for health
6. Securing better coordination and coherence of action
   - document country experiences in intersectoral collaboration
   - establish effective mechanisms for in-country coordination, coherence in regional and global action, and to ensure that global initiatives respond to country needs.

National Responses to the CMH Report Consultation, WHO, June 2002

How countries are moving forward

Since the global launch of the CMH Report, WHO and its Regional and Country offices have worked closely with governments to promote the Report's findings and to support country efforts to bridge the gap between national macroeconomic and health policies. The CMH follow-up process in countries has been providing opportunities to national groups – from a range of ministries to academic groups, civil groups, and the private sector — to debate their vision of health and to strategize on how to incorporate health into national development plans.

Many countries have already started to mobilize their knowledge, experiences, and resources to formulate long-term programmes for scaling up essential health interventions — usually as part of a national poverty reduction strategy — and are expressing interest in the CMH findings. Not all of these countries are planning to establish a NCMH but nearly all are placing the CMH follow-up work in the context of their national development agendas. The international community, including WHO, will not urge countries to set up NCMH but will support promising national macroeconomics mechanisms in efforts to develop an approach to macroeconomics and health. WHO's own approach will be refined and adapted to different country situations through a process of consultations with countries and development agencies.

During 2002 and 2003, Regional and Country Offices have given priority to advocacy and the dissemination of the Report's findings. The CMH Report has been translated from English into Arabic, Chinese, French, German, Russian, and Spanish, and has been widely distributed. In some countries, CMH websites have been constructed to publicize key CMH messages and disseminate local information on macroeconomics and health. All WHO Regional Offices have distributed the Report and related documents widely in an effort to promote its findings and sensitize senior policy makers on the relationship between health and economic growth, while simultaneously providing guidance on how CMH recommendations could be taken forward in countries.

A number of meetings and conferences have been organized — from national workshops to high-level regional events — to present the main findings of the Report to groups of politicians, academics, and researchers and to debate how its recommendations could be applied to countries interested in the macroeconomics and health approach. Most Regional Offices have also set up Macroeconomics and Health (or CMH) Task Forces to assess the relevance of the CMH findings, propose interventions and approaches tailored to the local situation, and to coordinate and support CMH follow-up action at country level.

Throughout the biennium, determined efforts by WHO Regional Offices to disseminate CMH findings have resulted in several successful events to publicize and debate the Report. As a result, high-level political interest and commitment have been mobilized in countries including: Federal Democratic Republic of Ethiopia, the Republic of Ghana, the Republic of Kenya, the Republic of Mozambique, the Rwandese Republic, in Africa; the Association of Caribbean States and the United Mexican Stated in Americas; the Hashemite Kingdom of Jordan

and the Sultanate of Oman in the Eastern Mediterranean region; the Kingdom of Nepal, Kingdom of Thailand, the People's Republic of Bangladesh, the Republic of India, the Republic of Indonesia, the Republic of Maldives, the Union of Myanmar in South-East Asia; the Kingdom of Cambodia and the People's Republic of China in the Western Pacific Region.

Missions to countries committed to CMH follow-up work continue to shape the content of country macroeconomics and health support work in different ways. For example, in countries undergoing reforms, decentralization, and poverty reduction processes, the CMH follow-up work assists governments and the donor community in accelerating existing health sector initiatives through providing technical expertise and supporting capacity building. The Report's findings are also considered to be of great value to the process of health reform — providing guidance to countries or regions on priorities for health financing (including public-private partnerships and the sharing of services) and an opportunity for integrating the work of diverse partners. In other countries undergoing reforms, the provision of technical and financial assistance to support the analysis of epidemiological, budgetary, and macroeconomic variables contributes towards the design of improved public policy for health.

In a growing number of countries, macroeconomics and health work is seen as a powerful tool for enhancing external assistance for health from donors, for raising additional domestic resources, and making more efficient use of existing resources. In others, additional health-related risks such as under-nutrition, unsafe water, and unhealthy environments are being integrated into the CMH follow-up action.

Elsewhere, in some of the world's most populous countries that are poised for further economic growth, governments are interested in pursuing and adapting the CMH recommendations. Because of their size, high disease burden, and great potential for improvements in health, there is a critical need to sustain the CMH recommendations as the means to economic growth. What happens in these countries is vital for the rest of the world. It is inconceivable that any meaningful progress can be made towards the Millennium Development Goals unless the world's most populous countries are on board.

National responses to the CMH Report

To identify future directions a "National responses to the CMH Report" Consultation was held at WHO Headquarters in June 2002. Ministers and senior representatives from the ministries of health, finance and planning from 19 countries came together with representatives from the World Bank, 12 bilateral agencies, the Bill and Melinda Gates Foundation, and WHO staff to discuss how to translate the CMH recommendations into country actions. The Consultation considered what could be done to dramatically increase investments for achieving the Millennium Development Goals (MDG) in health, and the steps countries need to take to accelerate national action.

Senior representatives from the following countries participated in the Consultation:

The African region
- Ghana
- Mozambique
- Senegal
- United Republic of Tanzania
- Uganda

The Americas region
- The Caribbean States
- Guatemala
- Santa Lucia and OECS countries

The European region
- Poland

The Eastern Mediterranean region
- Jordan
- The Islamic Republic of Iran
- Oman
- Pakistan

The South East Asian region
- Bangladesh
- India
- Indonesia
- Nepal
- Sri Lanka
- Economic and Social Commission for Asia and the Pacific (ESCAP)

Investing in Health Booklet

Concept and Production
Agnès Leotsakos

Editor
Sheila Davey

Editorial and Technical Contributors
Amin Kebe, B.S. Lamba, Maria Paalman, Mubashar Riaz Sheikh, Rubén M. Suarez-Berenguela,
Dai Ellis, Silvia Ferazzi, Tom O'Connell, Ann Rosenberg, Josh Ruxin,
WHO CMH Support Unit, and Evidence for Health Policy Department

Executive Secretary CMH, Support Unit
Sergio Spinaci

Editorial Assistants
Zarita Khamkhoeva, Tashina Krishniah

Art and Design
James Elrington

World Health Organization,
CMH Support Unit,
20 Avenue Appia,
CH-1211 Geneva 27, Switzerland
www.who.int/macrohealth

INVESTING IN HEALTH

A Summary of the Findings of the Commission on Macroeconomics and Health

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WORLD HEALTH ORGANIZATION
CMH SUPPORT UNIT
20 AVENUE APPIA
CH-1211 GENEVA 27
SWITZERLAND

Executive Summary

Macroeconomics and Health: Investing in Health for Economic Development

Report of the Commission on Macroeconomics and Health

Presented by Jeffrey D. Sachs, Chair
to Gro Harlem Brundtland,
Director-General of the
World Health Organization
on 20 December 2001

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Macroeconomics and Health: Investing in Health for Economic Development

The Commission on Macroeconomics and Health (CMH) was established by World Health Organization Director-General Gro Harlem Brundtland in January 2000 to assess the place of health in global economic development. Although health is widely understood to be both a central goal and an important outcome of development, the importance of investing in health to promote economic development and poverty reduction has been much less appreciated. We have found that extending the coverage of crucial health services, including a relatively small number of specific interventions, to the world's poor could save millions of lives each year, reduce poverty, spur economic development, and promote global security.

This report offers a new strategy for investing in health for economic development, especially in the world's poorest countries, based upon a new global partnership of the developing and developed countries. Timely and bold action could save at least 8 million lives *each year* by the end of this decade, extending the life spans, productivity and economic well-being of the poor. Such an effort would require two important initiatives: a significant scaling up of the resources currently spent in the health sector by poor countries and donors alike; and tackling the non-financial obstacles that have limited the capacity of poor countries to deliver health services. We believe that the additional investments in health—requiring of donors roughly one-tenth of one percent of their national income—would be repaid many times over in millions of lives saved each year, enhanced economic development, and strengthened global security. Indeed, without such a concerted effort, the world's commitments to improving the lives of the poor embodied in the Millennium Development Goals (MDGs) cannot be met.

In many respects, the magnitude of the scaled-up effort reflects the extremely low levels of income in the countries concerned, the resulting paltry current levels of spending on health in those countries, and the costs required for even a minimally adequate level of spending on health.

Because such an ambitious effort cannot be undertaken in the health sector alone, this Report underscores the importance of an expanded aid effort to the world's poorest countries more generally. This appears to us of the greatest importance at this time, when there has been an enhanced awareness of the need to address the strains and inequities of globalization.

We call upon the world community to take heed of the opportunities for action during the coming year, by beginning the process of dramatically scaling up the access of the world's poor to essential health services. With bold decisions in 2002, the world could initiate a partnership of rich and poor of unrivaled significance, offering the gift of life itself to millions of the world's dispossessed and proving to all doubters that globalization can indeed work to the benefit of all humankind.

November 2001

Jeffrey D. Sachs, Chair

Isher Judge Ahluwalia
K. Y. Amoako
Eduardo Aninat
Daniel Cohen
Zephirin Diabre
Eduardo Doryan
Richard G. A. Feachem
Robert Fogel
Dean Jamison
Takatoshi Kato
Nora Lustig
Anne Mills
Thorvald Moe
Manmohan Singh
Supachai Panitchpakdi
Laura Tyson
Harold Varmus

Executive Summary of the Report

Technology and politics have thrust the world more closely together than ever before. The benefits of globalization are potentially enormous, as a result of the increased sharing of ideas, cultures, life-saving technologies, and efficient production processes. Yet globalization is under trial, partly because these benefits are not yet reaching hundreds of millions of the world's poor, and partly because globalization introduces new kinds of international challenges as turmoil in one part of the world can spread rapidly to others, through terrorism, armed conflict, environmental degradation, or disease, as demonstrated by the dramatic spread of AIDS around the globe in a single generation.

The world's political leaders have recognized this global interdependence in solemn commitments to improve the lives of the world's poor by the year 2015. The Millennium Development Goals (MDGs), adopted at the Millennium Summit of the United Nations in September 2000, call for a dramatic reduction in poverty and marked improvements in the health of the poor. Meeting these goals is feasible but far from automatic. Indeed, on our current trajectory, those goals will not be met for a significant proportion of the world's poor. Success in achieving the MDGs will require a seriousness of purpose, a political resolve, and an adequate flow of resources from high-income to low-income countries on a sustained and well-targeted basis.

The importance of the MDGs in health is, in one sense, self-evident. Improving the health and longevity of the poor is an end in itself, a fundamental goal of economic development. But it is also a *means* to achieving the other development goals relating to poverty reduction. The linkages of health to poverty reduction and to long-term economic growth are powerful, much stronger than is generally understood. The burden of disease in some low-income regions, especially sub-Saharan Africa, stands as a stark barrier to economic growth and therefore must be addressed frontally and centrally in any comprehensive development strategy. The AIDS pandemic represents a unique challenge of unprecedented urgency and intensity. This single epidemic can undermine Africa's development over the next generation, and may cause tens of millions of deaths in

Table 1. LIFE EXPECTANCY AND MORTALITY RATES, BY COUNTRY DEVELOPMENT CATEGORY, (1995–2000)

Development Category	Population (1999 millions)	Annual Average Income (US dollars)	Life Expectancy at Birth (years)	Infant Mortality (deaths before age 1 per 1,000 live births)	Under Five Mortality (deaths before age 5 per 1,000 live births)
Least-Developed Countries	643	296	51	100	159
Other Low-Income Countries	1,777	538	59	80	120
Lower-Middle-Income Countries	2,094	1,200	70	35	39
Upper-Middle-Income Countries	573	4,900	71	26	35
High-Income Countries	891	25,730	78	6	6
Memo: sub-Saharan Africa	642	500	51	92	151

Source: Human Development Report 2001, Table 8, and CMH calculations using World Development Indicators of the World Bank, 2001.

India, China, and other developing countries unless addressed by greatly increased efforts.

Our Report focuses mainly on the low-income countries and on the poor in middle-income countries.[1] (See notes in the full report.) The low-income countries, with 2.5 billion people—and especially the countries in sub-Saharan Africa, with 650 million people—have far lower life expectancies and far higher age-adjusted mortality rates than the rest of the world, as shown in the accompanying Table 1. The same is true for the poor in middle-income countries, such as China. To reduce these staggeringly high mortality rates, the control of communicable diseases and improved maternal and child health remain the highest public health priorities. The main causes of avoidable deaths in the low-income countries are HIV/AIDS, malaria, tuberculosis (TB), childhood infectious diseases, maternal and perinatal conditions, micronutrient deficiencies, and tobacco-related illnesses. If these conditions were controlled in conjunction with enhanced programs of family planning, impoverished families could not only enjoy lives that are longer, healthier, and more productive, but they would also choose to have fewer children, secure in the knowledge that their children would survive, and could thereby invest more in the educa-

tion and health of each child. Given the special burdens of some of these conditions on women, the well-being of women would especially be improved. The improvements in health would translate into higher incomes, higher economic growth, and reduced population growth.

Even though we focus mainly on communicable diseases and maternal and perinatal health, noncommunicable diseases (NCDs) are also of great significance for all developing countries; for many middle-income countries the mortality from communicable diseases has already been significantly reduced so that the NCDs tend to be the highest priority. Many of the noncommunicable diseases, including cardiovascular disease, diabetes, mental illnesses, and cancers, can be effectively addressed by relatively low-cost interventions, especially using preventative actions relating to diet, smoking, and lifestyle.[2] Our global perspective on priorities needs to be complemented by each country analyzing its own health priorities based on detailed and continually updated epidemiological evidence. Our argument for outcome-oriented health systems also implies substantial capacity to deal with a range of conditions not detailed here, such as low-cost case-management of mental illness, diabetes and heart attacks. The evidence also suggests that approaches required to scale up the health system to provide interventions for communicable diseases and reproductive health will also improve care for the NCDs.[3]

The feasibility of meeting the MDGs in the low-income countries is widely misjudged. On the one side of the debate are those optimists who believe that the health goals will take care of themselves, as a fairly automatic byproduct of economic growth. With the mortality rates of children under 5 in the least-developed countries standing at 159 per 1,000 births, compared with 6 per 1,000 births in the high-income countries,[4] these blithe optimists assume that it's just a matter of time before the mortality rates in the low-income world will converge with those of the rich countries. This is false for two reasons. First, the disease burden itself will slow the economic growth that is presumed to solve the health problems; second, economic growth is indeed important, but is very far from enough. Health indicators vary widely for the same income level. The evidence suggests that 73 countries are far behind in meeting the MDGs for infant mortality, and 66 are far behind for meeting the MDGs for child mortality.[5] The disease burden can be brought down in line with the MDGs only if there is a concerted, global strategy of increasing the access of the world's poor to essential health services.

On the other side of the debate are the pessimists, who underestimate the considerable progress that has been made in health (with the notable exception of HIV/AIDS) by most low-income countries and believe that their remaining high disease burden is a byproduct of corrupt and broken health systems beyond repair in poorly governed low-income countries. This alternative view is also filled with misunderstanding and exaggeration. The epidemiological evidence conveys a crucial message: the vast majority of the excess disease burden is the result of a relatively small number of identifiable conditions, each with a set of existing health interventions that can dramatically improve health and reduce the deaths associated with these conditions. The problem is that these interventions don't reach the world's poor. Some of the reasons for this are corruption, mismanagement, and a weak public sector, but in the vast majority of countries, there is a more basic and remediable problem. The poor lack the financial resources to obtain coverage of these essential interventions, as do their governments. In many cases, public health programs have not been modified to focus on the conditions and interventions emphasized here.

The key recommendation of the Commission is that the world's low- and middle-income countries, in partnership with high-income countries, should scale up the access of the world's poor to essential health services, including a focus on specific interventions. The low- and middle-income countries would commit additional domestic financial resources, political leadership, transparency, and systems for community involvement and accountability, to ensure that adequately financed health systems can operate effectively and are dedicated to the key health problems. The high-income countries would simultaneously commit vastly increased financial assistance, in the form of grants, especially to the countries that need help most urgently, which are concentrated in sub-Saharan Africa. ***They would resolve that lack of donor funds should not be the factor that limits the capacity to provide health services to the world's poorest peoples.***

The partnership would need to proceed step by step, with actions in the low-income countries creating the conditions for donor financing, while ample donor financing creates the financial reality for a greatly scaled-up, more effective health system, with the shared program subject to frequent review, evaluation, verification, and mid-course corrections. The chicken-and-egg problem of deciding whether reform or donor financing must come first would be put aside with both donors and recipients frankly acknowledging that both finance and reform are needed at

each stage, and that both must be sustained by an intensive partnership. For lower-middle-income countries with large concentrations of poor, a prime task of national governments would be to mobilize additional resources to finance priority interventions that assure coverage of the poor within those societies.

The commitment of massive additional financial resources for health, domestic and international, may be a necessary condition for scaling up health interventions, but the Commission recognizes that such a commitment will not be sufficient. Past experience shows compellingly that political and administrative commitments on the part of both donors and countries are key to success. Building health systems that are responsive to client needs, particularly for poor and hard-to-reach populations, requires politically difficult and administratively demanding choices. Some issues, such as relative commitments to the health needs of rich and poor, relate to the health sector. Others, such as whether the public sector budget and procurement systems work or whether there is effective supervision and local accountability of public service delivery, are public management issues. Underlying these issues are broader questions of governance, conflict, and the relative importance of development and poverty reduction in national priorities.

The Commission recognizes the importance of these and other constraints and treats them in depth in several places in this Report. Success will require strong political leadership and commitment on the part of countries that can afford to contribute resources as well as from developing countries—in the private and public sectors and in civil society as well. It requires the evolution of an atmosphere of honesty, trust, and respect in donor-recipient interactions. Success requires special efforts precisely in those settings in which health conditions are most troubling and where public sectors are weak. Donor support should be readily forthcoming to help overcome these constraints. Where countries are not willing to make a serious effort, though, or where funding is misused, prudence and credibility require that large-scale funding should not be provided. Even here, though, the record shows that donor assistance can do much to help, by building local capacity and through the involvement of civil society and NGOs. This is a daunting challenge, yet one that is more than ever a strategically relevant objective. Governments and leaders who help stimulate and nurture these actions will be providing a specific antidote to the despair and hatred that poverty can breed.

The Commission worked hard to examine whether the low-income countries could afford to fund the health systems out of their own resources if they were to eliminate existing wasteful spending in health and other areas. Our findings are clear: *poverty itself imposes a basic financial constraint, though waste does exist and needs to be addressed.* The poor countries should certainly improve health-sector management, review the current balance among health-sector programs, and raise domestic resources for health within their limited means. We believe that it is feasible, on average, for low- and middle-income countries to increase budgetary outlays for health by 1 percent of GNP by 2007 and 2 percent of GNP by 2015 compared with current levels, though this may be optimistic given intense competing demands for scarce public resources. Low- and middle-income countries could also do more to make the current spending, public and private, more equitable and effective. Public spending should be better targeted to the poor, with priorities set on the basis of epidemiological and economic evidence. There is scope for private out-of-pocket spending in some cases being replaced with prepaid community financing schemes. Yet for the low-income countries, we still find a gap between financial means and financial needs, which can be filled only by the donor world if there is to be any hope of success in meeting the MDGs.

In most middle-income countries, average health spending per person is already adequate to ensure universal coverage for essential interventions. Yet such coverage does not reach many of the poor. Exclusion is often concentrated by region (e.g., rural western China and rural northeast Brazil), or among ethnic and racial minorities. For whatever reason, public-sector spending on health does not attend sufficiently to the needs of the poor. Moreover, since many middle-income countries provide inadequate financial protection for large portions of their population, catastrophic medical expenses impoverish many households. In view of the adverse consequences of ill health on overall economic development and poverty reduction, we strongly urge the middle-income countries to undertake fiscal and organizational reforms to ensure universal coverage for priority health interventions.[6] We also believe that the World Bank and the regional development banks, through nonconcessional financing, can help these countries to make a multi-year transition to universal coverage for essential health services.

The Commission examined the evidence relating to organizational requirements for scaling up and some of the key constraints that will have to be overcome. Fortunately, the essential interventions highlighted here

are generally not technically exacting. Few require hospitals. Most can be delivered at health centers, at smaller facilities that we refer to as health posts, or through outreach services from these facilities. We call these collectively the *close-to-client (CTC)* system, and this system should be given priority to make these interventions widely accessible. Producing an effective CTC system is no small task. National leadership, coupled with capacity and accountability at the local level, is vital. This will require new political commitments, increased organizational and supervisory capacity at both local and higher levels, and greater transparency in public services and budgeting—all backed by more funding. These, in turn, must be built on a foundation of strong community-level oversight and action, in order to be responsive to the poor, in order to build accountability of local services, and in order to help ensure that families take full advantage of the services provided.

Some recent global initiatives for disease control, including those for TB, leprosy, guinea-worm disease, and Chagas disease, have proved highly successful in delivering quality interventions and, in some cases, changing attitudes and behaviors in some very difficult situations over large geographical areas. An important feature of these initiatives is the inclusion of rigorous systems of monitoring, evaluation, reporting, and financial control as mechanisms for ensuring that objectives are met, problems are detected and corrected, and resources are fully accountable. The result is a growing body of evidence concerning both the degree of progress achieved and the operational and managerial strategies that contribute to success. Lessons from these experiences can provide useful operational guidance, especially for the delivery of interventions at the close-to-client level.

In most countries, the CTC system would involve a mix of state and nonstate health service providers, with financing guaranteed by the state. The government may directly own and operate service units, or may contract for services with for-profit and not-for-profit providers. Since public health systems in poor countries have been so weak and underfinanced in recent years, a considerable nongovernmental health sector has arisen that is built upon private practice, religiously affiliated providers, and nongovernmental organizations. This variety of providers is useful in order to provide competition and a safety valve in case of failure of the public system. It is also a fait accompli in almost all poor countries.

A sound global strategy for health will also invest in new knowledge. One critical area of knowledge investment is operational research regard-

ing treatment protocols in low-income countries.[7] There is still much to be learned about what actually works, and why or why not, in many low-income settings, especially where interventions have not been used or documented to date. Even when the basic technologies of disease control are clear and universally applicable, each local setting poses special problems of logistics, adherence, dosage, delivery, and drug formulation that must be uncovered through operational research at the local level. We recommend that as a normal matter, country-specific projects should allocate at least 5 percent of all resources to project-related operational research in order to examine efficacy, the optimization of treatment protocols, the economics of alternative interventions, and delivery modes and population/patient preferences.

There is also an urgent need for investments in new and improved technologies to fight the killer diseases. Recent advances in genomics, for example, bring us much closer to the long-sought vaccines for malaria and HIV/AIDS, and lifetime protection against TB. The science remains complex, however, and the outcomes unsure. The evidence suggests high social returns to investments in research that are far beyond current levels. Whether or not effective vaccines are produced, new drugs will certainly be needed, given the relentless increase of drug-resistant strains of disease agents. The Commission therefore calls for a significant scaling up of financing for global R&D on the heavy disease burdens of the poor. We draw particular attention to the diseases overwhelmingly concentrated in poor countries. For these diseases, the rich-country markets offer little incentive for R&D to cover the relatively few cases that occur in these rich countries.[8] We also stress the need for research into reproductive health—for example, new microbicides that could block the transmission of HIV/AIDS and improved management of life-threatening obstetric conditions.

We need increased investments in other areas of knowledge as well. Basic and applied scientific research in the biomedical and health sciences in the low-income countries needs to be augmented, in conjunction with increased R&D aimed at specific diseases. The state of epidemiological knowledge—who suffers and dies and of which diseases—must be greatly enhanced, through improved surveillance and reporting systems.[9] In public health, such knowledge is among the most important tools available to successful disease control. Surveillance is also critically needed in the case of many NCDs, including mental health, the impact of violence and accidents, and the rapid rise of tobacco and diet/nutrition-related diseases.

Finally, we need a greatly enhanced system of advising and training throughout the low-income countries, so that the lessons of experience in one country can be mobilized elsewhere. The international diffusion of new knowledge and "best practices" is one of the key forces of scaling up, a central responsibility of organizations such as the World Health Organization and the World Bank, and a goal now more readily achieved through low-cost methods available through the internet.

A war against disease requires not only financial resources, sufficient technology, and political commitment, but also a strategy, operational lines of responsibility, and the capacity to learn along the way. The Commission therefore devoted substantial effort to analyzing the organizational practicalities of a massive, donor-supported scaling up of health interventions in the low-income world. We started by noting the changes that will be needed on the ground within the countries themselves. After all, essential health interventions are delivered in the communities where poor people live. Scaling up must therefore start with the organization of the CTC delivery system at the local level. The role of community involvement, and more generally of mobilization of a broad partnership of public and private sectors and civil society, is crucial here. The CTC system should also be supported by nationwide programs for some major diseases, such as malaria, HIV/AIDS, and TB. Such focused programs have important advantages when properly integrated with community health delivery, by mobilizing communities of expertise not available at the community level, public attention and financing, political energies, and public accountability for specified results.

Since scaling up will require a significant increase in international financing, an effective partnership of donors and recipient countries, based on mutual trust and performance, is essential. In this context, the mechanisms of donor financing must change, a point that has been recognized in the international system in the past 3 years by the creative introduction of a new framework for poverty reduction, often termed the *Poverty Reduction Strategy Paper (PRSP) framework.*[10] The early results of the PRSP process to date are promising, and the Commission endorses this new process.[11] A concerted attack on disease along the lines that we recommend will help to ensure success of this emerging approach to donor–recipient relations. The strengths of the PRSP include: (1) deeper debt cancellation, (2) country leadership in the preparation of the national strategy, (3) explicit incorporation of civil society at each step of the process, (4) a comprehensive approach to poverty reduction, and (5) more

donor coordination in support of country goals. All of these are applicable—indeed vital—to the success of the health initiative proposed here. To achieve the potential benefits of the PRSP framework, donor and recipient countries must specify a sustainable financing scheme and investment plan for the health sector as an integral part of the PRSP scheme for health.

Though we advocate a greatly increased investment in the health sector itself, we stress the need for complementary additional investments in areas with an important impact on poverty alleviation (including effects on health). These include education, water and sanitation, and agricultural improvement. For example, education is a key determinant of health status, as health is of education status. Investments in these various sectors work best when made in combination, a point highlighted by the PRSP process. We did not, however, make cost estimates outside of the health sector.[12]

Within the context of the PRSP, the Commission recommends that each developing country establish a temporary National Commission on Macroeconomics and Health (NCMH), or its equivalent, chaired jointly by the Ministers of Health and Finance and incorporating key representatives of civil society, to organize and lead the task of scaling up.[13] Each NCMH would assess national health priorities, establish a multi-year strategy to extend coverage of essential health services, take account of synergies with other key health producing sectors, and ensure consistency with a sound macroeconomic policy framework. The plan would be predicated upon greatly expanded international grant assistance. The National Commissions would work together with the WHO and World Bank to prepare an epidemiological baseline, quantified operational targets, and a medium-term financing plan. Each Commission should complete its work within two years, by the end of 2003.

We recommend that each country will need to define an overall program of "essential interventions" to be guaranteed universal coverage through public (plus donor) financing. We suggest four main criteria in choosing these essential interventions: (1) they should be technically efficacious and can be delivered successfully; (2) the targeted diseases should impose a heavy burden on society, taking into account individual illness as well as social spillovers (such as epidemics and adverse economic effects); (3) social benefits should exceed costs of the interventions (with benefits including life-years saved and spillovers such as fewer orphans or faster economic growth); and (4) the needs of the poor should be stressed.

We estimate that by 2010 around 8 million lives *per year*, in principle, could be saved—mainly in the low-income countries—by the essential interventions against infectious diseases and nutritional deficiencies recommended here.[14] The CMH estimated the costs of this expanded coverage,[15] including related general costs of system expansion and supervision, for all countries with 1999 GNP per capita below $1,200, plus the remaining handful of countries in sub-Saharan Africa with incomes above $1,200 (see Table A2.B in the full report for the list of countries).[16] Total annual health outlays for this group of countries would rise by $57 billion by 2007 and by $94 billion by 2015 (Table A2.3 in the full report). The countries in the aggregate would commit an additional $35 billion per year by 2007 and $63 billion per year by 2015.[17] The donors, on their part, would contribute grant financing of an additional $22 billion per year by 2007 and $31 billion per year by 2015 (Table A2.6 in the full report).[18] Current official development assistance (ODA) is on the order of $6 billion.[19] Total donor spending, including both country-level programs and the supply of global public goods, would be $27 billion in 2007 and $38 billion in 2015. The increased donor financing for health would be additional to overall current aid flows, since aid should be increased in many areas outside of the health sector as well.

Most of the donor assistance would be directed at the least-developed countries, which need the most grant assistance to extend the coverage of health services. For those countries, total annual health outlays would rise by $17 billion by 2007 and $29 billion by 2015, above the level of 2002. Given the extremely low incomes in these countries, domestic resource mobilization would fall far short of need, however, rising by $4 billion by 2007 and $9 billion by 2015. The gap would be filled by donors, with grant assistance equal to $14 billion per year in 2007 and $21 billion per year in 2015. We also note that, on a regional basis, Africa would receive the largest proportion of donor assistance, a reflection both of Africa's poverty and its high disease prevalence. AIDS prevention and care would account for around half of the total cost of scaling up.[20]

To understand these sums, it is instructive to consider the costs of the health interventions on a per capita basis. We find that, on average, the set of essential interventions costs around $34 per person per year, a very modest sum indeed, especially compared with average per capita health spending in the high-income countries of more than $2,000 per year. The least developed countries can mobilize around $15 per person per year by 2007 (almost 5 percent of per capita income). The gap is therefore $19 per

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person per year. With 750 million people in the least-developed countries in 2007, that comes to around $14 billion. The other low-income countries can mobilize around $32 per person on average (again roughly 5 percent of per capita income). Some of these countries will need donor aid to reach the $34 per person requirement, and others will not. The other low-income countries will have a combined population of around 2 billion in 2007, and when calculated on a country-by-country basis will need roughly $3 per capita on average to close the financing gap, therefore requiring a total level of donor aid of approximately $6 billion. The low-middle-income countries will need an additional $1.5 billion, mainly to cover the high costs of AIDS.

It is important to put the total donor assistance into perspective. Although the required assistance is large relative to current donor assistance in health, it would be only around 0.1 percent of donor GNP, and would leave ample room for significant increases in other areas of donor assistance as needed. We stress that the increased aid for health must be additional to current aid flows, since indeed increased aid will be needed not only in health but also in education, sanitation, water supply, and other areas. Also, although the donor flows look large in relation to current health spending, particularly in the poorest countries, this reflects how little they spend, which in turn reflects their low incomes. This expansion of aid to the health sector needs to be phased over time to ensure that resources are used effectively and honestly, which led us to the time path of increasing coverage shown in Table 7 of the full report, which shows the basis of our costing. Note that the donor assistance will be required for a sustained period of time, perhaps 20 years, but will eventually phase out as countries achieve higher per capita incomes and are thereby increasingly able to cover essential health services out of their own resources.

This program would yield economic benefits vastly greater than its costs. Eight million lives saved from infectious diseases and nutritional deficiencies would translate into a far larger number of *years* of life saved for those affected, as well as a higher quality of life. Economists talk of disability-adjusted life years (DALYs) saved,[21] which add together the increased years of life and the reduced years of living with disabilities. We estimate that approximately 330 million DALYs would be saved for each 8 million deaths prevented. Assuming, conservatively, that each DALY saved gives an economic benefit of 1 year's per capita income of a projected $563 in 2015, the direct economic benefit of saving 330 million

DALYs would be $186 billion per year, and plausibly several times that.[22] Economic growth would also accelerate, and thereby the saved DALYs would help to break the poverty trap that has blocked economic growth in high-mortality low-income countries. This would add tens or hundreds of billions of dollars more per year through increased per capita incomes.

The $27 billion of total grant assistance in 2007 would be devoted to three goals: (1) assistance to low-income countries (and to a few middle-income countries for HIV/AIDS-related expenditures) to help pay for the scaling up of essential interventions and health system development ($22 billion, detailed in Appendix 2); (2) investments in research and development (R&D) devoted to the diseases of the poor ($3 billion); and (3) increased delivery of global public goods by the international institutions charged with coordinating the global effort, including the World Health Organization, the World Bank, and other specialized United Nations agencies ($2 billion). There would also be additional nonconcessional loan assistance for middle-income countries.[23] We believe that if well managed and phased in along the timetable that we recommend, these requisite flows could be absorbed by the developing countries without undue macroeconomic or sectoral destabilization.

These financial targets are a vision of what should be done, rather than a prediction of what will happen. We are all too aware of donor countries that neglect their international obligations despite vast wealth, and of recipient countries that abjure the governance needed to save their own people. Maybe little increased funding will take place; donors might give millions when billions are needed, and impoverished countries will fight wars against people rather than disease, making it impossible for the world community to help. We are not naïve: it is no accident that millions of people—voiceless, powerless, unnoticed by the media—die unnecessarily every year.[24]

The delivery of such large donor financing will require a new *modus operandi*. The Commission strongly supports the establishment of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), which initially will focus on the global response to AIDS, malaria, and TB. We recommend that the GFATM be scaled up to around $8 billion per year by 2007 as part of the overall $22 billion of donor aid to country programs. Given the unique challenge posed by AIDS and its capacity to overturn economic development in Africa and other regions for decades, we believe that the GFATM should support a bold and aggressive program

that focuses on prevention of new infections together with treatment for those already infected. Prevention efforts would aim at achieving a high coverage of prevention programs for highly vulnerable groups including commercial sex workers and injection drug users, and achieving widespread access to treatment of sexually transmitted infections (STIs), voluntary counseling and testing (VCT), and interventions to interrupt mother-to-child transmission. Given the costs and challenges of scaling up treatment, especially using antiretroviral therapy (ART) effectively and without promoting viral resistance to the drugs, scaling up should be carefully monitored, science-based, and subject to intensive operational research. We endorse the estimates of UNAIDS and WHO's ART program that 5 million people can be brought under antiretroviral treatment in low-income settings by the end of 2006.[25]

To help channel the increased R&D outlays, we endorse the establishment of a new Global Health Research Fund (GHRF), with disbursements of around $1.5 billion per year. This fund would support basic and applied biomedical and health sciences research on the health problems affecting the world's poor and on the health systems and policies needed to address them. Another $1.5 billion per year of R&D support should be funded through existing channels. These include the Special Programme for Research and Training in Tropical Diseases (TDR), the Initiative for Vaccine Research (IVR), the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) (all housed at WHO) and the public-private partnerships for AIDS, TB, malaria, and other disease control programs that have recently been established. In both cases, the predictability of increased funding would be vital, as the necessary R&D undertakings are long-term ventures. The existing Global Forum for Health Research could play an important role in the effective allocation of this overall assistance. To support this increased research and development, we strongly advocate the free internet-based dissemination of leading scientific journals, thereby increasing the access of scientists in the low-income countries to a vital scientific research tool.

The public sector cannot bear this burden on its own. The pharmaceutical industry must be a partner in this effort. The corporate principles that have spurred recent and highly laudable programs of drug donations and price discounts need to be generalized to support the scaling up of health interventions in the poor countries. The pharmaceutical industry needs to ensure that low-income countries (and the donors on their behalf) have access to essential medicines at near-production cost (sometimes

termed the *lowest viable commercial price*) rather than the much higher prices that are typical of high-income markets. Industry is ready, in our estimation, for such a commitment, enabling access of the poor to essential medicines, both through differential pricing and licensing their products to generics producers.[26] If industry cooperation is not enough or not forthcoming on a general and reliable basis, the rules of international trade involving access to essential medicines should be applied in a manner that ensures the same results. At the same time, it is vital to ensure that increased access for the poor does not undermine the stimulus to future innovation that derives from the system of intellectual property rights. Private industry outside of the pharmaceutical sector also has a role to play, including by ensuring that their own labor force—the heart of a firm's productivity—has access to the knowledge and medical services that ensure their survival and health. For example, the mining companies of southern Africa, at the epicenter of HIV/AIDS, have a special responsibility to help prevent transmission and to work with government and donors to ensure that their workers have access to care. The main findings of the Commission regarding the links of health and development are summarized in Table 2. An action agenda is summarized in Table 3. Our specific recommendations on increased international donor assistance and domestic financing are summarized in Table 4.

With globalization on trial as never before, the world must succeed in achieving its solemn commitments to reduce poverty and improve health. The resources—human, scientific, and financial—exist to succeed, but now must be mobilized. As the world embarks on a heightened struggle against the evils of terrorism, it is all the more important that the world simultaneously commit itself to sustaining millions of lives through peaceful means as well, using the best of our modern science and technology and the enormous wealth of the rich countries. This would be an effort that would inspire and unite peoples all over the world. We call upon the leaders of the international community—in donor and recipient nations, in international institutions such as the World Bank, the World Health Organization, the World Trade Organization, the Organisation for Economic Co-operation and Development, and the International Monetary Fund, in private enterprise, and in civil society—to seize the opportunities identified in this report. Now, united, the world can initiate and facilitate the global investments in health that can transform the lives and livelihoods of the world's poor.

Table 2. KEY FINDINGS ON THE LINKAGES OF HEALTH AND DEVELOPMENT

1. Health is a priority goal in its own right, as well as a central input into economic development and poverty reduction. The importance of investing in health has been greatly underestimated, not only by analysts but also by developing-country governments and the international donor community. Increased investments in health as outlined in this Report would translate into hundreds of billions of dollars per year of increased income in the low-income countries. There are large social benefits to ensuring high levels of health coverage of the poor, including spillovers to wealthier members of the society.

2. A few health conditions are responsible for a high proportion of the health deficit: HIV/AIDS, malaria, TB, childhood infectious diseases (many of which are preventable by vaccination), maternal and perinatal conditions, tobacco-related illnesses, and micronutrient deficiencies. Effective interventions exist to prevent and treat these conditions. Around 8 million deaths per year from these conditions could be averted by the end of the decade in a well-focused program.

3. The HIV/AIDS pandemic is a distinct and unparalleled catastrophe in its human dimension and its implications for economic development. It therefore requires special consideration. Tried and tested interventions within the health sector are available to address most of the causes of the health deficit, including HIV/AIDS.

4. Investments in reproductive health, including family planning and access to contraceptives, are crucial accompaniments of investments in disease control. The combination of disease control and reproductive health is likely to translate into reduced fertility, greater investments in the health and education of each child, and reduced population growth.

5. The level of health spending in the low-income countries is insufficient to address the health challenges they face. We estimate that minimum financing needs to be around $30 to $40 per person per year to cover essential interventions, including those needed to fight the AIDS pandemic, with much of that sum requiring budgetary rather than private-sector financing. Actual health spending is considerably lower. The least-developed countries average approximately $13 per person per year in total health expenditures, of which budgetary outlays are just $7. The other low-income countries average approximately $24 per capita per year, of which budgetary outlays are $13.

6. Poor countries can increase the domestic resources that they mobilize for the health sector and use those resources more efficiently. Even with more efficient allocation and greater resource mobilization, the levels of funding necessary to cover essential services are far beyond the financial means of many low-income countries, as well as a few middle-income countries with high prevalence of HIV/AIDS.

7. Donor finance will be needed to close the financing gap, in conjunction with best efforts by the recipient countries themselves. We estimate that a worldwide scaling up of health investments for the low-income countries to provide the essential interventions of $30 to 40 per person will require approximately $27 billion per year in donor grants by 2007, compared with around $6 billion per year that is currently provided. This funding should be additional to other donor financing, since increased aid is also needed in other related areas such as education, water, and sanitation.

8. Increased health coverage of the poor would require greater financial investments in specific health sector interventions, as well as a properly structured health delivery system that can reach the poor. The highest priority is to create a service delivery system at the local ("close-to-client") level, complemented by nationwide programs for some major diseases. Successful implementation of such a program requires political and administrative commitment, strengthening of country technical and administrative expertise, substantial strengthening of public management systems, and creation of systems of community accountability. It also requires new approaches to donor/recipient relations.

9. An effective assault on diseases of the poor will also require substantial investments in global public goods, including increased collection and analysis of epidemiological data, surveillance of infectious diseases, and research and development into diseases that are concentrated in poor countries (often, though not exclusively, tropical diseases).

10 Coordinated actions by the pharmaceutical industry, governments of low-income countries, donors, and international agencies are needed to ensure that the world's low-income countries have reliable access to essential medicines.

Table 3. AN ACTION AGENDA FOR INVESTING IN HEALTH FOR ECONOMIC DEVELOPMENT

1. Each low- and middle-income country should establish a temporary National Commission on Macroeconomics and Health (NCMH), or its equivalent, to formulate a long-term program for scaling up essential health interventions as part of their overall framework in their Poverty Reduction Strategy Paper (PRSP). The WHO and the World Bank should assist national Commissions to establish epidemiological baselines, operational targets, and a framework for long-term donor financing. The NCMHs should complete their work by the end of 2003.

2. The financing strategy should envisage an increase of domestic budgetary resources for health of 1 percent of GNP by 2007 and 2 percent of GNP by 2015 (or less, if a smaller increase is sufficient to cover the costs of scaling up, as may be true in some middle-income countries). For low-income countries, this entails an additional budgetary outlay of $23 billion by 2007 and $40 billion by 2015, of which the least-developed countries account for $4 billion by 2007 and $9 billion by 2015 themselves, and the other low-income countries the balance. Countries should also take steps to enhance the efficiency of domestic resource spending, including a better prioritization of health services and the encouragement of community-financing schemes to ensure improved risk pooling for poor households.

3. The international donor community should commit adequate grant resources for low-income countries to ensure universal coverage of essential interventions as well as scaled-up R&D and other public goods. A few middle-income countries will also require grant assistance to meet the financial costs of expanded HIV/AIDS control. According to our estimates, total needs for donor grants will be $27 billion per year in 2007 and $38 billion per year in 2015. In addition, the World Bank and the regional development banks should offer increased nonconcessional loans to middle-income countries aiming to upgrade their health systems. The allocation of donor commitments would be roughly as follows:

	2007	2015
Country-level programs	$22 billion	$31 billion
R&D for diseases of the poor	$3 billion	$4 billion
Provision of other Global Public Goods	$2 billion	$3 billion
Total	$27 billion	$38 billion

The WHO and the World Bank, with a steering committee of donor and recipient countries, should be charged with coordinating and monitoring the resource mobilization process. Implementing this vision of greatly expanded support for health requires donor support for build-up of implementation capacity and for addressing governance or other constraints. Where funds are not used appropriately, however, credibility requires that funding be cut back and used to support capacity building and NGO programs.

4. The international community should establish two new funding mechanisms, with the following approximate scale of annual outlays by 2007: The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), $8 billion; and the Global Health Research Fund (GHRF), $1.5 billion. Additional R&D outlays of $1.5 billion per year should be channeled through existing institutions such as TDR, IVR, and HRP at WHO, as well as the Global Forum for Health Research and various public-private partnerships that are currently aiming toward new drug and vaccine development. Country programs should also direct at least 5 percent of outlays to operational research.

5. The supply of other Global Public Goods (GPGs) should be bolstered through additional financing of relevant international agencies such as the World Health Organization and World Bank by $1 billion per year as of 2007 and $2 billion per year as of 2015. These GPGs include disease surveillance at the international level, data collection and analysis of global health trends (such as burden of disease), analysis and dissemination of international best practices in disease control and health systems, and technical assistance and training.

6. To support private-sector incentives for late-stage drug development, existing "orphan drug legislation" in the high-income countries should be modified to cover diseases of the poor such as the tropical vector-borne diseases. In addition, the GFATM and other donor purchasing entities should establish pre-commitments to purchase new targeted products at commercially viable prices.

7. The international pharmaceutical industry, in cooperation with low-income countries and the WHO, should ensure access of the low-income countries to essential medicines through commitments to provide essential medicines at the lowest viable commercial price in the low-income countries, and to license the production of essential medicines to generics producers as warranted by cost and/or supply conditions, as discussed in detail in the Report.

8. The WTO member governments should ensure sufficient safeguards for the developing countries, and in particular the right of countries that do not produce the relevant pharmaceutical products to invoke compulsory licensing for imports from third-country generics suppliers.

9. The International Monetary Fund and World Bank should work with recipient countries to incorporate the scaling up of health and other poverty-reduction programs into a viable macroeconomic framework.

Table 4. RECOMMENDED DONOR AND COUNTRY COMMITMENTS (billions of constant 2002 US dollars)

	2001 (CMH estimates)	2007	2015
DONOR COMMITMENTS			
Country-level programs:			
Least-Developed Countries	$1.5	$14	$21
Other-Low-Income Countries	$2.0	$6	$8
Middle-Income Countries	$1.5 ODA 0.5 Nonconcessional	$2	$2
of which: Global Fund to Fight AIDS, Tuberculosis, and Malaria	$0	$8	$12
Global Public Goods			
R&D	(<) $0.5	$3	$4
of which: Global Health Research Fund	0	$1.5	$2.5
International Agencies	$1	$2	$3
Total Donor Commitments	$7	$27	$38
DOMESTIC RESOURCES FOR HEALTH			
Least-Developed Countries	$7	$11	$16
Other Low-Income Countries	$43	$62	$74
COUNTRY-LEVEL PROGRAMS IN LOW-INCOME COUNTRIES			
Donor Commitments plus Domestic Resources	$53.5	$93	$119

Note: Recommendations are for annual commitments in a global scaled up program. As stressed throughout the Report, actual disbursements will depend on policy performance within recipient countries.

World Health
Organization
Geneva

A Rejoinder to The Report of the Sachs Commission on Macroeconomics & Health - An Alternative Perspective

N. H. Antia

N. F. Mistry

Foundation for Research in Community Health
Pune

Foundation for Medical Research
Mumbai

December 2002

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Background

The Sachs Report compiled by macroeconomists is based on a firm conviction that all human problems are essentially economic in nature. Hence their solution lies in the realm of Western economics theory and consequently of macroeconomists when it comes to solving them on a world wide scale. Also that the solution, even in a highly personalized and intensely human field like health can only be solved by the use of Western medical science. This argument is advanced, regardless of the entirely different social, cultural, economic conditions and the concepts and practices evolved by older and advanced civilizations based on a far deeper understanding of human beings and health rather than its failure. This is in keeping with the arrogance of the West provided by its newly discovered science which has given it the power to dominate and exploit the rest of the world to satisfy insatiable material needs and greed. This domination was achieved through imperialism in the past and now by enforcing a new economic order under the guise of globalization, liberalization and privatization evolved at Bretton Woods in 1944 which is equally devoid of the morals and ethics of civilized society.

Almost three decades earlier, Ivan Illich had foreseen that Western medicine with its eventual extensions into areas like `food fads' and `body image' parading under the guise of health, would itself become a new hazard to human health while providing a lucrative avenue for the unregulated and uncontrolled market forces of globalized capitalism in an area where consumer resistance is at its lowest. The demand created for the most expensive and lucrative aspects of illness care based on fear of pain and death, or for gratification of sheer vanity is now being assiduously promoted with the help of the new mass media. This has converted illness, under the guise of `health', into the fastest growing business and industry in the world today, while ignoring the more important and humane but non-

profitable preventive, promotive and basic curative aspects.

In a globalized market place dictated by the sole aim of maximizing profit, the prime targets are the affluent societies of the West followed by the co-opted 'Westoxicated' neo-elite of the newly independent countries who have become equally affluent by exploiting their own poor. Though small in proportion, they nevertheless offer a substantial market for the international `health' industry. This is regardless of the distortions it causes to the local health scene with its traditional values, practices and health systems which have sustained the majority of the inhabitants of this planet over the millennia. The last concern is for the poor and their health and well being, which is conveniently relegated to the level of Primary Health Care.

The Sachs Committee has involved the WHO to provide international credibility to a highly Westernized medical and technological approach to what is considered a `health' report. A WHO which has strayed, under the increasing pressure of its western donors, from its original Alma Ata declaration for providing basic health care to all citizens of this world. This holistic concept of 'Health for All' was enunciated by WHO in 1978 under the directorship of Dr. Halfdan Mahler(13) who knew the actual problems of health of the poor in different parts of the world from extensive personal experience.

Hence it is the original Alma Ata Report with its integrated social, political, technical and economic understanding of health that should have provided the guidelines to the Sachs Committee rather than the over-westernized techno-managerial approach of the present WHO which better suits their requirements. WHO is an `international' organization whose senior staff and experts are chiefly from the West. They are supported by equally westernized health professionals, bureaucrats and economists from the `need based' countries in order to provide the necessary international es

flavour to this document. Lured by lucrative emoluments they profess to represent the problems and interests of their countries, including that of the poverty stricken masses from whom they are both physically distanced and culturally alienated.

The major flaw of this Report lies in its blatant 'Westcentricity' which denies all other approaches to the world's health problems. Even worse is its advocacy of a blanket economic and techno-managerial solution restricted to only three select diseases of their choice. It fails to address the vast problems of health as a whole, with no concern for the entirely different social, cultural, political, epidemiologic and economic conditions in different parts of the world which vary between and even within each country. Yet it is these factors with the underlying worldwide poverty, with its social problems and diseases, which have been created by the globalization process which will ultimately determine success or failure even in the implementation of a world wide blanket westernized solution devised in Washington and Geneva restricted to three diseases. Paying mere lip sympathy to these fundamental socio-political factors has no relevance.

Diseases by and large fall into two categories:

a. Communicable diseases chiefly affecting the younger age group as a result of poverty - a socio-political cause.

b. Diseases of affluence which affect the aged rich, eg. the degenerative diseases affecting the physical body and the mental problems affecting all ages.

Western science with its Cartesian bio-mechanical concept of life fails to understand the complexity of the human mind and its interaction with the physical body; leave aside spiritualism with its higher values. And yet this is

the essence of most other systems of health such as ayurveda and yoga which to the West consist merely of an alternative source of non- synthetic remedies or a form of physiotherapy, both of which can also be marketed as another `health' related commodity. The theory and practice of economics divorced from this complex reality of life can hardly be expected to solve what are essentially self-created human and social problems.

The attempt to further narrow the vision of health to western technological solutions for three diseases viz malaria, tuberculosis and AIDS [and of course the inevitable family planning for the `developing (read `need based') countries] can hardly be expected to have any major impact on these problems. This has been demonstrated by the failure of population control programmes even after 50 years of imposing a western techno-managerial solution for an intensely human problem. This only further disturbs the integrated and holistic approach to health and medical care, an approach which is inherent in all other cultures and their health systems as was recognized even by WHO at Alma Ata. This holistic concept of health was soon converted into a series of Specific Primary Health Care programmes for individual diseases based on western medical technology as also for population control under the guise of Family Planning. The Sachs Report utilizing an even narrower approach of the existing WHO, advocates additional inputs of money to help provide a mask of concern to hide the ugly and ruthless face of capitalist greed.

2. Poverty the root cause of diseases

The failure of health as well as medical care is a part of the overall distortion of the process of development of the `need based' countries not only during imperialism but even after their gaining independence. The root cause lies primarily in the realm of poverty created as a result of continued systematic exploitation of the remaining natural resources of these countries, even

after the demise of imperialism, by capitalism guided now by the missile of economics. The report ignores, nay refuses to address itself to this primary question of poverty and its perpetuation under its economic compulsions. It only provides lip sympathy to poverty which is of their own creation.

The Sachs Report takes for granted that the poverty of these countries is now an established phenomenon which should not and cannot be questioned and must be left to the tender mercies of the `trickle down' theory. Nor does it explain why countries endowed with the greatest natural and human resources which produced the great civilizations of the world have also been reduced to poverty. The role of western imperialism, now perpetuated under the banner of economic globalization with its ancillaries of liberalization and privatization is conveniently ignored in this Report as this would open a Pandora's box.

The strategy for cultural and economic recolonization of the world was devised at Bretton Woods in 1944 even before the end of the internecine war fought by the Western powers for each others' colonies. It was for this that the twins, the World Bank the international usurer and The International Monetary Fund (IMF), the enforcers of conditionalities' after inveigling these countries into debt, were conceived. This strategy for redomination of the world and its resources was based on the crudest aspects of human nature namely selfishness and greed, the credo of capitalism. Following the destruction of the USSR (its ally during the war and a country which was able to provide a remarkable health service to all its people even during the subsequent cold war), it was realized that this strategy based on cultural and economic domination would be cheaper and more effective for exploiting the world's resources than crude military imperialism of the past which was to be reserved for the `non- cooperating' nations.

Trading on the pliability of the neo-elite leadership of the newly

independent countries has played a cardinal role in this strategy. Won over by covert and overt bribes and opiated with an affluent western life style, they have reopened the doors of their countries for exploitation by the West. They have participated in imposing a capital intensive export- oriented urban industrialization mode of development in what have traditionally been self sustaining and labour intensive agro-industrial economies; all this in return for a slice of the exported cake. This has also helped to polarize these societies in the capitalist mode.

There is no better example of this than in the field of health. Bribery and corruption are integral elements of this over-Westernized, over-centralized, over-bureaucratized, over-privatized and over-medicalized strategy. This has also facilitated the penetration of multinational corporations in search of profit, devoid of moral or ethical restraints. Having co-opted the medical profession, the pharmaceutical and medical instrumentation industries, which comprise the new medico-industrial complex, is now playing havoc not only in the `need based' countries but have increased the cost of medical care even in the most affluent country like the US to an unsustainable level. Health insurance, a new entrant in this industry has further increased the cost of such services under the guise of controlling costs.

The amoral and unabashed profit oriented western medical system based on providing curative medicine for the rich is now being thrust on the need based' countries as a purchasable commodity · regardless of its appropriateness or relevance. This is not only affecting the affluent class but is gradually percolating to the middle class and now even to the poor to extract even their `last drop of blood'. The symbiosis between capitalism and poverty under imperialism and now under globalization which has polarized the entire world is too well documented to require reiteration.

3. The role of market forces

The effect of this cannibalistic form of `development' is at its worst when such unregulated market forces using mass media have converted human suffering into a major international business and industry regardless of the consequences even on the poor who are now being enticed to spend almost 20% of their meager household expenditure(9) on what may be unnecessary and even dangerous drugs, injections and doctors. In this nefarious trade in human suffering, the rich are dangerously over-investigated, over-medicated and over-surgicalized, the middle class pauperized in imitating their role model, the rich, while the poorest are sought to be decimated either by a new form of population control based on western techno-managerial `fixes' or through affliction with the severest forms of diseases where affordability for cures is impossible. Examples from a state like Kerala which has demonstrated the achievment of good health care through education of its women at far lower cost are almost always ignored or understated.

A human facade is now sought to be provided by the Sachs Committee to this unwholesome strategy after giving full rein to their multinationals as also to the public and private health sectors of these countries. A sum of USD 27 billion is now being sought to be raised from the affluent Western countries for the control of these three diseases of poverty. A hypothetical and questionable economic cost of saving a human life based on disability adjusted life years (DALYS), a solely economic concept of life, is utilized to encourage this form of philanthropy' and charity'. Equally hypothetical projections are made up to 2025 under the assumption that there will be no changes and alternative to the present self created grim scenario.

Even worse is the stipulation that funds will have to be raised by the local governments themselves, by charging fees for services even from those

who have already been pauperized by an exploitative private sector under duress of pain and suffering when all alternatives are denied them. And yet even the richest countries like the US, are not willing to part with even 0.2% leave aside 0.7% of its GDP to gain such `merit'

The Global Health Fund is also proposed to be utilized for research for producing vaccines and `enticing' the pharmaceutical multinationals to produce drugs for these three diseases. Also for employing highly paid western experts as advisors and monitors for these programmes. This will ensure that a substantial part of this `generosity' will be recycled to the donor countries. The political vaccine against poverty which can control if not eradicate these and many other diseases and social problems is not on their agenda.

The people all over the world have lived for millennia in reasonable harmony with each other and with nature in a self sustaining form of economy by evolving social norms for enabling a stable civilized existence by curbing innate human greed and violence. This has been the preaching of all prophets and the wise throughout the ages, which has been propagated by the word; not by the sword. The present problems that face the human race, and its very survival, lie not in economics but in the loss of these well established age old values.

Western science divorced itself from these values when those like Galileo and Copernicus mistook papal dogma and persecution for Christianity not understanding the true values as preached by Christ. This science has therefore alienated itself from its very onset from social and moral values. Macroeconomics based on the values of this science therefore can only pander to selfishness and greed and hence cannot provide solutions to what are basically human and social problems and their associated values.

4. A brief appraisal of the economic aspects of Sachs Report

The Commission talks about the assurance of funds from recipient countries for scaling up health interventions. It examines how budgetary resources can be mobilized for health in low-income countries where income is least transferable to tax collection leave aside savings for a rainy day. The Report assumes firstly that on an average the low income countries must now increase their budgetary outlays on health by 1% GNP and by 2% of GNP by 2005. It further projects that quality health services can be purchased at USD30-45 per person. These estimates refer to a rather minimal health system and service that can attend to the major communicable diseases and maternal and perinatal conditions that account for a significant proportion of the avoidable deaths in low-income countries because it indirectly supports their priority of population control. Nevertheless a recent study undertaken by the IMF suggests that effective health coverage would require 12% of GNP of the low-income countries for reduction in only infant mortality (4).

Donor support from the G-7 nations is only one of the strategies put forward for health finance reform though most advertised. More insidious is the pre-payment community financing programs supported by charging for services hitherto provided free by the public health sector in both urban hospitals and rural PHCs for those reduced to poverty. This is presumably based on the assumption that because of inefficiency together with further charges by the public sector, the public will be willingly driven into the arms of the private sector well known for its profit oriented motive. The term prepaid community financing' is an allegorical reference to the introduction of private insurance schemes in the health sector, encouraged by the incentive of a 1:1 augmentation of this scheme by the national government. Introduction of external insurance will, as experience amply shows, only drive up the cost of health care which will invariably in the current scenario

be both inappropriate and unnecessarily excessive. These are part of the Bretton Woods strategy of capitalism for globalizing, liberalization and privatization for the motive of profit regardless of the consequences to the poor of the world.

A far superior, humane and more cost-effective strategy as utilized by all socialist countries would be the development of local community-based self-sustaining health services utilizing local human and financial resources effectively and augmented by the existing expenditure in the public health sector without need for either an exploitative private sector or health insurance. The cause would be best served if such a community based health system is firmly in place at the grass roots which can cater to a majority of health and illness problems as was in China after its independence. Such a system needs to be supported by inputs in information, education, encouragement, support and guidance of the community, which is unfortunately anathema to capitalist thought.

The Report talks about the costs of essential services, but is silent as to who decides the nature of these services or the guidelines in computing these costs. The Report's contents reflect a self-imposed isolation within the confines of a "Western curative approach" (even neglecting the preventive and promotive aspects) and not utilizing community resources and extensive utilization of their traditional practices and advanced systems of medicine and health care. This needs to be strongly deprecated since it will render entirely inaccurate any computing of the real cost. There is ample evidence that good health and medical care is remarkably cheap if divorced from the profit motive and devoid of unnecessary frills.

A countrywise case study is required not only to see the applicability of the Report's recommendations, but also to define the nature and cost of the essential interventions that are required to suit their own conditions. The

experience of people-based alternatives already documented within many countries needs study as well as their financial and logistic requirements. This is also ignored by this Report.

In order to even embark on some of the above mentioned economic analyses, two factors are as always, incumbent the political will of the country's rulers and the culture of the country's medical establishment both indigenous and of foreign origin.

5. Alternatives for Health

In the field of health, as in most areas of human endeavour, it is far easier and better to start at the micro end of the scale, for all life whether fauna or flora is composed of an aggregate of individual cells which, though specialized interact, coordinate and cooperate to form the ultimate structure of all living matter, including homo sapiens. This is the law of nature.

Health and medical care chiefly concerns the individual, the family and the local community. Nature has also provided all life with a remarkable immune system for self protection as also the means for the healing of wounds. This has ensured our survival long before the advent of modern medicine and surgery. Most societies have also established the need of a healthy diet utilizing locally available foods as also remedies based on locally available herbs and other natural substances. This has been achieved through prolonged observation, experimentation and usage. These have evolved into well established practices and formalized medical systems which by their very nature are also readily accessible at low cost and in harmony with nature. Western science has only added to this incrementally.

While each system has its inherent advantages and strengths, it is

unfortunate that they invariably fail to integrate for the common good. Western medicine is no exception. Unfortunately being the system of the foreign rulers who sought to glorify it as 'superior, it was employed not only for their expatriates but also imposed adhoc on the people they ruled. Unfortunately this also led to ignoring and even denigration of the local practises and systems, most of which had a more holistic understanding of life and health, than merely of disease. A philosophy in keeping with the age old concept of life and living.

Even after India gained Independence, this domination of allopathy with its high profile formalized structure consisting of medical colleges and hospitals has continued to dominate the local health scene. The major reason for its increasing domination has been the result of changing the human mindset including that of the local elite who have been enamoured by its glamorous high-tech and high cost curative aspects while ignoring the far more useful and cost-effective, preventive and promotive and many of its curative aspects. It is this dominant local elite who dictate their country's health policy to suit their beliefs and their newly created western life style and needs and adopt adhoc policies recommended by agencies like the World Bank and WHO especially when accompanied by sweetening grants and funds.

While the excessive promotion of western curative medicine of the wrong type for profit has exponentially increased the cost of medical care, an appropriate integrated use of the best aspects of all systems (including that of allopathy) and even of home remedies, diet, life style, health culture, mental health, traditional practices and spirituality can provide a very effective promotive, preventive as well as curative health care both physical and mental at remarkably low cost in a decentralized manner to all citizens of this world. An integrated approach is becoming increasingly difficult due to increasingly narrow specialization,in contrast to that of the poor majority

for whom it is necessarily so. This has become a part of their age-old culture.

The Rockefeller Report 'Good Health at Low Cost' of 1985 (2) has documented this for China, Costa Rica, Sri Lanka and Kerala. This report demonstrates that the prime requirement for achieving Health for All is the political will as also shown by socialist countries like the USSR, China, Cuba, Nicaragua, Vietnam and Chile (under Dr. Allende). Each of them have developed in their own way an affordable cost-effective and humane health care system accessible to all without the need for voluntary agencies, loans or charity. The commonality of the leadership of all such countries is the desire to provide health for all rather than wealth for a few. The Sachs Reports does not even mention the Rockefeller Report as also the predominance of the political system and its will in achieving real Health for All as demonstrated by the socialist counties.

While the policy decisions on the type and mode of functioning of health and medical services are generally centralized in most political systems, their forms are dependent on the sector through which they are implemented viz. the public, private, voluntary or the peoples sector. In the socialist countries the provision of health and medical care is chiefly through the public sector through in countries like China and Cuba the peoples' sector has played the dominant role.

In the older and more advanced European capitalist countries, the majority of health care is still chiefly through the public sector as also in the fields of education and social welfare. The private sector caters only to a small population of the elite while the voluntary sector plays only a marginal role. This is the result of pressure of an educated public. And yet in the most affluent market oriented capitalist society of the US where the expenditure on health is over 14.5% of its GDP, 15% of its population finds it difficult to

access even basic health and medical care. The majority of their population has to meet its needs for curative medicine through an excessively profit oriented private sector.

Unfortunately in the newly independent countries that have chosen to adopt the US model, under the guise of the representative type of democracy, over 80% of medical care, not only in quantity but even more so in quality, is monopolized by 15% of the population living in affluent urban enclaves by depriving 85% of its population that lives in rural areas or urban slums of even elementary health and medical care. This is in stark contrast to the less affluent socialist economics where appropriate health and medical care are provided to all as a matter of right, not charity.

All this demonstrates that good health and medical care is nowhere as expensive as made out by profit oriented capitalist societies. And yet it is the Report of the Joint Indian Councils of Social Science and Medical Science Research (ICSSR-ICMR) Report of 1981 Health for All : An Alternative Strategy(3) that clearly defines the social, cultural economic and political factors that play the dominant role in determining the health of the entire population in an appropriate and cost effective manner. That this can be best achieved by the people themselves with their own locally trained community health workers with graded support by their own trained functionaries together with a small supportive `Health Centre' providing professional, public health and medical and surgical facilities upto the broad based specialist level.

This has been demonstrated even in various parts of India as well as other newly independent countries like Bangladesh, besides that of China and Cuba on a countrywide scale. This has the inherent advantages of self interest, ready accessibility and accountability, all at low cost in a highly labour intensive field which no distant, unaccountable public sector or profit

oriented private sector can ever hope to achieve. Its most useful components are the preventive and promotive aspects which vary not only from region to region but often from village to village. Such a system has many other advantages like empowering women while providing opportunity for large scale employment within the villages at low cost. Though reflected in the WHO Health Forum(13), it is significantly missing in this Report.

The advent of Panchayati Raj as a constitutionally decentralized form of governance in India now provides both administrative as well as financial authority to local communities to devise and operate various rural development programmes including that of health (8).

The provision of large loans by the Sachs Report for Primary Health Care through an impersonal, over centralized and over bureaucratized public health sector with conditionalities that 40% of the loans be used for constructions, 30% for equipment and 15% for foreign training jaunts to senior doctors can only further corrupt the public sector with its lack of accountability to the people and drive even the poor into the arms of the private sector while increasing their country's indebtedness.

Let us examine how all the three diseases focussed in the Report can lend themselves to such a people based and people operated system if integrated with all other social and economic development activities of the Peoples Sector.

6. Tuberculosis

Tuberculosis has been one of the largest killing and disabling disease in the world for centuries. It's root cause lies in poverty. While the immunocompromised individual suffering from diseases like HIV/AIDS

offers it a ready host, far more people die of tuberculosis today than without HIV/AIDS. Tuberculosis started disappearing from Europe even before the causative organism was identified and it declined/ disappeared even before drugs and vaccines were available for its prevention and/or cure (7). This was a result of modest reduction in the alleviation of poverty due to the 'trickle down' effect of wealth extracted from their colonies.

Resurgence of the disease during the 1939-45 'internecine' war in Europe for each other's colonies and its disappearance within a decade of it termination demonstrates the intimate relationship of this disease with poverty. Cornia et al in 1988 (1) provided compelling evidence of a direct association between reduction in health expenditure and health status in 10 countries where World Bank guided financial reforms had been initiated. Significantly higher morbidities were reported for infectious diseases such as diarrhoea, pneumonia and tuberculosis. The Amsterdam Declaration of 1999 recognizes that TB is linked more strongly with poverty and rapid social change than any other major disease. Ninety eight per cent of annual deaths from TB and 95% of new cases are in the developing countries facing a dual onslaught of HIV-infection and multi-drug resistant tuberculosis (MDR-TB). Rising poverty and the ensuing nutritional deprivation ensures that the action of drugs is less potent and that the disease may well progress to a drug non-responder state. It is worth noting than no great interest was shown in this greatest killer disease till HIV/AIDS came on the scene.

Its present worldwide resurgence in the former colonies is also related to the increase in poverty as a result of the policy of globalization, liberalization and privatization which has not only polarized the world at large but also within each country. It is futile for the World Bank to attempt to control tuberculosis by refusing to address the root cause which is of their own making. The promoting of Direct Observed Therapy Stratgey (DOTS) and

attempts to produce a vaccine is another western techno-managerial approach to a problem (as in family planning) when the solution lies in the social domain namely poverty and lack of education. It is hence bound to fail and only diverts attention of the people from addressing the root cause while providing a facade of concern for the poor.

Even DOTS was designed as a techno-managerial solution based on a few isolated experiences with large medical and financial inputs. This can hardly be expected to succeed when implemented through the same public and private and voluntary health sectors which have failed to achieve results in most vertical programmes. These programmes like Family Planning (population control) can only further corrupt and distort both these sectors who will be ultimately blamed and further large loans provided to increase the country's indebtedness. Mere biomedical technical inputs such as early diagnosis, or drug sensitivity testing or identification of contacts cannot by themselves affect transmission of diseases precipitated by socio-economic malaise. Sensitivity of diagnostic tests in India is less than about 25% both in the public and private sectors and claims indicate that 30% of patients (probably comprising of problematic cases) are turned away from treatment centers by virtue of their place of residence or disease complications or previous history of refractoriness to anti-TB drugs (5). In any event such patients will shop for alternative treatment, face several episodes of disease and eventually die. Even if on the other hand second line treatment is provided for refractory patients, its efficacy will not exceed 50%, all this at a cost of Rs.2,00,000/- per patient besides additional loss of time and wages(11). Mismanagement in use of anti-microbials in India through self prescribing over-counter sales and medical malpractice will further ensure that primary resistance to even second line drugs will inevitably occur. The multinational pharmaceutical industry under the umbrella of the West are the major culprits for such unethical drug promotion.

Even worse is the evolving of a world economic culture which polarizes the newly independent countries, increases poverty on one hand and denies appropriate treatment to those afflicted by its consequences, (eg. second line treatment for MDR-TB).

The present approach is based on the presumption that people have no interest in themselves and cannot be trusted to implement such programmes for their own welfare. Yet local village health workers (women catering to their own neighbourhood as an extended family) have repeatedly demonstrated far better results for most health and medical as well as social problems. Early suspicion based on the cardinal symptoms, especially when they know the local index case, can help them to get the disease confirmed by sputum examination at their own Community Health Centre. This would also assure regularity of treatment far better than more highly paid formal government and private sector functionaries. Local concern for fellow beings which also protects their own family is a far better incentive at much lower cost than a distant government paramedic or primary health care or a profit oriented private doctor. Such a part time locally resident functionary can simultaneously undertake several other health and also non health functions if encouraged and supported.

The decision for such a decentralized people based system cannot be conceived by western experts of WHO or the World Bank nor by centralized public or the private sectors of countries who have vested interest in maintaining the status quo.

This can only be achieved by the people themselves who seek an order which serves their own interest. The prevention and control of such diseases and problems has been demonstrated repeatedly by almost all socialist regimes (before they too get bureaucratized and centralized) as also on a smaller scale even in countries like India. Education, awareness and eternal vigilance is the price for self improvement and safety which can be best achieved under decentralized people based Panchayati Raj.

7. HIV-AIDS

The acquired immuno deficiency syndrome (AIDS) a condition of progressive ill health, is the end stage of infection in the human immunodeficiency virus (HIV). Occupying the centre stage as a significant global public health problem, its original presence in healthy homosexual men in Los Angeles & New York in 1981 belies the much proclaimed scientific claim of the African Green Monkey as the origin of HIV. Rather its appearance is coincidental with the scientific era of the development of primitive, ill understood and poorly regulated genomics in the West.

The diversity of HIV spread throughout populations and countries is striking with prevalences ranging from 10% (Sub-Saharan Africa to less than 1% (India - 0.8%). Even in the low prevalence countries, the infection insidiously creeps from high risk groups into the normal population. The Sub-Saharan Africa region may display spread through high sexual promiscuity but it is also a region where wars, famines and poverty have taken a heavy toll in the last fifty years. The perceived value of life in regions such as these (representative of many areas that exist even in India) is so cheap that sanctimonious efforts at control such as limiting sexual partners or use of condoms are poorly valued. Several studies demonstrate that where death is no stranger and sometimes even a welcome guest, one harbinger is as good as another(6).

The engendering of such fatalistic viewpoints are favourable when accession to cure or even simply care is severely limited. The current 'cure' expenditure per day of singie and now multidrug therapy ranges from $40 - $300, a sum whose even minimal limit is out of bounds for a great majority of the AIDS sufferers. The accessibility to drugs (or vaccines) however advanced or effective will remain an insurmountable problem unless issues of affordability and accessibility are also simultaneously addressed. Whilst exaggerated expectations and the inherently difficult process of developing and testing a vaccine in poorer countries renders this approach almost impractical, the concerted rush by private (and public) industries/organizations of the richer nations to test out several vaccine

candidates in various parts of the world represents an intrinsic danger to the people of several countries where ethical norms of testing are often non-existent or flaunted.

Accepting the increasing gravity of the spread of AIDS does not preclude the questioning of the orchestrated hysteria whipped up by governments, mass media, World Bank, WHO and the technology business complex. In countries where weak surveillance systems exist, the overall prevalence of HIV infections is often computed from extremely limited sample surveys by national agencies. The recent challenge to national prevalence figures of 4 million in India by The Central Intelligence Agency of the USA (quoting 8 million) is surprising on two counts. Firstly, the Agency claims to have obtained its figures from Indian NGOs - a fact hitherto unknown and secondly the keen interest of a foreign (covert) security agency in the disease profile of another country now and in the distant future.

The increasing projections of AIDS cases in India by 2015 (25 million) and elsewhere ignores recent findings of a) the reversibility of HIV positivity b) the increasing proportion of long-term non-progressors (from HIV positivity to AIDS) for over 25 years. Both of these are indicators of the development of herd immunity which invariably develops in the natural course of history of most infections.

The race to produce ever increasing amounts of drugs, vaccines and even condoms are fatal attractions in the presence of the megabucks that are being pledged to AIDS control. More so because they prevent the questioning of an insane form of foisted development that renders vast masses of people, nomads -- be they refugees, unemployed youth turned drug pushers, truck drivers or migrant labour far away from their own homes.

The containing of the HIV/AIDS epidemic in the country of its origin, through education and awareness institutes should be a sobering lesson. Why have not conditionalities been imposed by financial organizations on recipient countries to promote Education for All and resources (not loans)

provided for a subject that not only deserves attention on its own merit but also confers benefits to many other fields which would also ensure self-sustaining economics for all.

The spread of this disease in the countries forced into urban industrialization to produce goods for the globalized elite is a major cause of the spread of AIDS by destroying their traditional small-scale village based agro industrial form of development sustained over the millennia.

Malaria

As stated previously there is no better example of the control of this disease on a countrywide scale by mobilizing the local population with their inherent self interest, social skills and local knowledge as was demonstrated on a country wide scale in India after gaining independence. The clinical suspicion and even diagnosis of this disease is remarkably simple, as also its treatment after confirmation by simple microscopic examination of a finger prick smear of blood and medication with chloroquine followed by primaquine. All this can be undertaken by training health workers from within the local community.

Even more important is their ability to mobilize the local community to control mosquito breeding and spraying of the houses with insecticide. The role of the medical profession is to train, mobilize and support the local population; and not converting it into a distant bureaucratic vertical governmental exercise. All this under the guidance and support of the local community and its non political leaders.

The malaria control programme in India using such a grassroots approach had remarkable success with morbidity figures in 1965 touching 0.1 million cases and no deaths. Thereafter the incidence started rising and reached a record figure of 6.4 million cases in 1976. Subsequent to the introduction of a modified plan of control the figure came down to 2 million cases since when the incidence has been static. While the failure to eradicate the disease is linked to chloroquine resistance and increase of the falciparum

type of infection, the severity of the disease is also clearly linked to immunocompromised populations and vulnerable groups such as children and pregnant women (10). Ironically in 1992 a massive 40% reduction in the national malaria programme was inflicted as a part of the Structural Adjustment Programme of the World Bank (12).

Furthermore malaria control is intrinsically linked with overall social, economic and political development. No amount of external financial inputs into the same vertical government programme which has failed to deliver the goods and take cognizance of the potential of local community action can ever hope to succeed on its own. Nor can scientific inputs like vaccines or bed nets be sole remedies for a disease which lends itself best to the local community's own effort. Even these technologies can to a major extent be utilized by the local community.

Scientific and financial inputs can help to a limited extent if they can reach the local community; not through a leaky pipe line controlled by vested interests at every level. Two larger issues also need consideration - the rapid emergence of drug resistance of malarial parasites both to pyrethroid impregnation of bed nets and to newer drugs such as mefloquine to whom resistance has been seen to develop within one year of its use as in Thailand.

As a precedent, the international vaccine initiative has proportioned only 17% for strengthening health systems whereas 83% has been for research and production of vaccines. In view of the problem of drug resistance, new drugs and vaccines will also place new demands on weak health systems. Seemingly minor changes such as transition of anti malarial first line treatment from chloroquine to sulphadoxine can take years to achieve or extensive replanning and evaluation may be required. High value products in the hands of unethical health workers of the public sector are also likely to leak into uncontrolled private sector channels.

9. Conclusion

A brief glance through the Reference Section of the Sachs Report reveals no or minimal documentation by researchers from those parts of the world which the Report intends to serve. It is therefore no surprise that the basic premise of the Report stems from a purely occidental viewpoint of diseases driving the wheel of poverty. The report fails right at the onset in identifying poverty as the driving force for all disease. It extends its failure further by assuming that an imposed economic solution on the poor nations of the world will singly wish away disease and ill health without realizing that most aspects of illness and health care are chiefly the concern of individuals, their families and the local community who to a defined limit can be given the appropriate knowledge and skills for their own action in an appropriate social and political milieu. Traditionally too the poorer countries mostly representing the ancient civilizations, perceive strong linkages between nature and health and recognize the strong body-mind relationships which can be bonded better through spiritual and moral values. These little traditions therefore have strong abilities to modulate a blind acceptance or conformism to scientific and technological solutions that are thrust on them.

The Report is undoubtedly a part of the hegemony of a monoculture being imposed on the world. Its ancestry is derived from the Breeton Woods (of which the WHO is also a part) credo of a global capture of markets. Its agenda of health is a part of the monoculture since an excess of science and technology has rendered it market-driven and vulnerable to exploitation since therein consumer resistance is also at its lowest. The Report does make a fleeting reference to the common problems of corruption, nepotism and the struggle between the haves and have nots in the poorer countries. Yet it hardly draws these severe difficulties into its analyses. The USD 27 billion which the Report pledges for health can therefore in the existing scenario only create corruption in the leadership and distortion of priorities and resources in the poorer countries. By relegating essential health services to a vague definition and by stressing on pre-paid community financing, (? a pseudonym for insurance) for accessing the same, it encourages the relinquishing of responsibility of

national governments and the assuming of a dominant role of the private sector. Whilst the voluntary sector is a part of the public private partnerships, no role has been assigned for a decentralized people's sector which has the potential for dealing with 70% of preventive, promotive and curative aspects of health and illness care at the grassroots level (2,8).

The health structure envisaged in the Report, coming as it is from a neoliberal economic background differs strikingly from the health care systems of the former socialist bloc and even the United Kingdom where governments took direct responsibility for all aspects of peoples' health and human welfare. The need for a voluntary sector, was obviated, the private sector, if any, well-regulated and self monitored and health (along with education) perceived as an inherent right. The expansion of the pharmaceutical, medical instrumentation and vaccine industries even in such politically committed countries has driven the cost of health care exceedingly high and substantially weakened their economies as well as the quality of their health care. The sole emphasis on commodity-based control measures of drugs, vaccines, condoms etc as a scientific fiat on diseases focussed on in this Report will undoubtedly benefit the pharmaceutical industry and the research centres of the West.

The WHO who should have been the chief guiding light of this Report has lost its independence and become an appendage of the multinational pharmaceutical and health industry. It has shelved the original concept of integrated health as stated in its Alma Ata declaration and now marches to a different tune. Starved of funds by the affluent countries, it can only raise USD 1.4 billion from government contributions towards a partial fulfillment of its annual budget of USD2.3 billion (3a). How it meets the rest of its requirements is a prudent question.

There is ample evidence which shows that good health care using all systems of medicine and devoid of the profit motive and frills is extraordinarily cost-effective. The Report excludes the mention and the analysis of these examples perhaps since they may pose strong opposition to the Report's aims. Almost all countries can provide health care within ged

their existing finances and budgets without need for external loans and exploitation and disruption provided in the guise of support. Choosing a health system and embarking on a biomedical research agenda that suits best its own local conditions and culture is the sovereign right of all national governments and more so their peoples' -- but do the people even know of how these rights are infringed and by whom.

Compassion is a far more suitable alternative to good health care than is economics. Nevertheless in the neoliberal era, economics and compassion make ill bed fellows.

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Foundation for Research in Community Health

3-4, Trimiti-B Apartments, 85, Anand Park, Aundh, Pune - 411007.

Phone : 91-020 588 7020 Fax : 91-020 588 1308

Email : frchpune@giaspn01.vsnl.net.in

Foundation for Medical Research

84-A, R. G. Thadani Marg, Worli, Mumbai - 400 018.

Phone : 91-22-2493 4989 Fax : 91-22-2493 2876

Email : frchbom@bom2.vsnl.net.in