



MACROECONOMICS AND HEALTH: AN UPDATE

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World Health Organization



MACROECONOMICS AND HEALTH

INTRODUCTION

Since the release of the Report of the Commission on Macroeconomics and Health (CMH) in 2001, several countries have evaluated the recommendations in light of their unique country health and socioeconomic contexts and have embarked on steps to implement policies that would secure health as an essential component of development planning. Countries are approaching the work as a vehicle to assert national health priorities and as another input into reaching the Millennium Development Goals through strategic social sector and economic policy.

A central theme to the follow-up work to the CMH Report as coordinated by WHO is to maintain a country-driven process, with countries assessing their individual situations in order to best develop and implement a long-term Health Investment Plan. Since almost every country has ongoing programmes and mechanisms to reach a variety of health and development goals, the approach taken by each country reflects the programmatic and financial resources (both budgetary and extra-budgetary) at their disposal to integrate development strategies with health priorities. This paper provides a summary of the achievements of countries thus far as they have begun to implement the recommendations of the CMH and describes the early processes and inputs into existing poverty reduction programmes and other national development strategies. This will include a description of country priorities and mechanisms by which pro-poor public policies have been developed, contributing to socioeconomic stability and economic growth.

BACKGROUND

The necessity of integrating health across sectors to create a viable development strategy was established by the findings of the CMH (December 2001). The Commission emphasised the central role of health in securing economic development, identifying the poorest populations as disproportionately affected by disease and the financial hardships caused by disease. The Report concluded that low- and middle-income countries must increase resource allocations to health, and high-income countries must increase their contribution to health in poor countries within a development framework. Equally important to increased health expenditures, the Commission recommended that countries examine their health systems and institutions to identify inefficiencies and limits to the capacity to absorb additional funds and to elucidate the inequities of health provision to the poor.

In parallel, WHO has stressed that Health for All and Primary Health Care (PHC) strategies cannot be successfully implemented without placing them within each country's socioeconomic context. The result is the emergence of an international consensus: socioeconomic growth and development can be achieved only by rigorously promoting the implementation of pro-poor health policies within a developmental framework and financed through a massive scaling up of health investments.

Though health is accepted as an important goal of economic growth and development, economic development alone has not brought about the achievement of national and global health goals. The World Bank reports that though countries are spending one third of their budgets in the health and education sectors, the benefits are primarily experienced by the rich, not the poor (World Development Report, 2004). Several reasons are cited as to why public services are falling short, including the failure of funds to reach the peripheral service delivery level, weak incentives at the local level, and also lack of demand by the poor due to financial, logistical, cultural and educational barriers to access.

Over the last decade, several reports have supported a concerted international effort for scaling up essential interventions for health promotion, disease prevention, treatment, and risk-factor reduction through a coordinated sectorwide approach (World Development Report, 2003; World Health Report, 1999 and 2002). It is widely accepted that a range of interventions exist that, if efficiently and systematically applied, could reduce the burden of disease of the poor.

The CMH Report called for health investments to be placed centrally in countries' development agendas through long-term macroeconomic policies, highlighting the links between health investment and poverty reduction. CMH Working Group 1 states that this "new thinking – that health enhances economic growth - supplements and, to a degree, realigns ideas of the justifications of spending on health, justifications that are based on humanitarian and equity arguments".

THE WORK THUS FAR

In June 2002, the 1st Consultation on National Responses to the Report of the Commission on Macroeconomics and Health (CMH) was convened in Geneva. Representatives from ministries of health, finance and planning from 20 countries came together to translate the recommendations of the CMH Report into concrete actions at the country level towards achieving the Millennium Development Goals (MDGs). The Consultation positioned WHO, inter alia, to support these efforts in countries and to provide opportunities for periodic consultations on the impact of the Macroeconomics and Health (MH) process.

WHO has responded by establishing a Coordination of Macroeconomics and Health (CMH) Support Unit that assists interested countries to analyse their health policies and create fiscally sound strategies. The Support Unit works with WHO and its partners to:

- 1) help align macroeconomic growth goals towards reducing poverty and improving the health outcomes of vulnerable groups; and
- 2) support the aims of sustainable growth and development by integrating MH into PRSPs, achievement of MDGs and other national development agendas.

A series of Consultations at the regional level provided countries the forum to share approaches and successes in the MH process. The 2nd Consultation on Macroeconomics and Health, "Increasing Investments in Health Outcomes for the Poor" (October 2003, Geneva), furthered the momentum of the countries. Discussion among ministers of health, planning, and finance, bilateral and multilateral partners, and financing institutions contributed to further focus MH work on improving access to health care and on innovative solutions to address the obstacles that hinder efficient use of financial resources. As expressed in the meeting declaration (see *Annex 2*), countries identified resource mobilization options, human resource constraints, and the harmonization of donor funding as key issues.

In the two years since the CMH Report was published, approximately 40 countries have taken steps to act on its recommendations with ongoing support by all levels of WHO. The work has been driven by three overarching themes:

- Develop a multisectoral investment plan to improve health outcomes, especially among poor people;
- Strengthen commitments to increased financial investments in the health plan to achieve MDGs and other national goals; and
- Determine how to minimize non-financial constraints to the absorption of greater investments by increasing efficiency and effectiveness.

Given the diversity of health, economic and social situations, efforts to place health in the macroeconomics context must accommodate the health priorities, opportunities and obstacles unique to each country. Specifically, governments are assessing their health priorities and evaluating the cost of providing necessary interventions to the poor, in light of the financing mechanisms available internally and externally and the constraints experienced within the system. Substantial progress is being achieved in many countries that have initiated the CMH follow-up work, which includes advocating for the central role of health in sustainable development, establishing alliances and developing focused economic analyses. The work has demanded a multi-sectoral approach. Implementation must take into account the cross-sectoral interaction of risk factors for disease. Without the complementary improvement of other sectors such as education, water and sanitation, and environment, countries will be unable to optimize investments in health or achieve national health objectives.

In summary, countries have built on existing mechanisms for health investment and policy and systems reform and have used the macroeconomics process to make these activities more central to poverty reduction and economic growth. During the process of developing a long-term Health Investment Plan, several key opportunities and outcomes have emerged within the countries:

- A process to identify and promote country health priorities and health-related MDGs
- The establishment of a cross-sectoral mechanism to further promote priorities and to negotiate and collaborate with bilateral and multilateral partners and donors
- A move to directed evaluations of health financing and resource mobilization options specific to the country social and economic context
- A vehicle to insert health more strongly into PRSPs and other poverty reduction instruments.

HOW COUNTRIES ARE MOVING FORWARD

1. Focus of WHO's Macroeconomics and Health support

Though cost-effective prevention and treatment tools are available for controlling major diseases (e.g. TB, HIV/AIDS, and malaria), insufficient resources, coupled with a diverse range of systemic constraints, continue to obstruct national efforts to reach the poor. WHO supports governments' leading role in the development of pro-poor investments and policies for health to help achieve national targets and the MDGs using the findings of the CMH as a starting point. Substantial progress is occurring in those countries that have initiated CMH follow-up work. This includes promotion of pro-poor strategies, expansion of developmental alliances across sectors and instigation of new research and analysis.

The CMH Report highlights the destructive impact of HIV/AIDS as a unique challenge to growth and poverty reduction. AIDS significantly lowers economic growth and drives more families into deepening poverty, whilst causing great suffering and loss of life. There is a growing disruption to the economic and social fabric that has increased the risk of political and community instability, particularly in low-income countries. The WHO and UNAIDS global initiative ('3 by 5') seeks to provide life-long antiretroviral treatment to 3 million people living with HIV/AIDS in poor countries by the end of 2005. Core principles include urgency, equity and sustainability, and a concerted and sustained action by many partners. MH's integrative approach helps place the response to such socially and economically devastating diseases into a broader context of pro-poor health policy and development. For example, HIV/AIDS initiatives and programmes need to be a part of long-term government socioeconomic reforms, especially concerning the poor, and part of the government's overall health investment plan.

Leveraging the opportunities presented by other sustainable development mechanisms (e.g. Poverty Reduction Strategy Papers and Medium Term Expenditure Frameworks), governments are assisted in building domestic macroeconomic and public sector modelling capacity so they can implement an investment plan for health. As countries attract additional sources of funds, the MH process builds institutional capacity to effectively absorb increased funds and strengthen primary health care. The aim is to extensively increase access by the poor and disadvantaged to essential and cost-effective health interventions, greatly improve health outcomes and contribute to sustainable socioeconomic growth.

Over 40 countries have expressed interest in adapting the CMH Report's findings to their growth and development agendas. The initial focus is to strengthen a country's ability to carry out sound macroeconomic analysis so as to develop evidence-based and equitable health policies. Several countries are designing national Health Investment Plans that scale up cost-effective interventions while addressing the multi-sectoral determinants of health.

2. Relationship to the Poverty Reduction Strategy Papers

The Poverty Reduction Strategy Papers (PRSPs) are broadly based upon the World Bank's Comprehensive Development Framework (CDF) and the Monterrey Consensus¹. PRSPs encompass five core principles: 1) country-driven, 2) pro-poor and results-oriented, 3) a multisectoral approach, 4) partnership-oriented, 5) sustainable. These match the spirit and thrust of the MH process, which is country-initiated and -directed, based on three themes arising from the CMH Report:

1. Give priority to multisectoral, pro-poor strategies that make health central to sustainable development agendas;
2. Strengthen commitment of all partners to increase significantly the resources invested to improving health outcomes;

¹ The International Conference on Financing for Development, held 18-22 March 2002 in Monterrey, Mexico, formally adopted the Outcome Document (the "Monterrey Consensus"). Developed, developing and transition economy countries pledged to undertake important actions in domestic, international and systemic policy matters.

3. Progressively eliminate non-financial constraints by increasing equity, efficiency and effectiveness of health-related interventions.

The MH approach augments PRSPs by placing health at the centre of development agendas and by identifying and addressing constraints to equitable access. A unique feature of the multi-stakeholder national MH mechanism is that it helps ensure increased investments are coupled with a pro-poor rationale to guide resource allocation and priority setting. Momentum is sustained through regional and country CMH focal points, utilizing a growing network of WHO partners including academia and civil society.

As the recent WHO survey on PRSPs has documented (WHO/HDP/PRSP/04.1), the health component of national strategies to reduce poverty and catalyse sustainable development lack an explicit implementation strategy that targets the poor. PRSP indicators are national aggregates and are often vaguely worded (e.g. "strengthen the capacity of district health workers"). Moreover, PRSPs frequently are additive compilations of sectoral plans, without any systematic way of rationalizing objectives, sequencing reforms and planning for financial sustainability. WHO adds value to the PRSP process, using the findings of the CMH Report, by helping countries craft a health strategy that significantly improves health outcomes, especially for the poor and marginalized segments of the population.

The CMH Report offers an analytical framework that, when used to assess the health components of the PRSP, can provide specific guidance on how to ensure the poor are clearly targeted and truly benefit from the strategies proposed. First, it helps to make a convincing argument to donors and senior political leaders for significantly increased funds for health (both through internal reallocations and by use of external grants). Second, the process uses a cross-sectoral approach to identify and progressively remove systemic barriers to more effective and equitable delivery of health services. Third, by emphasizing that resources should be allocated to preventive and primary health care before curative and tertiary strategies, the CMH Report helps countries put in place concrete steps to achieve the health-related MDGs.

Sixteen countries (Table 1) have both the MH process and PRSPs. In these countries, a MH approach helps focus partners on the need to place health centrally in development, operationalizing the health elements of the PRSP. In addition, the national MH mechanism strengthens high-level dialogues via regular inter-ministerial discussions that are inclusive of civil society and other stakeholders. Nine countries and one sub-regional grouping (CARICOM) do not have a PRSP process. Here the MH process initiates a high-level dialogue similar to that developed by the PRSP. The aim is to generate commitment to a sustainable approach to growth and development, which holds that improved health outcomes are a prerequisite for socioeconomic advancement.

Table 1: Annex: CMH countries with PRSP and HIPC

Region	Country	HIPC Y = Yes	PRSP/ I-PRSP Y = Yes	WB Category ^{2,3}	Indebtedness ⁴
AFRO	Congo, Rep of	Y		LIC	SI
AFRO	Ethiopia	Y	Y	LIC	SI
AFRO	Ghana	Y	Y	LIC	MI
AFRO	Kenya	Y	Y	LIC	MI
AFRO	Malawi	Y	Y	LIC	SI
AFRO	Mozambique	Y	Y	LIC	LI
AFRO	Nigeria			LIC	SI
AFRO	Rwanda	Y	Y	LIC	SI
AFRO	Senegal	Y	Y	LIC	MI
AMRO	Caribbean Community ⁵			varies	varies
AMRO	Mexico			UMC	LI
EMRO	Djibouti		Y	LMC	LI
EMRO	Iran			LMC	LI
EMRO	Jordan			LMC	SI
EMRO	Pakistan		Y	LIC	SI
EMRO	Sudan	Y		LIC	SI
EMRO	Yemen	Y	Y	LIC	LI
EURO	Azerbaijan		Y	LIC	LI
EURO	Estonia			UMC	MI
SEARO	Bangladesh		Y	LIC	LI
SEARO	India			LIC	LI
SEARO	Indonesia		Y	LIC	SI
SEARO	Nepal		Y	LIC	LI
SEARO	Sri Lanka		Y	LMC	LI
WPRO	Cambodia		Y	LIC	MI
WPRO	China			LMC	LI
WPRO	Lao PDR	Y	Y	LI	SI
WPRO	Mongolia		Y	LI	MI
WPRO	Papua NG			LI	MI
WPRO	Philippines			LMI	MI
Abbreviations:					
		LIC	Low Income Country	LI	Less Indebted
		LMC	Low Middle Income Country	MI	Moderately Indebted
		UMC	Upper Middle Income Country	SI	Severely Indebted

² Source: World Bank list of economies (July 2003).

³ World Bank *income group*: Economies are divided according to 2002 GNI per capita, calculated using the World Bank Atlas method. The groups are: low income, \$735 or less; lower middle income, \$736 - \$2,935; upper middle income, \$2,936 - \$9,075; and high income, \$9,076 or more.

⁴ World Bank *indebtedness*: Severely indebted means either of the two key ratios is above critical levels: present value of debt service to GNI (80 %) and present value of debt service to exports (220 %). Moderately indebted means either of the two key ratios exceeds 60 % of, but does not reach, the critical levels. For economies that do not report detailed debt statistics to the World Bank Debtor Reporting System (DRS), present-value calculation is not possible. Instead, the following methodology is used to classify the non-DRS economies. Severely indebted means three of four key ratios (averaged over 1999-2001) are above critical levels: debt to GNI (50 %); debt to exports (275 %); debt service to exports (30 %); and interest to exports (20 %). Moderately indebted means 3 of the 4 key ratios exceed 60 % of, but do not reach, the critical levels. All other classified low- and middle-income economies are listed as less indebted.

⁵ Caribbean Community sub-region States comprise 15 members including the former Commonwealth Caribbean, Suriname and Haiti.

3. Relationship to the Millennium Development Goals (MDGs)

The MDGs were endorsed by 147 heads of state in September 2001 at the UN Millennium Summit. At the "High-level Forum on the Health Millennium Development Goals" (Jan 2004) held in Geneva by WHO and the World Bank, it was stated that developing countries will not be able to achieve the health and nutrition MDGs "unless extraordinary actions are taken to improve the coverage and quality of health and nutrition services." During the summit, the experiences of Uganda and Tanzania were reviewed. A key finding was that the "lack of a holistic cross-sectoral view on priority interventions that improve health" significantly weakens planning to achieve health MDGs. And while the PRSPs do address various sectors, the approach is often more additive than integrative, with various sectoral activities lumped together without first undertaking a holistic assessment of overall national priorities and the effectiveness of current expenditures.

The MH process encourages a cross-sectoral dialogue to increase governments' and partners' awareness that a multisectoral analysis is needed to develop a sustainable and comprehensive approach to growth and poverty alleviation. MH research, analysing all factors influencing domestic health outcomes, can be used to redefine narrow sectoral priorities and strategies within a true multisectoral framework. The participatory MH process also helps garner the political commitment to institute an integrative approach to making resource allocations, helping to ensure that primary health care interventions of proven value are adequately funded.

One Cambodian expert described the relationship in this manner: "While the MDG targets for international development efforts over the next 15 or so years have been fixed, the CMH begins to construct the pathway towards attaining these goals."

4. Linkages and harmonization

Countries need regular and coherent dialogue with donors on what technical and financial support is essential, and how to best match delivery of both to the real absorptive capacity of countries. The MH process, by focusing on harmonization, creates a dialogue amongst major stakeholders as to how they can move from earmarked funding and discrete projects to allocating funds against comprehensive planning and expenditure frameworks, track progress against an agreed set of outcome indicators, and consolidate implementation procedures.

Further, donors and external agents are encouraged to pay more attention to the recurrent costs of investment programmes and to human resource needs. In several countries where the PRSP has been assessed, it was found that too many capital investments are included without adequate sustainability planning. Donor earmarking compounds the problem, since donor priorities end up determining distribution of resources, staff priorities and management time, rather than PRSP implementation being based upon a comprehensive and holistic method to reducing poverty.

To counter this fragmented approach, the MH process advocates for a national coordinating mechanism that could convene high-level representatives from government, NGOs, bilaterals and civil society to assess progress towards improved health outcomes for the poor. It would centre attention on the development of a comprehensive framework for planning and for financing, one that spans the various sectoral plans contained in national poverty reduction efforts, such as the PRSPs. Its purpose would be threefold:

- a) To advocate for donors to move from earmarked funding of discrete projects and vertical programmes to allocating funds against a comprehensive expenditure framework;
- b) To reduce transaction and administrative costs by harmonizing and streamlining implementation procedures;
- c) To track and evaluate progress against a common set of process and outcome indicators.

5. The process of MH at the country level

Support from WHO/HQ

Macroeconomics and Health is a country-initiated and -directed process. After analysing its needs, the government, with facilitation by WHO, compiles the necessary evidence base to mobilize partners and create political support. The resulting high-level political commitment culminates in the development and full implementation of a Health Investment Plan integral to ongoing poverty reduction strategies for sustainable development.

Country requirements are being met by the WHO's mobilization of organizational and partner resources. WHO helps countries access technical support so they can develop an evidence-based investment plan that garners cross-sectoral backing. An important element is the national coordinating mechanism, whether new or added to an existing high-level body, which encourages a pro-poor approach to health policy development. WHO also has a unique integrative role, using its established country-level relationships with partners, NGOs, and donors to place health investment plans within existing development agendas. The outcome is to strengthen and sustain political support and commitment, improve the predictability of donor financing, and develop *and implement* an investment plan to achieve national development goals.

Added value of regional support

The WHO regional offices leverage their close relationships with countries to disseminate the findings of the CMH Report and catalyse a Macroeconomics and Health strategic planning process. Regions identify local and international technical resources and collaborate with HQ to mobilize funds needed to sustain country activities.

African, Eastern Mediterranean and South-East Asian offices incorporated the CMH findings into their regional developmental strategies. AFRO and EMRO have regional concept papers that outline the local relevance and impact of MH and provide a framework for collaborative opportunities with HQ at the country level. EMRO and AFRO operationalized the process via regional workplans containing specific targets for advocacy, policy development and technical products as well as the necessary actions to reach these objectives.

EMRO organized a successful regional consultation in June 2003, while AFRO held a similar meeting in early August 2003. SEARO's meeting occurred on 18-19 August 2003. These provided a venue for the review of national actions and experiences to increase health investments. Countries discussed opportunities and obstacles to Health Investment Plan development, debated options and then outlined individual strategies to put in place a customized process for increased health investments.

Two unique features characterized these three regional intercountry meetings. First, the methodology was innovative in that it brought together senior officials and operational-level directors from ministries of finance, planning and health. The blend of viewpoints allowed a holistic assessment of the actual barriers to scaling up investments in health. Such barriers include low political commitment, weak physical infrastructure, inadequate monitoring and information systems, insufficient human resource capacity, and ineffective social mobilization efforts. Second, the participants were able to outline practical ways to implement a cross-sectoral strategy to addressing constraints, make better allocative decisions, collaborate to attract new sources of funds (e.g. public-private partnerships) and explore innovative financing mechanisms.

6. National Macroeconomics and Health process overview

Initiated and led by government, the MH process reflects the specific opportunities and constraints faced in the domestic health, economic, social and political environments. Based on the experiences of countries that were early adopters of MHS, three phases outline the main outputs and activities of a MHS and offer a sequenced approach to achieving essential objectives. Of the roughly 40 countries in various stages of planning and strategy development, over 30 are categorized as Phase 1 while seven are engaged in Phase 2 activities.

▪ **Phase I: Preparation**

Activities: Disseminate CMH Report to important stakeholders to analyse its relevance to the current national situation. Promote high-level commitment to the MH process. Identify resources required to embark on planning activities. Define research and technical support needs.

Outcomes: 1) Attain high-level national political commitment to MHS, for example, the development of terms of references (ToR) for a national MH coordinating mechanism. 2) Develop an outcome-oriented work plan outlining activities, linked to a budget and timeline. 3) Develop ToRs for research studies and any technical consultants needed.

Estimated time: 6 months

▪ Phase II: Planning

Activities: Assess the health status of the poor. Determine effectiveness, efficiency and equity of current health-delivery infrastructure. Identify health priorities, outcome gaps and limits in capacity. Evaluate health intervention options based on cost/benefit and cost-effectiveness studies. Perform cost analyses of investment package options.

Outcomes: 1) Sustain cross-sectoral commitment to increasing investments in health as part of the larger development framework, for example, the integration of health outcomes into ongoing PRSP or MTEF processes. 2) Develop long-term Health Investment Plan based on situational and costing assessments. 3) Define an implementation strategy, identifying key stakeholders and how their support will be secured.

Estimated time: 18 months

▪ Phase III: Implementation

Activities: Implement the Health Investment Plan. Ensure effectiveness of mechanisms to monitor the implementation process as well as assess the long-term impact on health outcomes and economic growth. Analyse impact and use this information to refine and optimize resource allocations. Garner political support for implementation and sustain cross-sectoral backing.

Outcomes: 1) Collect and track relevant health and economic indicators. 2) Secure an increase in internal investments for health and (if required) supplemental funding by external donors.

Estimated time: Several years

7. Tracking outcomes

There are two inter-related levels to tracking outcomes in countries employing a MH approach. Administratively, budgets submitted for country and regional CMH-related activities are carefully assessed by the Secretariat to ensure that expenditures are linked to specific outcomes and that outcomes are clearly on the critical path to creating a national Health Investment Plan. WHO then responds to accepted country and regional requests with technical products and financial support. As activities are undertaken, WHO regional and country focal points oversee implementation and monitor achievements of funded workplans. Achievements are conveyed to WHO/HQ using short technical progress reports at the end of each phase (*Annex 1*).

At the country level, the MDGs and national targets provide broad benchmarks to assess progress of poverty alleviation efforts. The country leads the process of developing domestic indicators, with technical support provided by WHO and other development partners. Three complementary approaches help a country track results. First, the CMH Report helps persuade senior decision-makers to support linking pro-poor health policies to specific outcomes defined by the health-related MDGs. Second, workshops, seminars and other mediums foster collaboration between all partners to implement national strategies in a unified manner, agreeing upon a core set of national indicators. Third, provision of resources and products (e.g. end-of-phase Technical Progress Reports) assists the country to use collected data to measure progress of its implementation efforts as well as its advancement towards health-related MDGs. To avoid duplication and needless paperwork, the Secretariat supports streamlined reporting processes and the improvement of current information sources by strengthening existing monitoring systems.

8. Achievements to date

1) Fostering high-level political support

Copies of the report and background papers, translated into multiple languages, have been widely distributed for country review. Many countries (e.g. Ghana, India, and China) held national workshops with essential stakeholders to assess how to incorporate CMH findings into national development strategies. Several countries initiated the MH process through a national launch event, allowing important government officials and other high-profile participants to express publicly their support of the MH process. For example, in India, the Indian National CMH was launched in January 2003 with a keynote address by Dr Jeffrey Sachs of Columbia University. In Sri Lanka, a Macroeconomics and Health event led by the National Health Council and chaired by the Prime Minister resulted in the establishment of a National Commission on Macroeconomics and Health (NCMH).

WHO products

- Technical support for advocacy tools, national workshops, and consultations to secure commitment from politicians and policy-makers. IEC (Information, Education, Communication) products include an "Investing In Health" information booklet, an electronic newsletter and the MH website (<http://www.who.int/macrohealth>). These maintain support, help disseminate experiences to date and inform additional stakeholders (e.g., development partners, donors, etc.) of progress.
- Seed funds to catalyse and promote a national launch and other activities aimed at securing broad-based support and national commitment.

2) Establishment of high-level national MH mechanism

National cross-sectoral mechanisms support the MH process, usually by expanding the scope of existing coordinating bodies. Occasionally, a national MH commission is established if no better mechanism exists (e.g. Ghana, India and Nepal). Comprised of representatives from multiple ministries including health and finance, the structure of the mechanism is country-dependant. For example, Sri Lanka's NCMH includes representatives from various ministries, the WHO Country Office, UNDP, the private sector and academia. The Commission is co-chaired by the Minister of Health, Nutrition and Welfare and the Minister of Rural Economy and Deputy Minister of Finance. A different structure exists in Ethiopia. Their MH coordination is provided by a newly hired Macroeconomics and Health Country Coordinator (an Ethiopian economist) and by a Technical Working Group operating under the Ministry of Health.

WHO products

- Technical guidelines to design Terms of Reference (ToRs) for domestic MH coordinating mechanisms, with provision of case examples of other countries' coordinating efforts.
- Support to identify and place an in-country focal point, when requested by the country.
- Seed funding to establish the national MH mechanism.

3) Development of outcome-oriented workplans

Linked to a budget and timeline, this plan outlines the activities, outputs, and objectives unique to a country's strategic plan. It includes the identification of resources and support needed to carry out the described activities. Over 20 countries have submitted Phase 1 work plans, and a majority of these have received partial funding. These preparatory workplans pave the way for development of the Health Investment Plan.

WHO products

- Mobilize technical and financial resources necessary for the development and implementation of a realistic and outcome-oriented work plan, budget and timeline.
- Guidelines, templates and outlines to help countries assess gaps in technical expertise they will need for policy development and planning.
- WHO, especially regional focal points, identifies and places local experts by collaborating with universities and regional and national NGOs, and by the selected use of international consultants. Over 21 countries have participated in regional technical meetings, with many also receiving in-country follow-up visits by technical experts.
- Regional workshops to assist country progression, share country experiences and lessons learnt, and develop specific strategies to create and fully implement a plan for investing in health.

4) Assessment of health situation and analysis of health infrastructure

Several countries, including Indonesia and Sri Lanka, have produced country concept papers to adapt the findings to local health, economic and political situations. These concept papers are an initial assessment of the health and health delivery structures of the country.

Countries, in this phase, execute an in-depth epidemiological survey of the causes and risks associated with

morbidity and mortality, disaggregated by income level, ensuring that the conditions most impacting the poor will be targeted. Also, an analysis of the capacity of current health systems to absorb additional funding and assessment of funding gaps for scaling-up of the current health infrastructure and services to the poor is finalized. This provides a basis for sequencing and prioritization of targeted health investments. Indonesia, for example, received funds to prepare an assessment of public health expenditures aimed at assessing the poverty reduction impact of current and proposed spending patterns. Eight countries have now entered this phase of the MH process (Cambodia, China, Ghana, Ethiopia, Rwanda, Mexico, Indonesia, and Sri Lanka).

In this planning stage, countries are identifying the need for experts and institutional technical support to perform such analyses. Technical experts are recruited to assist countries in planning and executing the necessary assessments and analyses. Technical experts will also assist countries in developing important linkages with local and regional partners, such as representatives from the World Bank and NGOs.

WHO products

- Mobilise and coordinate technical support for environmental scanning and the identification of key stakeholders and socioeconomic factors.
- Fund selected research, as well as aid countries to create ToRs for technical and research groups.
- Develop and maintain relationships with academic and development partners to assist in analyses and evaluation at the country level.
- The Earth Institute at Columbia University and the Royal Tropical Institute (KIT) are supporting specific assessment activities in several countries, as well as helping define ways countries can strengthen institutional research and analytical capacity.

5) Development of a Health Investment Plan

Countries will develop investment strategies based on the assessment of options and determine a package of high-priority, cost-effective interventions. A costing analysis of the selected interventions will ensure a sound evidence base on which to develop a long-term Health Investment Plan. Governments are working to foster and sustain cross-sectoral support for the Health Investment Plan. An important management element will be putting into place an internal mechanism for tracking of key outcomes. We expect eight countries to complete this phase by 2005.


WHO products

- Continue to develop and access a pool of experts who can address countries' research needs (e.g., economics, epidemiology, health services research, etc.)
- Will collaborate with countries to identify key economic and health indicators, including health-related MDGs and country-specific health goals (i.e. Healthy Indonesia 2010), by which to track the effectiveness and impact of the investment plan.
- Assist countries in building linkages with development partners, NGOs, donors, and academic institutions to sustain support and integration with ongoing poverty reduction plans and public health projects.

The next section will give some examples of the varied paths to the MDGs being built by countries employing a Macroeconomics and Health Strategy.

Table 2: CMH 2004 Country Progress¹⁴

WHO Region	Country	CMH Phase	Funding provided	Through end of Phase 2 (tracking MHS process)					
				Initial contact and request for info	Country missions or regional meetings	Follow-up plan, budget submitted ⁶	Plan, budget approved	National mechan. created ⁷	National mechan. in action
AFRO ⁸	Angola	1		Aug 03		Aug 03			
	Botswana	1		Aug 03	Sep 03	Sep 03			
	Congo	1		Aug 03		Sep 03			
	Ethiopia	2	Y	Aug 02	Oct 03	Mar 03	Sep 03	⁹	
	Ghana	2	Y	Jun 02	Apr 03	May 03	Apr 03	Apr 03	
	Kenya	1		Jun 02	Mar 03	Sep 03	May 03	Nov 02	Nov 02
	Malawi	1		Aug 03		Aug 03			
	Mozambique	1		Aug 03	Sep 03	Sep 03			
	Nigeria	1		Aug 03		Aug 03			
	Rwanda	1 2	Y	Jan 03	Mar 03	Aug 03			
	Senegal	1	Y ¹⁰	Aug 03		Sep 03	Sep 03	Sep 03	Nov 03
AMRO	Caribbean Community ¹¹	1	Y	Dec 02		May 03	May 03	Sep 03	Sep 03
	El Salvador			Jul 03	Sep 03				
	Mexico ¹²	2		Jun 02	Jun 02			Jul 02	Aug 02
EMRO	Djibouti	1	Y	Apr 03	Jan 04	Jul 03	Sep 03		
	Jordan	1	Y	Jun 02	Jun 03	Jun 03	Jul 03	Apr 03	
	Iran	1	Y	Apr 03	Jun 03	Jul 03	Jul 03		
	Pakistan	1	Y	Apr 03	Jun 03	Aug 03	Sep 03		
	Sudan	1	Y	Dec 02	Jun 03	Jun 03	Jul 03		
	Yemen	1	Y	Apr 03	Jun 03	Sep 03	Sep 03	Mar 03	
EURO	Azerbaijan			Nov-03	Nov-03				
	Baltic States: Estonia	1		Dec 02	Mar 03				
SEARO	Bangladesh	1	Y	Apr 02	Aug 03	Nov 03	Feb 04	Jul 03	
	India	1	Y	Jun 02	Aug 03	Nov 02	Dec 02	Jan 03	
	Indonesia	2	Y	Dec 02	Aug 03	Sep 03	Mar 03	Sept 03	Sept 03
	Nepal	1	Y ¹³	May 03	Aug 03	Oct-03	Mar 04	July-03	Aug-03
	Sri Lanka	2	Y	Jun 02	Aug 03	Feb 03	Mar 03	Jul 02	Dec 02
	Thailand	1		Aug 02	Aug 03	Jan 04			
WPRO	Cambodia	1	Y	Dec 02	Feb 03	May 03	Aug 03		
	China	1	Y	Oct 02	Dec 02	Jan 04	Jul 03	Dec 02	
	Philippines			Aug 03		Sep 03	Jan 04		
	Lao PDR			Sep 03		Jan 04			
	Mongolia			Sep 03		Jan 04			
	Papua NG			Sep 03		Jan 04			

 Included in a regional proposal

⁶ Only the latest date shown for missions, meetings and funds dispensed, e.g. a Phase 2 date will overwrite the Phase 1 date.

⁷ A few countries have developed a National Commission on Macroeconomics and Health as the mechanism for driving this process (e.g. Mexico, Ghana, Sri Lanka, India). Several others are using or considering the use of existing multi-partner/trans-sectoral commissions to manage the MHS process (e.g. Indonesia, Djibouti, Ethiopia, Argentina). In this case, they are rewriting existing ToRs to look at health economics and financing issues within a cross-sectoral framework. In most cases they are also expanding the membership of such committees to include civil society, private sector and other ministries (e.g. Defence & Agriculture in Djibouti).

⁸ AFRO worked with Ghana and Ethiopia to disseminate their experiences during the "2nd Consultation on Macroeconomics and Health" (October 2003).

⁹ Ethiopia is hiring a CMH country coordinator to work with the Ministry of Health.

¹⁰ Funding provided for support from KIT: Royal Tropical Institute Amsterdam.

¹¹ Caribbean Community sub-region States comprise 15 members including the former Commonwealth Caribbean, Suriname and Haiti.

¹² Funded by non-WHO resources, primarily internal government resources.

¹³ Funding provided for support from KIT: Royal Tropical Institute Amsterdam.

¹⁴ This table only shows those countries that have expressed a strong interest in committing to Phase 1 activities, or those countries already actively pursuing Phase 1 or Phase 2 strategies.

is central to poverty reduction.

Following the AFRO CMH workshop in Addis Ababa, Angola plans to elaborate a structured framework encompassing the CMH findings, key elements of the CMH workshop discussions, and an outline of existing Angolan public expenditure mechanisms in health. This will aim to integrate the MH process into current national development plans and initiatives.

The Republic of the Congo

Epidemiological data shows malaria to be the leading cause of morbidity and mortality among the poor, with other infectious diseases having a large impact (e.g. HIV/AIDS, TB, and vaccine preventable diseases). 15 July 2003 saw the country's draft I-PRSP well received, with World Bank (WB) and donors agreeing to ensure quick access to debt relief through Heavily-Indebted Poor Countries (HIPC) Initiative.

The Republic of the Congo notes that it will require significant and effective international support, both financial and technical, in order to reach the Millennium Development Goals (MDGs). National public sector spending on health has only reached 4.35%, so more advocacy at the highest political levels is needed in order to place health more centrally to the budgetary planning process. An important challenge to be faced, despite new oil revenues forecasted, is the continued heavy scheduled external debt service obligations (currently 46% of government revenue). The economy is poorly diversified and almost entirely export-based. The goal is to increase public health spending to 20% by 2008, and this will be a major part of the Congolese MH strategy.

Ethiopia

The MH process is generating awareness of the important links between health and economic development among essential target audiences. The authorities welcomed a MH approach and the opportunity to establish a Technical Working Group under the Ministry of Health and the country's Central Joint Steering Committee of the Health Sector Development Programme.

A Macroeconomics and Health Country Co-ordinator (MHCC) was recruited in December 2003 to assist the Technical Working Group. The MHCC and Technical Working Group, under the guidance of the Health Minister, will direct research to evaluate the current health care frameworks and the costs of increased health care expenditures. The MH Plan of Action received final approval and endorsement by the Ministry of Health in May 2003. The Technical Working Group has started to assess how the MH process can integrate into the established PRSP. An MH workshop was completed during the Annual Review Meeting of the Health Sector Development Programme II (HSDP) in April 2003.

Ethiopia hosted the Intercountry workshop for CMH for AFRO states in August 2003, giving the government an international platform to share its experiences, whilst exchanging ideas on developing a country-led MH process with other countries. In addition, visits by the Columbia University team and by WHO HQ occurred several times throughout 2003. International experts from Columbia University provided technical expertise in economic and technical analysis to support Ethiopian efforts to carry out needed research and build an effective evidence base for policy development.

Ghana

A high-profile launch of the Ghana Macroeconomics and Health Initiative (GMHI) was held in Accra in November 2002. The Ghana Commission on Macroeconomics and Health (GCMH) is carrying forward the GMHI, analysing the Ghanaian Poverty Reduction Strategy in light of the CMH Report's findings. Six technical papers sponsored by the GCMH were reviewed, investigating cross-sectoral factors affecting health (published in February 2003). Ghana is focusing on three main issues: health insurance, access to water and sanitation, and human resources capacity at village level. A Technical Working Group has investigated performance and outcome gaps in every area of the Ghana PRSP implementation, identifying cross-sectoral causes of health system deficiencies. In one notable outcome of the MH process, analysis has prompted new policies and strategies that aim to increase the capacity of human resources within the health sector.

In Ghana, the MH strategy is positioned to heighten commitment of important ministries that influence the allocation of resources through the national planning process. In addition, Regional Ministers, a potent political force, are being sensitized to the necessity of reassessing current health investments. Moreover,

such downstream political support is necessary to develop the capacity of district managers to design and implement realistic district plans. The predicted increase in the capacity to deliver essential health interventions ties in well with Ghana's establishment of sector-wide insurance schemes. Additionally, MH work supports MDG achievement.

The GMHI has completed several early objectives. This is embodied in three groups of reports: 1) the technical reports commissioned by the GCMH, 2) the consultant's report "Investments in Health to Reduce Poverty and Stimulate Economic Development in Ghana: Findings and Recommendations of the Consultant, December 2002", and 3) the report "Scaling –up Health Investments for Better Health, Economic Growth and Accelerated Poverty Reduction, June 2003". These three documents will form the conceptual basis for the Health Investment Plan, along with other background materials currently in preparation. Completion in early 2004 of this analytical work will allow it to influence the PRSP and budgetary review processes and to help develop national policies optimizing the uptake of new resources and investments.

Kenya

In March 2003, the Columbia team met with the newly appointed Minister of Health, the head of the National AIDS Control Council (NACC) and donor organizations in Nairobi to discuss the potential value of implementing a cross-sectoral plan for increased health investments. The Minister of Health, the NACC and donor groups requested technical assistance to evaluate the financial needs for scaling up health expenditures in Kenya. The President is keenly interested in expanding health prevention and interventions in the country, making this a pertinent time to engage in a MH process. In July 2003, a Columbia team met with senior health and finance policy makers to discuss options for commencing the MH process and potential linkages between existing health frameworks and PRSPs.

Since the CMH workshop in Addis Ababa, the team led by Ministry of Health 's health economists has focused on consensus building among stakeholders. Toward this objective, briefings have been carried out for: 1) The Permanent Secretary and Director of Medical Services in Ministry of Health, 2) Permanent Secretary Ministry of Planning and Development, 3) the Minister for Health, and 4) Chief Executive for National Hospital Insurance fund and senior management of the Ministry of Health.

The team has also finalized the Plan of Action for Phase 1 for the next 6 months. It aims to link the MH process and subsequent health investments to: 1) the Economic Recovery Strategy (ERS) investment programme; 2) the next National Development Plan (2006-15); 3) the national budgetary process; and 4) and UN Development Assistance Framework Group (UNDAF) workplan.

The Republic of Malawi

Political and socio-economic development is constrained since Malawi is a landlocked, single cash crop agricultural economy with concentrated ownership of assets, limited foreign and domestic investment and a high population growth and density. Malawi participated in the CMH workshops in Addis Ababa, but is still in the preliminary stages of deciding how best to use the findings of the CMH Report. As a Heavily Indebted Poor Countries (HIPC)-I country, the delegation felt that a possible CMH entry point was the reallocation of funds, previously tied to servicing external debt, into the PRSP-defined poverty reduction objectives. The MH process will be located in Ministry of Economic Planning & Development (MOEPD). The MOEPD holds cross-sectoral meetings once a month on development programmes and projects. The other opportunity is that the MOEPD coordinates the activities of the PRSP jointly with Ministry of Finance.

Mozambique

"It is strong health and education services that give people the tools they need to take advantage of expanding economic growth." -- Dr. Humberto Cossa, Director, National Directorate of Planning, Ministry of Health.

Mozambique has made significant progress in conceptualising various strategic options for investing in health. In 1999 an Action Plan for the Reduction of Absolute Poverty (Plano de Acção para a Redução da Pobreza Absoluta—PARPA) defined the actions and priorities to be implemented across sectors. PARPA was taken as the basis for the design of the Interim Poverty Reduction Strategy Paper (PRSP). Linkages to the Medium-Term Expenditure Framework (MTEF), giving emphasis to the objective of poverty reduction, are being defined.

The goals of the MH process in Mozambique are to streamline the analysis and evidence of the CMH Report into the national development agenda: Accelerated Economic Growth and Absolute Poverty Reduction.

Mozambique views the Minister of Health as the "pivot of the process", who will lead efforts to assess studies, available data and policy documents so as to formulate a country-specific report on Macroeconomics and Health. Important steps include assessing the interrelationships and the opportunities presented by the "Health Expenditure Review" (PER), the "Expenditure Tracking and Service Delivery Survey", and the "National and Sectoral Medium Term Financing and Expenditure Framework".

Phase 1 of MH work will concentrate on effective advocacy and social mobilization and the use of good communication techniques. The overarching objective is to put into place a solid basis for the design of a long-term investing in health strategy. Ownership building, particularly inclusion of bodies such as 2025 National Development Agenda Council, will be emphasised.

Nigeria

Nigeria accounts for 13% of sub-Saharan Africa's GDP and 55% of West Africa's GDP, so an enhancement of Nigerian socio-economic progress could have tremendous spill-over effects for the continent. Oil and gas account for 20% of GDP, 95% of foreign exchange earnings and up to two thirds of government revenue.¹⁵ A significant window of opportunity currently presents itself to initiate a multi-sectoral process that will generate development of a Health Investment Plan integral to poverty reduction mechanisms. It is important to note that Nigeria is a heavily indebted poor country with severe debt-servicing constraints, even with the nonconcessional rescheduling of Paris Club debts (December 2000). Access to bilateral credits is virtually non-existent, while commercial credit exists only at market rates.

Nigeria's Minister of Health chaired an important session which closed the 2nd Consultation on Macroeconomics and Health, "Increasing Investments in Health Outcomes for the Poor" (28-30 October 2003), synthesizing the various themes of the meeting and helping push forward the draft Declaration from the Consultation. Following this Consultation, the Minister of Finance from Nigeria chaired part of the recently-completed High-level Forum on the Health MDGs, co-sponsored by WHO and the World Bank. Nigeria also chaired a number of sessions at the 53rd Regional Committee which took place in September 2003 in South Africa. Present were 45 ministers of health from the AFRO region who unanimously endorsed the CMH agenda and requested WHO to provide technical support to countries.

Nigeria's MH process is to be directed in the Department of Health Planning and Research of Federal Ministry of Health. This department has a government mandate to coordinate the implementation of the health components of ongoing initiatives such as NEPAD, PRSP, MDG, etc. Social mobilization will be embarked upon concurrently, in partnership with other sectors such as Women Affairs, Water resources, Environment, Agriculture and Education. Various partners (e.g. NGOs, civil society, donors, etc) will be targeted for a comprehensive briefing on the relevance of CMH findings and recommendations to Nigeria. This will spur national ownership of the process and garner the support required to the implement the CMH action agenda.

The Phase 1 objectives comprise two main prongs: 1) to build consensus on the relevance of the findings of and recommendations of the CMH Report at federal, state and local levels, and 2) to set up an appropriate institutional mechanism for moving forward the MH agenda in Nigeria. The latter includes defining linkages to the PRSP efforts and support for establishing National Health Accounts to track the sources and flows of funds to and within the health sector. This includes economic research studies, analysis of intervention options and assessment of financing mechanisms. Once funding is secured, the government will inaugurate a national mechanism to drive the MH process, create a concept paper on MH in Nigeria, and develop the specific operational strategy to integrate relevant CMH findings into long-term health investment strategies.

Rwanda

In March 2003, a team from Columbia University visited Rwanda at the invitation of the President of Rwanda, the Minister of State for HIV/AIDS, and the Executive Secretary of the National AIDS Commission (CNLS). The purpose was to identify how the MH process could be adopted. A PRSP was completed in June 2002, with a priority on rural development and agricultural transformation. The aim was to realize a real annualised GDP growth rate of 6-7% and to reduce poverty from 60% in 2001 to 30% by 2015. The Minister

¹⁵ Source: Foreign Direct Investments December/January issue, 8 December 2003, Financial Times Business.

of Finance and Economic Planning and the Minister of Health both worked with WHO to develop a Macroeconomics and Health Strategy. Initially, the plan will focus on four areas for analysis and research:

1. The potential contribution of community health insurance schemes ('health mutuels') to finance health service delivery and improve access to healthcare in Rwanda;
2. Strategies for enhancing the salary, professional development, and incentive packages of health professionals in the public sector to enable the scale-up and sustainability of public health programmes;
3. An evaluation of spending on major health interventions, and the need to prioritize health care expenditures;
4. The macroeconomic impact of healthcare spending in Rwanda.

Focal points are the Director of PRSP Planning and Monitoring in the Finance Ministry and the Director of Planning for the Ministry of Health. Columbia University has placed an in-country adviser to support these individuals as well as the Secretariat for the National Task Force.

Senegal

On 28 April 2003, the International Monetary Fund (IMF) approved a new 3-year agreement under the Poverty Reduction and Growth Facility (PRGF) mechanism to support Senegal's economic reform program for 2003 to 2005, totalling about US\$ 33 million. This is closely articulated with the Senegalese I-PRSP framework and is heavily reliant on wide-ranging structural reforms. At this critical juncture, Senegal wishes to ensure the centrality of essential health interventions, and that macroeconomic analysis carefully looks at health outcomes when deciding upon the shape and nature of proposed structural reforms.

The Ministry of Finance has primary responsibility for defining a global public expenditure control policy. As Senegal moves to full implementation of a MTEF through a PTIP (programme triennial d'investissement public), capital budgetary expenditures will become more scrutinised, especially since they will be linked with the performance based budgeting (PBB), introduced in 2002 to the health and education sectors. Of note, Senegal has identified a reduction in HIV/AIDS growth as a high priority. This implies a substantial public health component to ensure achievement of this objective.

The MH process can provide a strong analytical and evidence-based argument for significantly increased health investments. Phase 1 objectives for Senegal revolved around two main thrusts: wide dissemination of key messages from the CMH Report, and the development of a national and high profile mechanism to manage and sustain the MH process. The country wishes to support the creation of an evidence base showing the impact of various health investment scenarios upon health outcomes, especially for the poor.

United Republic of Tanzania

During the AFRO workshop in Ethiopia, participants from Tanzania and Zanzibar proposed a Framework for CMH Plan of Action covering November 2003 to March 2004. Two principal objectives were identified: 1) to build consensus on the relevance of the findings and recommendations of CMH, and 2) to establish institutional arrangement for facilitating implementation of the CMH recommendations.

Good opportunities exist for sparking strong interest in the MH process. For example, Tanzania will place the CMH Report's findings as an agenda item in the annual health sector review, as well as in the PRSP reviews. Additionally, joint meetings of the Ministries of Health of the Tanzania Mainland and Zanzibar will seek to best coordinate efforts and leverage their various experiences.

Uganda

Several entry points for commencing a MH process were identified by Uganda's participants to the CMH workshop in Addis Ababa. Core on-going processes, for which the mechanism to manage the MH process can be linked, include:

1. Revision of the PRSP (PEAP)
2. Developing Health Sector Strategic Plan II
3. Studies to generate evidence for Health Sector Strategic Plan (HSSP) II, e.g. burden of disease studies
4. National Health Accounts
5. Health systems performance assessment and the Benefit Incidence Analysis
6. Inter-ministerial efforts to improve health and level of funding
7. Health sector working group

The principle outcome sought for the first six months is the forging of a consensus on carrying forward the work on MH at the country level. The objectives are:

- Define the framework and structure for articulating health and development.
- Outline the advocacy package for investing in health.

The MH process will be located in the Prime Minister's (PM's) office, as the PM's mandate will be to coordinate inter-ministerial health financing. The comprehensive approach to health and economic development will be discussed during the upcoming scheduled PRSP review. This will also delineate linkages and potential synergies with the revision of the Poverty Eradication Action Plan (PEAP) and the Health Sector Strategic Plan (HSSP) II development process.

2. The Americas Region (PAHO/AMRO)

PAHO/WHO has suggested opening a dialogue on the implications of the CMH Report for the Americas, initially with a few key regional stakeholders such as the Central American Integration System (SICA), the Andean Health Agency (ORAS), and MERCOSUR.

PAHO's success in the HIV/AIDS strategy to mobilize health investments for anti-retroviral packages has been noted. The importance of having a macroeconomic foundation for managing the health sector has been stressed. At the country level, PAHO/WHO is interested in incorporating National Health Accounts into the local MH process as basic tools. They also feel that the MH-triggered research will contribute to the epidemiological database to assess the burden of disease of the poor and options for cost-effective interventions.

The regional office participated in the 2nd Macroeconomics and Health Consultation, "Increasing Investments in Health Outcomes for the Poor", 28-30 October 2003.

Caribbean Community

The 15 member states that make up the Caribbean Community (CARICOM) have set up a Caribbean Commission for Health and Development. CARICOM includes Antigua and Barbuda, The Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, St. Kitts and Nevis, Saint Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago. On 22 September 2003, the official launch of the CARICOM CHD announced the plan of action and objectives for the Commission. Chaired by the former head of PAHO/WHO, Sir George A. O. Alleyne, this Commission is patterned after the WHO CMH, and is charged with the responsibility of providing guidelines for action to the 15 member states. The overall goal is to "give substance to the Nassau declaration that the health of the region is the wealth of the region and respond to Millennium Development Goals in which health and development are priorities."

A policy framework is being developed to assist the CARICOM member countries in structuring their health and development agendas. This will be accomplished by a clear assessment of all determinants of health, coupled with selected studies on burden of disease and cost-effectiveness analysis. A macroeconomic framework will assess the aggregate returns for areas such as direct foreign investment, tourism and trade that can be expected by a coherent long-term strategy towards investments in health. Research proposed includes papers on the labour market returns to health and inequalities in health and income. Such research will convince senior government leaders of the necessity for increased health investments that are pro-poor.

An 18-month timeline guides the creation of a framework establishing priorities for health financing, including public/private partnerships and the sharing of services. The framework, plus locally developed evidence, will help member states structure their health and development agendas in an interrelated manner, while focusing on provision of pro-poor health services. An important outcome for the Community is partnership building, catalysed by multi-sectoral workshops to be sponsored in the various member states.

The Caribbean Community has obtained donor support for a significant part of their work plan, showing the value of engaging all local stakeholders into the earliest stages of developing a work plan for implementing a MH strategy. PAHO/WHO will be the executing agency and will provide needed technical support in concert with WHO-HQ, using local and regional technical experts when possible.

EI Salvador

The Ministry of Health of El Salvador organized the first of a series of three seminars on Macroeconomics and Health in cooperation with PAHO/WHO. Held in May 2003, the first seminar included a presentation of the recommendations of the CMH Report, a presentation on National Health Expenditures in countries of the Latin American and Caribbean (LAC) region and the presentation of detailed studies on Health Accounts from El Salvador. The second seminar (September 2003) focused on health, equity and poverty issues.

The first and second activities are preparatory activities to launch the national MH Commission, which will be the third activity to take place in 2004. El Salvadorian officials are working through the local PAHO office to initiate the mechanisms to get WHO support to:

- sponsor participation of a high-visibility participant at the El Salvador CMH launch; and
- develop a long term MH strategy, using focused technical support and experts working collaboratively with a high-level national mechanism.

Mexico

The Mexican Commission of Macroeconomics and Health (CMMS) was inaugurated in July 2002. Since then, the Commission has scheduled periodic meetings, set up a web site to disseminate the Report findings widely, and outlined plans for forward movement of the process. The WHO/PAHO representative is coordinating the preparation of the proposal. Based on the consensus reached on the priorities and activities for the joint work plan, WHO/PAHO will also work with the Secretariat to assess funding sources. The CMMS continues moving forward towards the completion of a report on the different aspects of the relationship between health and economics in Mexico.

In order to better organize this challenging research project the CMMS was divided into five working groups, each of them coordinated by one of its members. The groups were established based on a careful process in which policy needs were prioritized. Each group will generate a report that would feed the CMMS's final product. The five working groups are the following: (1) Diagnosis of the health status of the Mexican population and of the public health system *vis-à-vis* the achievement of the MDGs, (2) Health, economic development and poverty reduction, (3) Intra and inter sectoral health related public policies, (4) Health insurance and social protection and (5) Global and regional public goods for health in Mexico.

3. The Eastern Mediterranean Region (EMRO)

In WHO's Eastern Mediterranean Region, the Commission on Macroeconomics & Health (CMH) Report was discussed at the 18th Meeting of the Regional Director with WHO Representatives and Regional Office staff in October 2002, with the participation of the CMH Secretariat. Further, EMRO's 26th Regional Consultative Committee (RCC 2002) commissioned work to assess the "impact of economic trends on health care delivery with special emphasis on deprived populations." The 27th RCC meeting (July 2003) noted that an EMRO task force on Macroeconomics and Health was formed and discussions with Headquarters colleagues culminated in a proposal and a plan of action to support poor countries in the region. Moreover, they placed on the 28th RCC agenda (July 2004) another issue relevant to macroeconomics and health: mechanism for prioritization of public health problems in the region and health research priorities.

On 9 June 2003, representatives of the CMH Secretariat participated in an "Experts Consultation to Discuss the Regional Strategy on Sustainable Health Development and Poverty Reduction" in Fez, Morocco. Along with World Bank representatives and other partners, CMH joined a roundtable discussion on strengthening the mechanisms for collaborative vision and integrated work within and outside WHO.

Linked to the Expert's Consultation, the WHO/HQ and EMRO hosted a Meeting to Facilitate the Implementation of CMH in the Eastern Mediterranean Region, 13 - 14 June 2003 in Fez. Themes from the Expert's Consultation fed into the CMH workshop, particularly the drive to build upon Community-Based Initiatives (CBI) and incorporate lessons learnt following the World Bank Development Report (1993) into current efforts for long-term investments in health. Country, Regional and the CMH Support Unit staff came together to draft CMH national plans and a regional MH strategy.

Main themes from workshop discussions stressed that operationalizing MH work requires a solid government commitment to reallocate national budgets and seek additional internal resources for health.

The success of Health Investment Plans will also rely on clear outcome tracking, strong supervision and addressing known constraints realistically by offering practical steps to remove barriers. EMRO supports country strategies that link MH work to WHO initiatives (e.g. Community Based Initiatives, "3 by 5"), as well as with existing national mechanisms such as PRSPs and Sector Wide Approaches (SWAs). Finally, participants agreed that investment plans should show a coherent path towards achievement of the MDGs.

The Regional Concept paper on sustainable development was presented at the Regional Committee (RC) for the Eastern Mediterranean (29 September - 2 October 2003, Cairo). Ministers of Health, other RC delegates and the Regional Secretariat approved the paper, entitled "Investing in Health of the Poor: Regional Strategy for Sustainable Health Development and Poverty Reduction".

In March 2004, a joint WHO mission from CMH and the MDG/PRSP team met with EMRO focal points for sustainable development, Basic Development Needs (BDN) and CMH follow-up. EMRO staff requested that WHO/HQ work with them to develop a more coherent range of analytical and technical tools, which could be made available to WHO country offices. Such tools would help national ministers and WHO representatives (WRs) clarify the strategic linkages needed among various initiatives (such as PRSP, Heavily Indebted Poor Countries (HIPC) Initiative, Global Alliance for Vaccines and Immunizations (GAVI), Global Fund for AIDS, TB and Malaria (GFATM), etc.) and national policies.

Djibouti

The Minister of Health gave a presentation at the 2nd Consultation on Macroeconomics and Health, "Increasing Investments in Health Outcomes for the Poor", 28-30 October 2003. Describing efforts to implement a Macroeconomics and Health strategy, he noted that Djibouti has a poor physical and human resource base. Furthermore, Djibouti has some of the highest rates of poverty, illiteracy, morbidity, and maternal and infant mortality in the world. As the Ministry of Health's allocation has dropped from 5.7% to 4.2% of the total government budget, the Minister places a priority on raising awareness among senior government leaders of the centrality of health to developmental strategies. The country has just commenced the first stage of a multi-year programme to reduce poverty, improve health and other social sector outcomes and spur economic growth and development. The World Bank and USAID have recently agreed to fund health and educational interventions in Djibouti with a total of approximately US\$ 50 million over the next three years.

Initial MH efforts aim to insert a strong health component into the World Bank and USAID programmes for restructuring and reform, which accompany the national development plan. Currently, the national macroeconomics steering committee and CMH technical group are being put in place, to be directed by the Health Ministry. As over 50% of the health budget is funded externally, Djibouti finds its national priorities dictated by external donors. Cooperation between the Ministries of Health and Finance is increasing, but the health sector is allotted a very small portion of internally-generated resources.

In October 2003, a member of the Secretariat spent nine days in discussions with the Secretary General for the Ministry of Health and the Director of Budgets for the Ministry of Financing and Planning. This led to revision of the Djibouti work plan and a preliminary situation analysis in which epidemiological and economic data was collected and collated. Additionally, Djibouti was assisted in preparing for their participation at the 2nd Consultation on Macroeconomics and Health in Geneva (28-30 October 2003), where they gave a well-received country presentation on their perceptions of the MH process.

A follow-up visit by a member of the CMH Secretariat as well as by a consultant health economist from EMRO took place in January 2004. The objective was development of a concrete plan of work to draw up a national Health Investment Plan by October 2004.

The Islamic Republic of Iran

The highest levels of the Ministries of Health, Planning and Budget have debated the CMH recommendations. The Deputy Minister for Social Affairs felt that the provision of technical support to analyse existing data, which could then be used to develop an evidence base for pro-poor policies, would be critical for success.

Medical education is integrated under the Ministry of Health, with provincial health ministers also filling the role of medical school deans. Iran is building upon the success of recent poverty alleviation initiatives to increase community involvement in health. One important gap they have identified is the weakness of current

information management systems, which are inadequate for generating an analysis useful to decision-makers. WHO is being requested to aid in identifying IT tools, and the Regional Office and HQ will work with Iran to explore various options to remove this constraint to progress.

In assessing the macroeconomic and political constraints to increasing pro-poor health services, the Deputy Minister for Social Affairs noted that Iran and many other countries are facing opposing inputs: on one side are "neo-classical inputs pushing privatisation and downsizing of public sector services" while on the other side are calls for "increasing investments in health services to the poor, which can only be delivered by the public sector". The resolution of this "political question" needs the involvement of WHO in its role as global advocate for equitable health services.

In June 2003 Iran sent a team to the EMRO CMH meeting that included the Deputy Minister for Social Affairs. Iran notes that a 5-year health & development plan is being finalized now, creating a window of opportunity for ensuring the centrality of health to poverty reduction and sustainable development strategies. The country feels that the basis of such multi-sectoral planning should be reliance on Iran's internal resources, with reallocation based on evidence. These comprise two prime objectives of Iran's Phase 1 work plan for Macroeconomics and Health.

Jordan

The government of Jordan is embarking on a social and economic transformation program of which health is a prominent component. Intersectoral collaboration is also evident in the establishment of the National Committee on CMH with representatives from the Ministry of Planning, Ministry of Finance, and other concerned parties. Health problems such as malnutrition, diarrhoea, infant and maternal mortality, clean water and sanitation and access to a functional referral system and quality care are considered to be impacting the poor disproportionately. Basic essential interventions that have greatest impact on the poor are needed, and this requires a planned intersectoral effort (clean water, adequate sanitation, primary education) with appropriate policies and mobilization of resources to respond adequately and equitably to the health needs of the poor.

The government of Jordan is highly committed to advancing the CMH model by expanding evidence-based essential interventions to all people, including the poor and disadvantaged. Therefore, in December 2002, the Prime Minister has established a high-level National Committee to respond to the CMH initiative, chaired by the Health Minister and including the Minister of Planning and the Secretary General of the High Health Council. A technical committee has emerged and is charged with developing a strategy and plan for health services consistent with the CMH model.

Currently, the High Health Council (HHC) is leading the effort to develop a pro-poor Health Investment Plan in cooperation with a local consultant and the Technical Committee on CMH. The HHC's efforts are directed at the policy and strategy level and aim to improve health system performance and to achieve effectiveness, efficiency and equity in health services in Jordan. A Jordanian team from the HHC, Ministry of Health, Ministry of Planning, and Ministry of Finance, attended all the regional and international meetings on CMH organized by the WHO.

There are plans to establish a country-wide health information system. This will facilitate decision-making and foster cooperation between the different health sub-sectors. The Healthy Villages Program is considered to be one of the successful experiences that can be built upon, because it can effectively meet the needs of the poor in Jordan. Expansion of this program to include more villages is under consideration. The Healthy Village Program is an example of what an intersectoral approach can achieve.

Human resources development is one of the top priorities in Jordan. Two studies to assess the dental and nursing workforce situation in Jordan are underway. These studies are being conducted by the High Health Council in cooperation with consultants from local universities. Another response to the health needs of the poor is development of a universal health insurance program, a topic currently under study in Jordan.

Next steps to implement a National Health Plan:

1. The CMH concepts are rarely disagreed upon and therefore advocacy in this regard is not difficult. However, a national body with a full mandate is needed to maintain momentum and enthusiasm for the MH process.

2. Effort is needed to identify the poor so as to reach them with well-targeted interventions.
3. In order to reach a consensus on a list of essential evidence-based, feasible interventions, technical assistance will be needed during the process.

In Jordan, work to develop a national Health Investment Plan has already started and is expected to be finalized in a few months.

Pakistan

Pakistan has a multi-pronged approach to reducing poverty, based on the Poverty Reduction Strategy Paper (PRSP) and incorporating 1) acceleration of economic growth, 2) governance reforms, 3) expanding social safety nets, and 4) investing in human resources. Health sector investments are viewed as part of the Poverty Reduction Plan, with attention shifting to the provision of primary care and community-based initiatives. The foundation of the current health sector reform process is felt to be improved governance. As the PRSP is already finalized, the objective for Pakistan will be to disseminate the major findings of the CMH Report, translate them into the local macroeconomic context, and use them to define research to construct an evidence base for integrating health into the PRSP. While reaching the MDGs is a high priority, the pressing need is to reach the 45% of the population that currently does not have access to essential health services.

At the EMRO CMH workshop, the WHO Representative (WR) stressed that technical support was more urgently needed than financial support and that increasing local institutional capacity was critical. He felt the entry point for implementing CMH-related findings will be the augmentation of the capacity of countries to carry out strategic thinking and policy analysis that can support a multi-partner, multi-sectoral strategy for health and poverty reduction.

The Secretary of the Ministry of Health made the case that the MH process provides an opportunity to re-examine health strategies from a macroeconomic perspective. He strongly suggested to EMRO colleagues that each health ministry form a distinct "policy development" unit that has high political clout, adequate resources to "conduct macroeconomic analysis for strategic planning", and includes at least one health economist and one political strategist. This will aid in devising policies and strategies that will win support from the most senior levels of government. He also stressed that the chair be the prime minister or president, someone who could break down sectoral walls and foster bold initiatives to strengthen all the determinants of health. The NCMH should also have technical working groups dealing with research, analysis, policy development and implementation. These would be chaired by influential political leaders, respected for their technical ability, and able to take concrete steps to achieve desired outcomes.

Sudan

Sudan is a large country of nearly 32 million inhabitants that must cope with almost 1 million internally displaced people and a rural population of about 10 million. Within the context of severe civil strife and a large trans-national migrant population, long-term strategic health planning must rely on coordinating a diverse network of internal and external partners, aid agencies and other agents. Since the push for primary health care, there has been a marked inability to foster intersectoral collaboration or achieve coordination of various plans even within one public sector. The PRSP is merely one of many UN initiatives, and the government feels some integrated framework to rationalize all these initiatives is needed. They expressed the hope that the CMH focus on building up existing networks and strengthening partner networks will lead to a real cross-sectoral dialogue and participation in poverty reduction efforts.

The WR has pointed out that there is a window of opportunity presented by HIPC funds since the International Monetary Fund has agreed that 100% of these released obligations will be applied to the PRSP. The National Plan for Health Investments will aim to take advantage of this. Senior Ministry officials in delegation (Finance, Health, Social Welfare) discussed and revised the MH workplan.

A joint WHO CMH/PRSP mission visited Sudan in March 2004. Based on feedback from the Ministries of Health and Finance, the team suggested that the government use the momentum provided by the MH process to build upon increased inter-ministerial dialogue and seize the opportunity for more holistic approaches for health sector planning. Furthermore, it could employ a health systems framework to restate key health policy issues, allowing strategic options to be addressed effectively, while reconciling immediate post-conflict activities with broader, more comprehensive development of the health sector.

Yemen

Yemen's Coordinator for the Macroeconomics and Health Program (MHP) attended the EMRO CMH workshop accompanied by the Assistant Deputy Minister for Foreign Affairs from the Finance Ministry and the Director General of Projects from the Ministry of Planning. The team identified the following priority areas for work: 1) the determination of burden of disease of the poor and vulnerable, 2) advocacy, and 3) the creation of a consensus among stakeholders. The health sector reform initiative was identified as an entry point for the MH process. The PRSP process will be the vehicle for operationalizing the MH process, with the Yemen MHP Coordinator maintaining momentum and developing buy-in from influential stakeholders.

The Coordinator of the MHP is located within the Ministry of Public Health and Population. The Ministry has set up an inter-sectoral National Commission on Macroeconomics and Health to adapt the CMH Report to its national strategic priorities.

At the request of the Ministry of Health of Yemen and the WHO Resident Representative of Yemen, a joint PRSP and CMH mission from WHO Geneva visited Sana'a from 9 to 12 March. The objectives of the mission were to assist the Ministry of Health in strengthening its health sector strategy, which will then feed into the PRSP, and to assess the role of the Macroeconomics and Health initiative in supporting this process, as well as identifying areas in which WHO-HQ could provide further support.

The main findings of the mission were that the Health Investment Strategy being developed by the MH process can be an effective tool in linking goals, health systems function strategies and health expenditure plans as well as a tool for advocacy. The team recommended that the MH work focus on:

- 1) Analysis: Using the three themes of the CMH Report to assess the evolving health sector strategy.
 - a) Pro-poor strategies: assess if current and proposed strategies specifically target interventions to improve the health status of the poor (e.g. primary health care (PHC) over tertiary care, and preventive over curative interventions, etc.). Then, assess if the implementation strategy includes a data collection strategy that allows monitoring and evaluation of outcomes and impact on the poor (e.g. are epidemiological data, household health spending surveys and assessment of health facility usage being disaggregated by household income quintiles, etc.)
 - b) Greater financing for health. Assessment of the financing gap to look at both options for internal reallocations of funds to health and how external funds can predictably fill gaps. Includes commission of studies to develop a localised impact analysis of the socio-economic benefits of significantly greater investments in health, especially PHC and improving access to essential health interventions among the poor and rural populations.
 - c) Removal of system barriers to access by the poor. The primary focus is to stimulate a dialogue on how the various health and health-related sectoral strategies (e.g. education, water, and sanitation strategies) can be harmonized, how local evidence can be used to set priorities, and how the various strategies can be correctly sequenced to sustain achievements. Strategies should explicitly consider how to progressively build up institutional and human resource capacity, using progress towards the MDGs as one way of tracking success.
- 2) Planning: The MH process works within the Ministry of Health to assess the quality of the evidence base, commission research to fill gaps (two papers are being completed to address these first two points), cost various health strategies, and then determine priorities and sequencing of strategies. This well-costed and evidence-based strategy will be the basis for requests for increased internal allocations and donor support.
- 3) Implementation: The national CMH team has drafted a Terms of Reference for a coordinating body that can provide input into health sector strategy, advocate for greater public expenditure on health and track the impact over time of the pro-poor elements of health plans. Two short-term objectives, incorporated in the PRSP, are to:
 - a) Support National Policy on Essential Drugs and Logistics, including the review and approval of the Essential Drug List and National Treatment Guidelines
 - b) Encourage NGOs to participate in provision of health services (e.g. Yemen Family Health Association).

4. The European Region (EURO)

Following the release of the CMH Report, the Regional Director of the WHO European Region decided to set up a special Task Force to assess the relevance of the Report's findings to the Region and propose specific interventions. The Task Force work plan is in line with the implementation of RC52 Resolution on Poverty and Health (EUR/RC52/R7). The first meeting of the EURO Task Force was held at the end of January 2003, in videoconference link with WHO Geneva and the European Observatory on Health Care Systems in Brussels. A strategy was outlined for follow-up and for the assessment of available resources.

Preliminary analytical work of the Task Force has highlighted that:

- 1) EURO countries, even at the lowest income level, have a health system in place, a tradition of public health, a work force with a higher level of skills and a better developed infrastructure than countries at a comparable level of economic attainment elsewhere;
- 2) Health data show relatively lower levels of infant, child and maternal mortality and high levels of adult mortality;
- 3) Predominant health challenges are more complex than in developing countries from other Regions, and include chronic non-communicable diseases, such as cardiovascular disease and injuries, or more difficult infectious diseases, such as multi-drug resistant tuberculosis.

EURO participated in the 2nd Macroeconomics and Health Consultation, "Increasing Investments in the Health Outcomes of the Poor", 28-30 October 2003, in Geneva.

Azerbaijan

A Country-Wide National Workshop on "Poverty and Health" was held in Baku on 19-21 November 2003. The workshop was a joint collaboration between the Ministry of Health of Azerbaijan, the European Regional Office of the World Health Organization (EURO) and WHO Headquarters. The objectives were to:

- Familiarise participants with the notions of investing in health for development;
- Provide an overview of the challenges and successes of integrating health in the PRSP;
- Provide an overview of how different health system functions and technical programmes are changing to better tackle the problems of the poor in Azerbaijan;
- Explore concrete examples of integrating social and economic determinants of population health into policy development.

The workshop blended theoretical and scientific input with practical tools useful for participants involved in decision-making at different levels of policy development in Azerbaijan. Practical experiences and case-studies were utilized.

This occurred within the context of the new Biennial Collaborative Agreement between the Ministry of Health of Azerbaijan and EURO for 2004 to 2005. One priority element of this agreement is the participation of a country representative in a "knowledge forum on pro-poor health action", with the purpose of supporting policy-makers to exchange experience on managing progress towards placing health in the context of poverty reduction strategies and MDGs.

At this time (January 2004) WHO/HQ are collaborating with the WHO country office and Ministry of Health of Azerbaijan to determine the best ways to move forward. One possibility, dependant on funding, is the placement of a short term consultant in Azerbaijan to help with efforts to integrate health into the broader development agenda.

Baltic States sub-regional initiative: Estonia

Estonia is a middle-income country in transition, a new member of the World Trade Organization steadily moving toward a market economy with increasing ties to the West, including the pegging of its currency to the euro. A major goal is accession to the EU, possibly by 2004. The overall health status of the Estonian population has been found to be poor as compared to EU and Nordic countries, for some problems lower than the reference countries of Central Europe. Infant mortality rate is 12.32 deaths/1,000 live births. Among the main health problems affecting Estonia are cardiovascular diseases, chronic liver disease and cirrhosis, alcohol abuse, occupational health and violence-related problems. Tuberculosis and HIV/AIDS are raising particular concern and have contributed to most of the 50% increase in infectious disease mortality since the late 1980s. Lack of estimates of poverty (as well as homelessness) is an obstacle to in-depth analysis of the

links between poverty and health problems, but a 2002 study commissioned by the World Bank and Ministry of Social Affairs of Estonia reached the conclusion that wide inequalities exist and are worsening.

In March 2003, WHO presented its work on the MH approach to a group of decision-makers and officials from the Estonian Ministries of Social Affairs, Foreign Affairs and Finance, academic representatives and international agencies. The Government has expressed an interest in the CMH approach, and a member of the Secretariat gave a presentation on MH strategies entitled, "Investing in Health to Reduce Poverty and Spur Development." Good interactions and dialogue followed the meeting, and Estonia is considering ways to follow up.

5. The South East Asian Region (SEARO)

The Regional Office in South East Asia has been active in communicating to countries the relevance of the CMH Report. SEARO has established a dedicated Working Group to engage in disseminating the Report's findings, making policy decisions regarding implementing its framework in the countries, and providing support to countries in this effort. Inter-ministerial and intersectoral meetings involving donors, development agencies, NGOs, media, and academia, for disseminating the core messages of the CMH Report, preceded the work. A Regional Conference of Parliamentarians on the CMH Report was held in December 2002. The Report was also on the agenda of the recent meeting of the Regional Director with WHO Country Representatives, in April 2003. Earlier, the meetings of Health Secretaries and Health Ministers, held in April and September 2002, had the CMH Report on their agendas.

In conjunction with the above meetings, the Regional Office finalized the Country Guidelines for CMH Follow-up and a related document, Outline for a Strategic Framework and Investment Plan.

In response to country interest and need for support, SEARO organized the Regional Consultation on Macroeconomics and Health for the South-East Asian Region (SEAR). This meeting was held at the World Health House in New Delhi on 18-19 August 2003. The meeting brought together representatives from the Ministries of Health, Finance and Planning from 9 SEAR countries, including Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, and Thailand. Also, East Timor-Leste was represented by the head of the WHO office in that country. Other participants included WHO representatives from HQ, Region and Country level and representatives from the World Bank, Columbia University, and USAID.

The meeting provided the countries a venue to discuss and share experiences and challenges in this process. Also, the countries had an opportunity to work with the WHO offices at all levels to discuss the support needed in terms of advocacy, technical work and building alliances with donor and development partners. Out of deliberations among countries, country status presentations, and outcomes of working groups, several considerations and challenges associated with planning and implementing a MH strategy were identified by the SEAR countries. These issues are the foundation of future coordination of efforts among countries, WHO offices, funding entities, and other partners.

Bangladesh

Bangladesh has made significant strides in improving the health of its citizens over the last two decades, including increasing life expectancy from 48 years to 61 years and decreasing total fertility rate from 6.3 to 3.3. Significant income-based inequality in health and in the provision of health services, however, continues to be an important issue. Bangladesh is currently participating in various poverty reduction and health promotion strategies in partnership with bilaterals, including developing a i-PRSP and receiving funding from the Global Fund for AIDS, TB and Malaria.

In this setting, Bangladesh plans to build on the available data and analyses done in conjunction with these initiatives and to supplement this information with further work on pro-poor planning and policy formation. The government is committed to a pro-poor health strategy that targets resources for priority health objectives and the Essential Services Package (ESP) within its new Health, Nutrition and Population Sector Programme (HNPS, 2003-2006).

A successful advocacy workshop held by the Ministry of Health and Family Welfare and the WHO-Dhaka office in May 2002 and Ministerial representation at the Regional Conference on Macroeconomics and Health in August 2003 initiated the Bangladesh MH work. Currently, the Ministry of Health and Family Welfare is in the process of establishing a NCMH equivalent - the National Commission on MacroHealth and Poverty Strategy - with the Health Economics Unit of the acting as the secretariat.

A work plan has been developed for the Commission which emphasizes continued advocacy activities linking poverty and health, evaluation of the evidence available for a situational assessment and costing identified essential health interventions.

India

India is spending less than 1% of its gross national product on its health care budget, and private health spending, mostly in the form of out-of-pocket expenditures by families and individuals, accounts for 82.2% of total health expenditures. The 2002 Indian national health policy strongly advocates increased spending by the central government. The policy envisages raising health expenditures from 5.2% of GDP in 2001 to 6% of GDP by 2010, with government health spending increasing from 0.9% of GDP to 2% of GDP.

A well-received presentation on the CMH Report during the 2002 meeting of Health Secretaries and Health Ministers led the Government of India, in January 2003, to establish a National Commission for Macroeconomics and Health (NCMH), co-chaired by the Health and Family Welfare Minister and the Finance Minister. The objectives of the NCMH are to evaluate the impact of increased investments in health on poverty reduction and economic development and to formulate a long-term strategy for scaling-up essential health interventions, with a focus on the poor.

A sub-commission will function as the technical and operational arm of the NCMH, with the chair and Member Secretary already selected and the remaining spots to be filled by 1-2 economists and 1-2 public health specialists. The sub-commission will conduct meetings and hire consultants and experts as necessary.

The work of the NCMH has been slow to commence, but building on the momentum from the 2nd Consultation on Macroeconomics and Health in October, the NCMH technical sub-commission is developing a detailed work plan and budget for 2004, identifying the key issues for India and the resources that will be needed to adequately analyse these issues. The main areas of analyses that will go into the development of a Health Investment Plan include an assessment of the current health financing mechanisms and options for mobilizing additional resources, costing of an essential health services package, the role of the public and private sector in delivery of this package, and the implications of the HIV/AIDS epidemic. Overarching issues include monitoring and accountability, decentralization, inter-sectoral coordination, ensuring equity and economic development.

In coordination with the country, regional and HQ WHO offices, necessary linkages with technical groups and expertise from WHO and other institutions are being made to assist the NCMH in the identified analyses and assessments. The end product of the work of the NCMH sub-commission will be a report by October 2004 that will be the foundation of a Health Investment Plan, and further work will be undertaken to best ensure implementation and long-lasting effects of these recommendations.

Indonesia

In 2000, total spending on health amounted to 1.6% of GDP in Indonesia, or about US\$ 8 per person. Additionally, overseas development assistance (ODA) to Indonesia averages US\$ 2.3 billion annually, of which only 6% is dedicated to the health sector. Many of Indonesia's most significant health problems – tuberculosis, malaria, infant and maternal mortality, and malnutrition – are problems from which the poor suffer disproportionately. Indonesian children from the poorest families are nearly four times more likely than children from the richest families to die before their fifth birthday.

The government of Indonesia will integrate its health and development initiatives under an overall macroeconomics and health policy framework. The objectives of this framework are to 1) accelerate existing initiatives for pro-poor policy and funding commitments: CGI (Consultative Group of Indonesia, chaired jointly by the Coordinating Minister for Economic Affairs and World Bank), PRSP, etc.; 2) provide focused technical assistance to address systemic issues and integrate pro-poor priorities into policy processes; and 3) increase political commitment for health as a means of poverty reduction and economic development.

Within this framework and in the setting of fiscal decentralization and decreased economic growth, Indonesia aims to improve overall health status through policy development and corresponding financial commitments. To fulfil the health outcomes outlined within Healthy Indonesia 2010 and the MDGs, the Consultative Group on Indonesia Health Working Group, the Government of Indonesia and the donor community have agreed on a shared plan of work consisting of 6 objectives:

1. Reduce financial vulnerability to major medical expenses
2. Optimize the participation of private and NGO health providers in increasing coverage
3. Ensure pro-poor institutional environment under decentralization
4. Ensure sufficient resources to priority health programs (financial)
5. Ensure access for the poor (non-financial constraints), and
6. Ensure accountability by local government.

Indonesia, as part of its MH work, is in the process of completing several important areas of focused research including the completion of a book that conceptualises health and poverty and describes the place of health priorities within the PRSP, a report on costing essential health services, and an assessment of human resource distribution of health care workers. Additionally, studies have been contracted to review decision-making process for sectoral allocation and absorption issues and a review of public health expenditures.

Nepal

Nepal's public expenditure on health as percentage of GDP per capita is approximately 1.06%. The trend has been a slight decrease in health sector allocations as compared to those in other sectors. By contrast, the allocations to the education and water sectors have increased. Investment in health has increased during the last 10 years from 2.1% to 5.2% of the overall government budget. Recent political instability, however, has slowed this trend.

Nepal has improved many national health outcomes, with expansion of Essential Health Care to about 70% of the population. Access to health care facilities and workers in its rural communities has significantly improved. However, geographical variations among other health indicators persist, with rural populations having poorer health outcomes. According to a recent situational analysis prepared by the Royal Tropical Institute (KIT) of Amsterdam, health financing stems mainly from taxes and users fees, with the poor bearing the brunt of these fees. There are significant resource gaps on the road to achieving MDGs.

In response to the CMH recommendations, a Sub-Commission on Macroeconomics and Health (SCMH), part of a National Commission on Sustainable Development, has been formed. The Sub-Commission is chaired by the Ministers of Health and Finance and is comprised of representatives from most of the ministries, the National Planning Commission and the private sector. The WHO Representative to Nepal and the WHO Health Planner have been in close contact with the Sub-Commission. The Sub-Commission has identified key activities and areas of research (including advocacy workshops, epidemiological profile of disease among specific populations, a study on private health expenditures, and developing a coordinated effort for health sector reform and poverty alleviation) needed to move forward the MH process. Some studies that are relevant to the work of the SCMH are being carried out by the Health Economics and Finance Unit of the Planning Division of the Ministry of Health, including pilot projects with Social and Community Health Insurance schemes and studies of private health expenditures.

Nepal has developed a work plan for the SCMH for 2004 and is collaborating with the Royal Tropical Institute (KIT) of Amsterdam to carry forward the initial situational analysis and other technical assistance relevant to the Macroeconomics and Health work.

Thailand

Many in the government of Thailand believe that to achieve better health, a holistic approach, demanding strong support from non-health sectors, is crucial in overcoming health-related problems. The increasing roles of development banks in various structural adjustment programmes, including health, are evident in Thailand. Examples include the trend toward hospital autonomy and the public sector reform initiative.

In response to the CMH Report, the Ministry of Public Health of Thailand has set up a Working Group on Macroeconomics and Health, co-chaired by the Senior Advisor to the Ministry in Health Economics and comprised of 15 experts from the health, economic, and financing sectors. The Working Group has developed a proposal to set up a National Commission on Macroeconomics and Health (NCMH). It has been proposed that the NCMH be jointly chaired by the Health and Finance Ministers. A joint secretariat will be set up comprised of representatives from National Economic and Social Development Board (NESDB) and the Bureau of Policy and Strategy to develop a strategic framework for an investment plan targeting the MDGs.

The MH process for Thailand as defined by the Working Group consists of five steps: 1) Analysis of current situations and trends focusing on the poor and marginalized, 2) Diagnosis and prioritization of the main health problems, 3) Examination and evaluation of selected health interventions for cost-effectiveness and feasibility, 4) Development of a Strategic Framework and Investment Plan; and 5) Advocacy for mobilizing political support for integration of health into poverty reduction strategies. The Working Group has identified study on cost-effectiveness of interventions in the Thailand context in 15 diseases as a priority area of further study.

Sri Lanka

Sri Lanka has had well known and significant successes in the public health arena, including decreasing birth rates and death rates, increasing life expectancy to levels of developed countries and low infant mortality rates and maternal mortality rates. However, there are still significant disease challenges for Sri Lanka. Malaria, TB, and mental illness are on the rise and malnutrition is not under control. Sri Lanka is also addressing current human resources issues, such as a shortage of nurses and paramedics as well as the commitment by the government to absorb all graduating doctors through 2009.

In light of the existing health issues, Sri Lanka is assessing whether it is investing enough in health. Compared to other countries in the region and globally, Sri Lanka's national health expenditure as a percentage of GDP (3.2%) is low. Sri Lanka is currently evaluating various strategies to mobilize funding for health, including the feasibility of private insurance, community financing, ear-marked taxes, and cost-containment strategies.

Sri Lanka formed a National Commission on Macroeconomics and Health (NCMH) in early 2003 to address health sector priorities, including mobilizing funding for health and the shortage of health care workers. The NCMH is co-chaired by the Minister of Health, Nutrition and Welfare and the Minister of Rural Economy and Deputy Minister of Finance and includes representatives from various ministries, the WHO Country Office, UNDP, the private sector and academia. The work of the NCMH is synergistic with Sri Lanka's Poverty Reduction Strategy Paper (PRSP) and Vision 2010 –which formulated an economic development strategy calling for sustained 7 to 9 % annual GDP growth – in developing a long-term policy that highlights pro-poor health and development issues and achievement of the MDGs.

The NCMH is commissioning health financing studies on designing and costing a basic health care package for the poor, human resource planning and issues of decentralization. The NCMH has also commissioned a report entitled "Macroeconomics and Health Initiatives in Sri Lanka".

The NCMH has developed a work plan for 2004, which will culminate in a needs-based ten-year investment plan and report of the NCMH, based on the studies summarised above and others looking at the economic implications of disease and scaling up interventions. Additionally, the Commission will focus on building the capacity for MH work at the central and provincial levels, including a potential National Centre in Macroeconomics and Health.

6. The Western Pacific Region (WPRO)

The recent outbreak of Severe Acute Respiratory Syndrome (SARS) led the Western Pacific Regional Office to devote scarce resources to confronting this grave event. In spite of this, they continue to support strongly the further dissemination of the CMH Report's findings. They are working with member states to increase the uptake of this evidence base into national health policy development and the design of poverty reduction mechanisms. Despite the challenges posed by the SARS outbreak, two states, China and Cambodia, have moved forward substantively with instituting a Macroeconomics and Health process.

In addition, a regional proposal outlining the MH activities and outcomes for governments of Papua New Guinea, Philippines, Lao PDR, and Mongolia has been developed by the country and regional offices.

People's Republic of China

Sparked by a strong expression of interest by the Government for information about MH strategies and the findings of the CMH, the Commission's Report was translated into Chinese in November 2002. Follow-up discussions stimulated authorities to integrate health investment into reform agendas and new developmental policies. Recently, the urgency of investing in health was heightened by the media attention surrounding SARS.

China has made considerable progress in the past 20 years towards improving living standards, including health, as well as reducing poverty and achieving strong macroeconomic growth. Large-scale poverty reduction has been one of China's greatest accomplishments during its economic reform period. Since the early 1980s, GDP growth has averaged 10 % per annum, life expectancy and mortality rates have continued to improve markedly, while some 400 million people have been lifted out of poverty.

In the aggregate, China has made considerable progress in improving its key health indicators in the last 50 years mainly because of the public health emphasis of government spending prior to 1980. For the most part, these gains have been maintained or slightly improved with the early market economy reforms which emphasized provision of fee-for-service rural care and rapid adoption of higher technologies. The improvements, however, mask sharp underlying disparities. Inadequate financing of health services in poor areas and limited access in remote areas, particularly in western China, have resulted in widening disparities in health conditions. Since 1980, the share of villages with Rural Cooperative Medical Systems (RCMS) has declined from about 90% to just 14-15%. Even in urban areas, community health services are under-supplied, while there has been a proliferation of high-cost hospital services.

China's public health spending shrank as a share of GDP (to 1.3%). During the same period patient fees and insurance payments, mainly for non-public health services, rose sharply in both absolute value and their relative importance. External funding by the foreign assistance community remained an important stimulus and source of finance, helping central and local authorities attend to immunization, nutrition, tuberculosis and other infectious diseases, and to emphasize the needs of the poor and creation of public goods in health.

A key constraint to effective delivery of health services includes a decentralized system of inter-governmental finances, exacerbating regional inequalities and the effective delivery of health services. Local governments bear heavy expenditure responsibilities, including for providing health services, which are not matched by adequate own-revenue sources or sufficient government transfers.

Strategic, targeted increases in government spending on the health of the poor will build their capacity for production and increase their ability to contribute to the rural economy. This will help ensure overall socioeconomic stability and create options for sustainable health insurance systems. Health investments can be an important development objective, as it will improve rural health conditions, decrease regional health disparities and, by improving the health of the local workforce, augment the output of the rural economy.

Along with Health Partners in China, the Ministry of Health has set forth an outcome-oriented follow-up to the CMH Report. Chinese authorities are building a local evidence base to systematically link poverty alleviation and health reforms to the UN Development Assistance Framework, especially in conjunction with the UN Theme Group on Health. The CMH process has built momentum among China's policy makers to use the Report's evidence to design national policies that integrate health and economic development. The challenge is to better integrate individual initiatives within an overall policy framework to provide common direction based on the nature of poverty and health in China. The initial analyses undertaken that placed the CMH recommendations in the China context included a study on the sub-provincial linkages on health and local economic growth, a analysis of China's macroeconomic policies (in conjunction with DFID), a study describing the economics of rural health, and an analysis of the effect of migration patterns on health care.

In April 2003, the Ministry of Health and the Chinese Health Economics Institute held a work session to review follow-up activities, strengthening their conviction to develop a Macroeconomics and Health strategy. China participated in the 2nd Consultation on Macroeconomics and Health (October 2003, Geneva) where they presented their overall strategy through a China State Council-backed document entitled "Macroeconomics and Health in China" and led a meeting which enabled Consultation participants to discuss China's experiences and progress made on public health issues. This document identified three main issues: 1) Inadequate health service capacity, 2) Inadequate health services for disease control and prevention; and 3) Incompatibilities between the health management system and the new economic system of the socialist market economy.

China's activities during the 2nd phase have focused on continuing the work already begun, including expansion of the sub-national National Health Accounts analysis and a new studies that will potentially analyse the options for rural health scale-up under the New Cooperative Medical Schemes and analyse community-based social insurance for health. Other work includes the analysis of the effect of SARS-related investments on pro-poor health investments and health system development and the development of the overall MH strategy.

The planned work for China in 2004 will centre on the integration of the studies commenced, the review of the various epidemiological profiles in China and finally to incorporate the evidence collected into a medium-term investment plan. This work will be carried out in cooperation with high-level government participation, WHO offices, local academics and experts and in integration with existing bilateral and multilateral initiatives and projects.

Cambodia

Cambodia has strong interest in implementing the findings of the CMH Report, especially in light of the desire to move purposefully towards the achievement of the MDGs. The Health Strategic Plan of 2002 provides a framework for cohesion among three other important efforts: a medium-term expenditure framework; a monitoring and evaluation framework for analysing cross-sectoral performance; and guidelines for developing annual operational plans for Health Ministry departments. This is enhanced by the Health Sector Support Project, funded by a broad coalition of donors, instrumental in the government's adoption of a long-term Poverty Reduction Strategy for 2003-2005.

Within this dynamic context, the WHO country office built commitment and support for the first health sector review. This led to the Finance, Planning and Health Ministries to debate how to introduce the MH process and ascertain entry points into health policy issues. In February of 2003, Dr. Jeffrey Sachs visited Cambodia and discussed with senior government leaders how the evidence provided by the CMH Report could be localised to achieve substantive outcomes.

On 22 May 2003, the Royal Government of Cambodia and the WHO Country Office jointly drafted the "Proposal on Macro-Economics, Poverty and Health". Government authorities are ready to scale up access of the poor to essential health interventions as defined by epidemiological evidence on Cambodia's burden of disease, especially among the poor and disadvantaged.

With government support strong, the Proposal requested that a National CMH (NCMH) be established, firmly integrated into the overall PRSP process. Chaired by both the Ministers of Health and Finance, and involving influential stakeholders from society, donors and other partners, the Commission will serve to implement a long-term strategy for increased health investments.