

The financial crisis and global health

Report of a high-level consultation

Geneva, Switzerland – 19 January 2009



**World Health
Organization**

Acknowledgements

This report was produced by the WHO Secretariat using documentation from the high-level consultation on the financial crisis and global health (Geneva, 19 January 2009).

Preparatory work for this consultation was carried out by a working group co-chaired by Dr Anarfi Asamoah-Baah, WHO Deputy Director-General, and Dr Marc Danzon, Regional Director, WHO Regional Office for Europe. The working group was supported by a group of external experts:

- *María Soledad Barría Iroume, former Minister of Health, Chile*
- *Eduardo Doryan, Costa Rican Social Security Fund, Costa Rica*
- *Antonio Duran, Técnicas de Salud, Spain*
- *Chris Lane, African Department, International Monetary Fund, Washington DC, United States of America*
- *Robert Madelin, Directorate General for Health and Consumers Affairs, European Commission, Brussels, Belgium*
- *Diane McIntyre, School of Public Health and Family Medicine, University of Cape Town, Cape Town, South Africa*
- *Martin McKee, London School of Hygiene and Tropical Medicine, London, United Kingdom of Great Britain and Northern Ireland*
- *Richard Newfarmer, Special Representative to the United Nations and the World Trade Organization, the World Bank, Geneva, Switzerland*
- *Viroj Tangcharoensathien, International Health Policy Development, Ministry of Public Health, Thailand*

WHO staff:

Denis Aitken, Adelio Antunes, Henk Bekedam, Ties Boerma, Guido Carrin, Andrew Cassels, Eleonora Cavagnero, Nico Drager, David Evans, Tim Evans, Josep Figueras, Lea Guido, Mohamed Jama, Miloud Kaddar, Mouhamadou Kebe, Joses Kirigia, Liu Yunguo, Nata Menabde, Jai Narain, Adrian Ong, Alex Ross, Hossein Salehi, Benedetto Saraceno, Alaka Singh, Ian Smith, Ruben Torres, Guadalupe Verdejo, Diana Weil

© World Health Organization 2009. All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitations of its frontiers or boundaries.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

WHO/DGO/2009.1

The financial crisis and global health

Report of a high-level consultation

Geneva, Switzerland – 19 January 2009



CONTENTS

1

REPORT

- 1 Introduction
- 5 Conclusions

7

OPENING STATEMENTS

- 7 • HE Nimal S. DE SILVA – Chairman
Minister of Healthcare and Nutrition (Sri Lanka)
- 9 • Dr Margaret CHAN
Director-General, World Health Organization (Switzerland)
- 11 • Dr Andrew STEER
Director General, Department for International Development (UK)
- 14 • Mr Richard NEWFARMER
Special Representative to the United Nations and the World Trade Organization, the World Bank (Switzerland)
- 19 • HE Maria Farani AZEVÊDO
Ambassador, Permanent Representative of Brazil, Permanent Mission of Brazil to the Office of the United Nations and other International Organizations (Switzerland)
- 21 • Dr Manoj KURIAN
Programme Executive, Health and Healing, World Council of Churches (Switzerland)

24

BACKGROUND PAPER

- 25 Impact of the crisis on health
- 29 Mitigating the health impact of the financial crisis

34

MODERATOR, PANELISTS AND PROGRAMME

Introduction

1. In response to concerns expressed by Member States, the Director-General convened a high-level consultation before the opening of the Executive Board's 124th session on the impact of the global financial and economic crisis. The objectives were:
 - a) to build awareness of the ways in which an economic downturn may affect health spending, health services, health-seeking behaviour and health outcomes;
 - b) to make the case for sustaining investments in health; and
 - c) to identify actions – including monitoring of early warning signs – that can help to mitigate the negative impact of economic downturns.
2. This report summarizes key points from the discussion and the conclusions of the meeting. The whole document also includes a background paper, the meeting programme with a list of panelists, and the opening remarks made by the Chairman of WHO's Executive Board, the Director-General and the four invited panel members.

All countries will be affected, but some will be affected more than others

3. As a consequence of the financial crisis in OECD countries, the world risks the most **serious economic downturn** since the 1930s. The impact of earlier increases in the cost of food and fuel are estimated to have tipped more than 100 million people back into poverty. The challenge facing the world now is to prevent an economic crisis becoming a social and a health crisis.
4. Earlier crises in the 1980s and 1990s started in developing countries. In the current case, the crisis began in the industrialized world; it is therefore possible that the full effects have yet to be manifest in developing countries. At the same time, for the many low-income countries that have been facing chronic financial shortages, hardship is not new. **A grave human crisis is already happening.** The problem is that their situation may get even worse as they are affected by the downturn, and through causes which are not of their own making.
5. **Some countries are at particular risk.** These include developed countries that have required emergency assistance from the International Monetary Fund, where spending restrictions may be imposed during loan repayment. Many developing countries are in a far better fiscal position than they were in earlier crises, and most will continue on a path of economic growth, albeit at a slower rate. However, those that depend heavily on donor funding in health risk facing a decline in aid receipts. Populations in those countries affected by or emerging from conflict, with few financial reserves, weak institutions and damaged infrastructure, are especially vulnerable. Others, particularly small island developing States, have to face an economic downturn while coping with the imminent impact of climate change.

6. In high- or low-income countries, however, it is the poor – and those made poor through loss of income or housing – that will be hardest hit. Identifying **vulnerable populations** is as important as identifying vulnerable countries.

Solidarity in times of crisis: safeguarding progress, standing by commitments and keeping promises

7. In recent years, governments of many low-income countries have increased spending on health. Aid for health has doubled between 2000 and 2006 and overall commitments to aid spending have increased. Many countries have made impressive progress towards the achievement of the Millennium Development Goals. Making significant inroads into reducing levels of absolute poverty is now a real possibility.
8. Ensuring that financial and economic crises do not undermine these aspirations and achievements requires a strong sense of **solidarity**:
 - a) between donor governments and the countries that require their support: keeping to promised levels of development assistance;
 - b) between governments and their citizens: promoting an ethical dimension to public policy – and in particular, maintaining essential health and social services, and
 - c) between citizens: sharing risks and responsibilities as the basis of strong health systems.
9. **Civil society** should maintain vigilance with regard to the commitments of governments, donors and international agencies.
10. In summary, the financial crisis has provoked an examination of the values that underpin societies worldwide. The health response should likewise aim to be transformative and promote a focus on **social justice**.

There is much that can be done to mitigate the impact of the financial crisis

11. The effects of the crisis in many low- and-middle income countries are increasingly evident: private financial flows are falling (from US\$ 1 trillion to half that amount); foreign direct investment and remittances are decreasing; and exports from developing countries are down in terms of price and volume. The consequent effects of unemployment and decreasing revenues impact on household income, government spending and the capacity of other actors in the private and voluntary sector to contribute to the health effort. All this is happening at a time of greater health need.
12. Participants of the consultation provided many examples of ways in which to protect health and health spending in times of crisis. There was agreement that the world is somewhat better prepared to deal with the crisis than was the case in the 1980s. Although **short-term measures** to mitigate negative consequences of the crisis are urgent, many participants stressed the need to take a **longer-term perspective** that will have the effect of making the health sector more resilient in the future.

Protecting health spending

13. In contrast to what has happened in previous crises, several countries reported an increase in health budgets. Those that were expecting to face growing pressure from ministries of finance need evidence-based arguments that demonstrate the **economic benefits from investment in health**. Others pointed out that access to health care is an **entitlement** in its own right, and that this too must be part of the case made to governments and financial institutions.
14. A policy of protecting overall health spending may be necessary, but is not always sufficient. In Brazil, experience has shown the need to specify the proportion of state and municipal budgets that must be allocated to health. The World Bank highlighted the need to ensure that health spending was **targeted to the poor**, as experience shows that otherwise the benefit of spending in health may be captured by richer households.

Saving lives and protecting incomes

15. Several participants noted the importance of social protection, making the link between the need to **safeguard incomes as well as health** – for example, through temporary employment schemes which themselves have social benefits, such as building schools and clinics. Again, targeting is critically important to ensure that spending through safety-net programmes reaches those that need it most. The Mexican participant highlighted the potential for schemes that transferred cash to poor families to be used as a means of promoting the uptake of preventive health interventions.
16. Social protection requires **policy coordination** across several sectors – linking policies that stabilize prices, reduce the cost of buying food, help people maintain health insurance payments, and keep children in education. Social health protection – pooling risks through tax or insurance-based systems for health financing – is a crucial component of the mix.

Making health spending more effective and efficient

17. There was widespread agreement that, if government budgets come under pressure and household income drops, the **demand on public services will increase**. Experience has shown that spending in the private sector tends to decline in an economic downturn, as patients either defer care completely or turn from the private to the public sector, if care is available at lower cost. Unless public sector services are ensured adequate financial support in these circumstances, quality of care is likely to deteriorate.
18. In line with the theme of solidarity, several participants highlighted the importance of working towards universal coverage, as part of an overall **primary health care approach**. In this regard, strategies to mitigate the impact of the financial crisis need to be seen also as **opportunities for reform** – in the way services are both financed and organized. There was strong agreement that calls for greater efficiency should be seen as a stimulus for smarter, more effective ways of working, not as another word for cuts.

19. A recurrent theme in the discussion of more effective health spending was the importance of **sustaining support for prevention**. Curative care attracts more political attention, and it is tempting for preventive activities to be sacrificed in the face of budgetary pressures. Getting the balance right between maintaining essential curative services and sustaining preventive programmes – and convincing the economists in ministries of finance of their value – is essential in managing the health sector at times of crisis.
20. Better health is an outcome of activities across society. **The response to the crisis needs to be multisectoral**, seeking health gains through demonstrating the importance of health in all policies. The participant from New Zealand made the point that international agencies and development banks need to review their own investments in terms of how they address the broader **social and economic determinants of health**.

Collaboration between and within countries

21. The role of **civil society organizations, as service providers and advocates**, comes to the fore particularly at times of crisis. Governments should recognize this role and use the assets they provide to the full.
22. It was noted that countries in the WHO European Region will meet in Oslo in April 2009 in order to discuss the impact of the financial crisis in health, and there were calls for, and examples of, **regional leadership** and collaboration – to monitor development cooperation and as well the effects on health services in countries facing similar problems.
23. Participants stressed that a key characteristic of the crisis is the **speed** with which it evolves, and the consequent **uncertainty** facing policy makers. Rapid assessments, effective communications, exchange of experience, effective and flexible working arrangements will all be essential to success.

Informing policy through better monitoring, analysis and research

24. Past crises provide limited guidance as to best practice. There was a strong call for a more rigorous approach to monitoring and analysis – bringing science and modelling to bear on the situation. Analysis should provide the basis for effective **contingency planning** in relation to specific aspects of health care. Examples cited included care for the elderly and employment-based insurance schemes.
25. Monitoring **early warning signs** requires information from different sources. International organizations – particularly the World Bank, WHO and regional banks – were urged to work collaboratively.
26. **Research** should not be regarded as a luxury. Rather, research can be a critical tool in developing the health response to the crisis.

Aid for health

27. In developing countries aid will be crucial for maintaining spending on key services. In addition to the need to fulfil commitments on the part of donors, participants stressed that both the **quantity and quality of aid** are important. Tapping innovative sources of funding (currently being explored by the High-Level Task Force on **Innovative Financing** for Health Systems) can raise additional funds for health. However, several countries and panel members stressed that greater **predictability** of external financing is vital – to facilitate planning and to obtain better value for money. There was also a suggestion that all donor agencies, but particularly the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance, should make greater efforts to streamline their application processes.
28. **Fragmentation** between the many different actors and funding channels was acknowledged as a major problem in many aid receiving countries. More rapid progress through initiatives such as the International Health Partnership – which seek to implement the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action in the health sector – is needed.
29. The consultation suggested five areas where action at global, regional and country levels – with support from WHO – will help to ensure that the health sector emerges from the crisis in good condition.

Conclusions: a five-point framework for action

• *Leadership*

Leaders in health must be prepared to speak out – unequivocally and on the basis of sound evidence – to make the case for health at times of crisis. This must happen at country level, where health ministers and their officials work with ministries of finance. Regional institutions can be a powerful force in bringing countries together. At global level, it is imperative that the need for safeguarding progress in health, and ensuring that donors keep to their commitments, becomes a focus in meetings of global leaders. WHO should ensure a strong voice for health through its work on advocacy.

• *Monitoring and analysis*

Contingency planning must be based on good quality information. It is clear that the impact of the crisis will vary country by country. Country-specific analysis will therefore be essential to guide policy and to assess the potential impact on different populations and institutions. Early warning systems will require collaboration

between organizations with complementary fields of expertise. In addition, WHO will pay particular attention to monitoring financial flows for health from governments and donors as well as the cost and availability of medicines and other forms of care.

- *Pro-poor and pro-health public spending*

There is widespread agreement that counter-cyclical public spending provides a means of reviving economies. Aid will play a key role in providing a boost that many low-income countries cannot finance alone. The challenge is to ensure that spending is genuinely pro-poor and that, where possible, it has a positive impact on health. Infrastructure investments provide one route, but other opportunities for safeguarding lives and income can also be identified. Short-term measures can provide the basis for more ethical public spending in the future.

- *Policies for the health sector*

Primary health care provides an overarching approach to policy at a time of financial crisis. Its continuing relevance lies in its value base – stressing the importance of equity, solidarity and gender; through inclusiveness – and the objective of working towards universal coverage and pooling of risk; through a multisectoral approach to achieving better outcomes; and through utilizing the assets of all health actors in the private, voluntary and nongovernmental sectors. WHO should provide support, on request, through country offices supported, as necessary, by regional offices and headquarters.

- *New ways of doing business in international health*

The financial crisis requires that the international health community asks some fundamental questions about the way it operates. These include: how to reduce overlap and duplication between the work of different agencies; how to promote greater synergy between individual health programmes; how to ensure that key health promoting interventions in areas such as nutrition and sanitation are not neglected; how to accelerate progress in United Nations reform; how to bring a greater number of specific initiatives more in line with country priorities? Progress will depend on action at country, regional and global level. WHO is also concerned to increase its own effectiveness, and work is in hand to seek efficiencies, to explore new and better ways of working, and to review priorities.

OPENING STATEMENTS

HE Nimal S. DE SILVA

Minister of Healthcare and Nutrition, Sri Lanka

Dr Margaret Chan, Director-General of WHO, your excellencies, distinguished members of the panel, distinguished delegates, ladies and gentlemen, at the outset I take the opportunity to thank the Director-General for convening this high-level consultation on the financial crisis and global health with a view to building awareness on possible ways in which the economic crisis may impact the health sector and also to identify actions that could help to prevent and mitigate the negative impact of the economic downturn.

I am grateful for having been afforded this opportunity to chair this important meeting.

We are indeed living in an unprecedented period with three major crises confronting us – food, energy and most importantly, the financial crisis. The financial crisis in particular has affected across the globe, without exception, not only the economies of the developing countries but also those of developed countries.

We are here to discuss the ways in which we could prevent and minimize the adverse impact of this economic tsunami which could devastate the social sector, particularly the health of our people. Therefore it is very timely that we collectively explore the ways and means of ensuring that the health systems are protected to the greatest degree possible from the impact of this financial crisis.

Expenditure on health should be always seen as an investment for human development which will have reflex actions on economic gains. Therefore it is essential that we look at health expenditure as a priority, over and above the other types of expenditure in our national budgets.

We must also be mindful that in many countries private expenditure constitutes a significant part of all health expenditure. With loss of avenues of income as a result of this financial crisis, many people in our countries will lose their capacity to afford these private health expenditures. This will further burden the government sector and will make it absolutely necessary to safeguard the investments in health.

We have a global commitment to achieve the Millennium Development Goals and it is unfortunate that the crisis has come at a time when our countries are striving hard to reach these goals in good time. This makes it almost imperative that the funding of the health sector is not compromised at any cost.

In most of the WHO regions, including the South-East Asia Region, we need to ensure that nutrition and immunization are not in any way affected, for these could have considerable long-term consequences for all our populations. Communicable diseases

in general, particularly poliomyelitis, avian influenza, HIV disease and the like are also equally important, as many of these are potentially critical and could lead to pandemics and they do not recognize any geographical boundaries.

My own country, Sri Lanka, has been seriously affected by the present global financial crisis. Our main export commodities, tea, rubber, coconut and cinnamon, now fetch very low prices in the world market but also are less in demand. The demand for finished goods such as garments is declining and that will have serious repercussions in this sector. Despite these economic setbacks and the high defence expenditure on the fight against a terrorist movement, my Government has not compromised its investments in health in any way. We deliver free health care to the whole nation, with no user fees at all. In fact, in 2009 the total budgetary allocation for the health sector increased to 87 billion rupees (the equivalent of US\$ 800 million) from 67 billion rupees (US\$ 600 million) in 2008, a real increase of more than 25%, and this despite the problems that I mentioned, demonstrating the commitment of the Government of Sri Lanka to protect the social sector.

As the Chairman of the Executive Board, it is my duty to emphasize that, as WHO is the global leader for health, we must zealously guard and protect its capacity for meeting its responsibilities. I am sure all of us are deeply conscious of this and the Member States and our partners that provide considerable funds to WHO will not allow WHO's capacity to be compromised in the midst of this crisis.

United Nations agencies, private-public partnerships and nongovernmental organizations have strengthened the health systems in many developing countries. It is our fervent wish that their capacities to continue their humanitarian missions will not be affected.

Leading global financial agencies, such as the World Bank, the International Monetary Fund, and the Asian Development Bank, and the international community also have a responsibility to find innovative ways and means to bridge the gaps that will be created by this financial crisis.

We have a very distinguished panel from the key areas relevant to the financial crisis and I am sure will hear extremely rich contributions to stimulate this discussion. I am sure we will have a very interactive and fruitful discussion.

Now I have great pleasure in inviting the Director-General, who mooted this idea, to make her opening comments.

Dr Margaret CHAN

Director-General, World Health Organization, Switzerland

Honourable ministers, distinguished experts, ladies and gentlemen, let me extend my warmest welcome to all of you, and my special thanks to panel members for agreeing to join us on such short notice. The topic is acutely relevant. Time is short. I will be brief.

I have convened this consultation for several reasons. First and foremost, countries at all levels of economic development are concerned about the impact of the financial crisis on health.

Officials are worried that health in their own countries may worsen as unemployment rises, safety nets for social protection fail, savings and pension funds erode, and spending on health drops. They are concerned about mental illness and anxiety, and a possible jump in the use of tobacco, alcohol, and other harmful substances. This has happened in the past.

Officials are also worried that present levels of financing for international health development may not be maintained. These issues are extremely important for initiatives such as the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

In a time of austerity, how do we set priorities? How do we decide what to continue, and what to cut?

Such concerns are fully justified. The situation is alarming and highly volatile, as it has some unprecedented dimensions.

Financial markets, economies and businesses are more closely interconnected than ever before. As we have seen, financial turmoil is contagious, moving very rapidly from one country to another and spreading very quickly from one economic sector to many others.

The crisis comes at a fragile time for public health. We are in the midst of the most ambitious drive in history to tackle the root causes of poverty and reduce the gaps in health outcomes. No one wants this momentum to stall.

In times of economic crisis, people tend to forego private care and make more use of publicly financed services. This trend will come at a time when the public health system in many countries is already vastly overstretched and underfunded.

In many low-income countries, more than 60% of domestically sourced health spending is private, largely in the form of direct out-of-pocket payment. Economic downturn increases the risk that people will neglect health care, with prevention falling by the wayside. Less preventive care is particularly disturbing at a time when demographic ageing and a rise in chronic diseases are global trends.

We know, too, that women and young children are among the first to be affected by a deterioration in financial circumstances and food availability. Moreover, recent trends in international trade have left many countries with little self-sufficiency in the production of staple food items, a cornerstone of food security.

I have convened this consultation for three further reasons.

- First, we must seize every opportunity to protect populations and pre-empt adverse effects on health. Together, we need to use past experiences to get as good a grip as possible on what might happen, what are the warning signals, when to intervene, and what to do.
- Secondly, ministries of health and foreign affairs need a set of compelling arguments for persuading other ministries to protect funding for health, nationally and internationally. In the past, we have seen the social sectors robbed in times of economic downturn, with dire long-term consequences.
- Finally, we need to be very smart and cost-conscious in the early warning systems and protective measures we recommend. I want to assure you that WHO is looking at the use of existing systems and instruments.

I am personally looking at the overall efficiency of WHO's operations. And I want to assure you that I am prepared to exercise strict financial discipline in my capacity as chief technical and administrative officer of this Organization.

Dr Andrew STEER

**Director General, Department for International Development,
United Kingdom of Great Britain and Northern Ireland**

Your excellencies, Ministers of Health, Director-General, friends, thank you for the invitation to this very important event. Congratulations to the Director-General and staff of WHO for convening and leading us. Thanks too to WHO for the excellent background paper.

The global recession

The world economy has entered its most severe downturn since the 1930s. Coming on top of the food and fuel crises of 2008 this is likely to seriously set back the fight against global poverty.

Already 100 million people were pushed into poverty by last year's events. And it would not be surprising if another 100 million fall into poverty as a result of the global recession.

Many middle-income countries have already felt the impact through the channel of financial markets. Most low-income countries have not – but should expect to in the months ahead.

- Capital flows to developing countries will decline sharply – probably by half, from about US\$ 1 trillion per year to about US\$ 500 billion.
- Foreign direct investment is likely to decline – as investors find it difficult to raise finance, and seek to avoid risk.
- Exports from developing countries may well decline, for both volume and price reasons, as world trade falls this year for the first time in nearly 30 years.
- Remittances, which have amounted to around US\$ 280 billion per year, are expected to fall as host-country economies suffer.

Some of these declines may seem modest, but they must be compared with the rapid growth that countries have become used to in recent years. Private investment decisions are based upon expectations of continuing growth – and thus may now fall sharply.

As a result growth in incomes and employment in developing countries will shrink; tax revenues will be much lower than budgeted; unemployment is likely to increase; and poverty will rise in many areas.

We do not know the precise impact of course, but we need to be prepared. At a minimum we expect growth rates to fall by 2% to 3% for the next two years. It is fair to guess that by the end of 2010 African per capita income levels will be at least 5% lower than they would otherwise have been. This is an average figure. Many poor families will suffer bigger declines.

Impacts on health

Impacts on health will vary greatly by country and context, but past downturns show some common patterns.

The impact on the poor will be especially serious, as risk-management options are limited: the poor may need to sell productive assets, nutritional standards are likely to fall and the ability to spend on private health care will fall.

We hope that the current downturn will not be as severe as that suffered by east Asian countries a decade ago. In that situation morbidity and mortality rates rose, with infant mortality rising in many local areas.

A common feature of most downturns is that spending on private health care falls as people turn to public health care. The demand for public health care rises significantly at precisely the time that governments feel the financial need to cut back. In such situations it is the poor who are almost always squeezed out. And it is important to remember that many millions of poor families are entering this period in an already weakened state because of last year's price volatility. Tragically, it is estimated that 40–50 million children experienced permanent cognitive and physical injury last year as a result of the food crisis alone.

What to do?

Most obviously, we need to **do** all we can to minimize the depth of this recession, and its spread to developing countries. Nobody could fault our leaders for not trying hard in this regard. No previous downturn has ever had as much money, effort and brainpower put into finding a solution. The G20 Economic Summit on Recovery and Jobs, to be held in London on 1 and 2 April 2009, will bring together the leaders of the Group of Twenty countries with the aim of agreeing on common coordinated solutions.

- *Adequate resources*

Closer to home in the health sector, we need to ensure that resources for health do not fall. For rich countries, this means keeping our promises. Promises made at the International Conference on Financing for Development (Monterrey, Mexico, 2002) and at the G8 (Gleneagles, Scotland, 2005, and Hokkaido Toyako, Japan, 2008) and European Union summits must be kept. Keeping promises in good times is not difficult. The test of sincerity comes in difficult times. In the past three global recessions, official development assistance levels fell – at precisely the time when it was needed the most. In the past two global recessions, such assistance for health also fell.

The United Kingdom Government has announced its determination to honour its pledge to raise official development assistance to 0.56% gross domestic product in 2010 and 0.7% in 2013. It is very important that that assistance not be diverted from health and other social sectors. The Government is committed to provide £6 billion (US\$ 9 billion) for achieving the health-related Millennium Development Goals by 2015. This implies a spending of almost £1 billion per year.

In addition, we are committed to spend 90% of our bilateral assistance on low-income countries, and we expect to spend about 62% of our total bilateral official development assistance in fragile states, the home of the “bottom billion”.

Under the principles of “mutual accountability” that we agreed in the Paris Declaration on Aid Effectiveness (2005) and Accra Agenda for Action (2008), we expect to be held accountable for these commitments we have made, just as partner countries will want to be held accountable as they make sure that their own budget resources are not diverted from health and other social services, as has sometimes happened in the past.

- *Innovative sources of finance*

We will also need to be more innovative in seeking new sources of funding. This is why a High Level Taskforce on Innovative International Financing for Health Systems was created at the United Nations last September, under the chairmanship of the United Kingdom's Prime Minister Gordon Brown and Robert Zoellick, President of the World Bank. The Taskforce will report to the G8 Summit to be held in La Maddalena, Italy, in July, with a final report ready for the United Nations General Assembly in September.

It will explore a range of options – including scope for encouraging non-traditional donors, and voluntary levies earmarked for health in poor countries. It will also explore options for front-loading official development assistance, and making it more predictable. This can help add to the value of the aid. The Centre for Global Development has shown how the value of money rises by 11% if it is truly predictable, and in the right circumstances front loading also makes the money more valuable. The International Finance Facility for Immunization has already demonstrated high returns, and the Taskforce will explore whether such an approach would be possible for investment in health systems.

Innovations in public-private partnerships also need to be aggressively pursued. The pilot advance market commitment programme for new drug development needs to be monitored and (very likely) expanded. So too with innovations in product development partnerships with private and nongovernmental laboratories. And the remarkable innovations we have seen over the past decade in the GAVI Alliance, the international drug purchase facility UNITAID and the Global Fund to Fight AIDS, Tuberculosis and Malaria need to be understood and mined for further expansion.

- *Spending money better*

Finally, we need to make health funding go further. Let us be frank **here**: in the health sector we have not been as cost-effective as we might. In many countries we still are not able to trace exactly how much money really reaches the interface with the client, and how much gets used up for administration along the way. We need to do a better job at monitoring flows of funds, ensuring that they reach the front lines, and deliver high-quality health at the lowest cost possible. We also need to invest more heavily in systems to monitor emerging health problems and to track results.

At the international level there is still scope for much better teamwork among agencies and donors, offering in turn opportunities to deliver better value for money. The International Health Partnership is beginning to play an important role in this regard, and we look forward to the upcoming ministerial meeting here in Geneva in two weeks' time.

A final word

Progress over the past decade has been impressive by any historical standard. As a result we stand where no generation has stood before: with a realistic chance of eliminating mass poverty within our generation. Access to good health care is a central plank of this goal.

The current crisis seriously threatens this dream. We must all use every ounce of energy and innovation to make sure that this dream stays alive. The people in the room this morning – ministers of health, donors, international agencies, the World Bank, nongovernmental organizations, and WHO itself – have a crucial role to play. I wish you the best in your important deliberations.

Mr Richard NEWFARMER

**Special Representative to the United Nations and the World Trade Organization,
the World Bank, Switzerland**

We applaud WHO's Director-General, Margaret Chan, for convoking this timely session on the health consequences of the current financial crisis, and appreciate the opportunity to speak at this consultation.

I should like to make three points: regarding the duration of the crisis, the current crisis is rapidly spreading to the global economy, and, while most forecasters see the beginnings of recovery in late 2009 or early 2010, the actual duration of the recession depends on the speed and effectiveness of policies in the developed countries. In terms of the consequences for developing countries, the full force of the global recession has not yet hit developing countries, so countries should begin to design macroeconomic and trade strategies now to weather the storm. With regard to the effects on health in low-income countries, the silver lining around this otherwise dark cloud is that, for now at least, no forecaster is predicting the kind of devastating economic collapse seen in East Asia during the 1997 crisis, in Mexico in 1995, or in Argentina in 2001; so the consequences for health may not be catastrophic. However, they will be severe, so the lessons of those episodes are important. The most immediate effects are likely to be through the scissors of rising health costs and diminished resources. The cost of imported health inputs rise because of depreciating currencies; resources shrink as lower incomes depress private spending on health and slower growth cuts into tax revenues that would otherwise be available for public health. Key priorities are programmes that maintain or expand health services to the poor and encouraging donors to keep development assistance, which is critical to health financing.

Time permitting, I shall say a bit about the World Bank's response to the crisis. The current crisis is rapidly spreading to the whole world economy, and while most forecasters see it lasting for another 12 months or so, the actual duration of the recession will depend on the speed and effectiveness of policies in the developed countries. The European Union, Japan and the United States of America – which account for some 70% of world's gross domestic product – are now in recession. Most forecasters see a deepening recession in 2009 that will rival only that of the 1980s in post-war severity. However, in contrast to the 1980's deep recession, where the crisis originated in developing countries themselves, this crisis emanated from the United States. This means, first, it is likely to hit the developing countries with a short lag, so the worst is still to come. But second, and this is the silver lining, it means that most developing countries may yet avoid economic contraction and the shattering effects of previous crises, such as in East Asia in 1997 or Latin America during the 1980s. Finally, it also means that policies in high-income countries hold the key to recovery.

How long will the crisis last? The duration will depend on the success of policies in high-income countries in three arenas: First, success in stabilizing the financial sectors and getting credit flowing again. Here, only modest progress is evident so far. Inter-bank lending rates have come down and stabilized, but banks are not yet lending. This will take time, more aggressive write downs of bad assets, and unfortunately probably more public capital. Second, the quality of fiscal stimulus is as important as its

quantity. The United States contemplates a US\$ 820 billion stimulus package over two years. Amounts in Europe are somewhat less. The trick will be convincing the financial markets that stimulus now will be followed by a return to lower deficits once recovery gets traction: the quality of the stimulus is therefore critical: public expenditures, especially on unemployment insurance, food stamps, and programmes to help the poor weather the crisis, have much stronger multiplier effects than tax cuts. More importantly, these programmes are also much easier to phase-out than tax cuts once growth resumes. If the stimulus takes the form of tax cuts benefiting the wealthy, subsidies to declining industries, or appears to increase the deficit permanently, investors may well turn their back on government paper, leading eventually to currency depreciation, and the recession could be prolonged. Third, success in keeping global trade open. Governments have to resist the temptation to adopt “beggar thy neighbour” trade policies. This proved fatal during the Great Depression – and it would prove fatal now. So far governments – for the most part – have resisted this temptation.

Most forecasters are predicting the beginnings of recovery only very late in 2009 or early 2010. The Consensus Forecast, which averages 26 leading private and academic forecasts, indicates a contraction in the United States of 1.8% in 2009 – with contraction in every quarter through 2009, and growth beginning in 2010, reaching 2.3 % for the year. This pattern is likely to be echoed in Europe and Japan, with recession somewhat less steep and recovery somewhat less strong.

Here, let me remind you that there is a reason why economics is called “the dismal science”. Even if governments act aggressively and take the best policy path, there is considerable uncertainty and risk. We simply do not know when banks will begin lending again. We do not know with certainty the willingness of investors to hold increased public liabilities associated with the fiscal stimulus. And we do not know when beleaguered consumers, now trying to reconstitute their decimated wealth position, will feel comfortable in beginning to spend. So we should take all forecasts with a grain of salt and, these days, maybe the whole salt shaker.

The global recession has not yet hit developing countries with full force, but warning signs are evident, so countries should begin now to design macroeconomic and trade strategies now to weather the storm. The recession in the North will be transmitted to the South through three principal channels. Declining incomes in the North will mean slower growth of trade with the South – and indeed initial reports from some countries indicate that trade contraction is looming. Growth of exports was negative in December for all of the major developing countries – Brazil, China, India, Russian Federation, South Africa – as well as countries as diverse as Argentina and Thailand. Moreover, global trade is expected to contract in 2009. This would be the first global contraction since since 1982. A second channel is commodity prices. These have fallen from their historic levels, hurting the countries that rely on those exports, while helping countries that import them. Price movements transmit directly to the rural sector where most of the world’s poor live. Over the longer term, prices are expected to remain higher than during the 1990s for the next 20 years. Oil prices are likely to average about US\$ 75 a barrel for the next five years. Food prices are expected to remain about 25 percent higher than they were in the 1990s. Third, private financial flows are likely to be reduced by half – from about US\$ 1000 billion to about US\$ 500 billion. With rising unemployment in the North, remittances from the diaspora of immigrants into the United States and Europe are likely to fall, though not as sharply. This is one reason why maintaining development assistance is so important.

What are the growth prospects for developing countries? GDP growth in the developing world is likely to fall from its average in the last three years of more than 7% to the neighborhood of 4.5% or somewhat less in 2009. While these forecasts are subject to an unusually high degree of uncertainty, and revisions have trended downward, few analysts are yet predicting economic recession in developing countries. That said, several countries are at exceptional risk: conflict countries, countries going into the crisis with unstable macroeconomic environments, countries suffering sharply adverse terms of trade, and countries relying heavily on trade with the high-income countries in recession (for example, Mexico with the United States and the eastern European countries with the European Union).

Everything possible should be done to ensure that the slowdown does not turn into a recession in developing countries because the situation would become much worse. Past recessions – such as those in Indonesia, Thailand after July 1997, Argentina in 2000, and Mexico 1995 – have shown that women and children have borne the brunt of crises. During recessions, infant mortality rises; the under-five mortality rate rises as children go unvaccinated or do not have access to health services; and the number of women dying of birth complications increases.

To avoid more severe slowdowns, the prudent course for developing countries is to avoid complacency and prepare for the worst with three sets of actions: many countries can afford a modest increase in deficit spending to finance targeted programmes that affect the poor. Some deficit spending will counteract export losses in the short term. Countries now have some headroom to borrow. Moreover, the World Bank, the International Monetary Fund, and other multilateral development banks are making available new lines of financing, so this increase in fiscal activity need not be inflationary or destabilizing. The World Bank intends to make available US\$ 100 billion over three years for middle income countries and front load its soft-loan window, recently replenished with US\$ 42 billion of donor contributions, for low income countries. Actively promote exports – including by designing strategies to improve competitiveness that keep exports growing. This means making sure that prices encourage exports, that backbone services such as telecoms and transportation are as efficient as possible, and that the costs of exporting (including customs procedures and port delays) are cut to a minimum. Here, too, the World Bank and regional banks have programmes to help. Accelerating, not delaying, reforms that improve the efficiency of the economy: slowdown always brings pleas from affected parties to “implement programmes more gradually.” While some may have merit, now is a time to accelerate reform, not delay it.

The crisis will undoubtedly have an impact on health in developing countries, with the most immediate effects through lower private spending on health as income growth slows and through tighter national budgets that will constrain public health expenditures.

The economic slowdown comes right after price surges in food and fuel have – by Bank estimates – already pushed more than 100 million people into extreme poverty, and the number of people suffering permanent cognitive damage due to malnutrition amounted to an extra 44 million people in 2008. Slower growth will compound these effects by increasing unemployment: incomes of groups living close to the poverty line may contract, and women and children suffer. On aggregate, we know that a three percentage point decline in the growth rate of developing countries leaves about 60 million people stranded in poverty who would have otherwise been lifted above the poverty line.

The health effects are potentially severe. The crisis has put health systems in the scissors of rising costs and diminishing resources. Costs are likely to rise as currency devaluations occur in many countries as an unavoidable side effect of the crisis. Devaluations increase the costs in local currencies of all imported health expenditures: medicines, autoclaves, syringes, X-ray machines and other hospital equipment. Already, several major currencies have fallen against the US dollar by 10–40%. For example, the largest countries – Brazil, India, Russian Federation, and South Africa – have experienced nominal devaluations averaging about 38% since their peaks in 2007–2008.

Meanwhile, resources for health are contracting. Lower incomes will constrain private expenditure on health. Surveys in the wake of the Argentine crisis of 2001–2002 indicated that 38% of households cut back on expenditures for their children’s preventive care. Public spending will also become constrained. Slower growth means lower tax revenues and, possibly, lower spending on health. This underscores the importance of maintaining development assistance. In Ethiopia and Rwanda, more than 50% of government expenditures is financed by donors, and off-budget donor funding for health is more than 100% of government health expenditures. In 2006, 23 countries had more than 30% of total health expenditures funded by external sources.

Policies can offset these effects. Those that have proven most effective include: policies aimed at financing specific services used by the poor – vaccines, primary health care and nutrition programmes; policies expanding the coverage of safety net programmes through low-cost insurance mechanisms (for example, the *Bolsa Família* programme in Brazil, and 30-Baht/universal coverage insurance in Thailand); conditional cash transfer programmes providing cash subsidies that require recipients to keep their kids in school, get immunized, or take advantage of health services to mothers and children; enlisting donor coordination can increase efficiency and resources through efforts like the International Health Partnership Plus (IHP+). These can provide greater levels of resources, greater continuity of resource flows, and greater efficiency in their deployment. (The Bank is proud to be a partner with WHO and others in the IHP programme.)

Let me close on a word of optimism. Developing countries may yet avoid recession, and its most devastating health consequences. But for this to occur, the United States and other high income countries have to manage their economic policy well – and so do developing countries. And everyone has an interest in maintaining the flow of development assistance to low-income countries. The World Bank is pleased to be working hand-in-hand with WHO and other development partners to maintain the flow of resources and provide adequate technical support. Working together we believe it is possible to ensure that the economic and financial crisis in high-income countries does not become a social crisis in low-income countries.

Response of the World Bank

The World Bank is working at several levels. These include:

- *Increasing financial support for developing countries, particularly the poorest:*
 - IBRD could make new commitments of up to US\$ 100 billion over the next three years. This year, lending could almost triple to US\$ 35 billion.
 - IDA: this facility is now in place to speed US\$ 2 billion to help poorest countries deal with effects of the financial crisis. The money is to be used for safety nets, infrastruc-

ture, education and health which is part of the US\$ 42 billion IDA 15 fund for the poorest people.

- *Shoring up the private sector: New IFC facilities will:*
 - ensure trade flows. IFC plans to double its existing Global Trade Finance Programme to US\$ 3 billion over a three-year period and mobilize funds from other sources.
 - bolster distressed banking systems. IFC plans to launch a global equity fund to recapitalize distressed banks. IFC expects to invest US\$ 1 billion over three years, and Japan plans to invest US\$ 2 billion.
 - keep infrastructure projects on track. IFC expects to invest at least US\$ 300 million over three years and mobilize at least US\$ 1.5 billion to provide rollover financing and recapitalize viable private infrastructure projects in financial distress.
 - shift advisory support to help companies weather the crisis. IFC is refocusing advisory services programmes to help clients cope with the crisis. It estimates a financing need of at least US\$ 40 million over three years.
- *Ensuring liquidity and resources for specific activities:*
 - the Multilateral Investment Guarantee Agency supports developing country financial sectors by providing guarantees to foreign banks that help inject much-needed liquidity into these markets. Its planned support to such projects in Ukraine and the Russian Federation is expected to bolster confidence in the financial system in these countries. Similar guarantees are expected in Africa and eastern Europe.
 - energy for the poor – the poor have been hard hit by the impact of rising fuel costs. The Bank is moving forward with a new programme to give rapid support so countries can strengthen their social safety nets.
 - food crisis response – nearly US\$ 900 million is approved or in the pipeline to help developing countries cope with the impact of high food prices through our US\$ 1.2 billion food facility
 - technical analysis and advice – for example with contingency planning for small banking systems.

In health specifically, the World Bank Group activities are intensifying:

- We project nearly US\$ 3.0 billion in health, nutrition and population commitments in Financial Year 09. About 40% has already been approved. This is an increase from sectoral commitments averaging US\$ 1.4 billion between Financial Years 03 and 08. (Financial Year 08 had a particularly low total of US\$ 0.95 billion.)
- The second largest share of these new resources will go to Africa in Financial Year 09 – nearly US\$ 800 million. Latin America is expected to have the largest health, nutrition and population sectoral commitments (US\$ 864 million) in Financial Year 09, followed by South Asia (US\$ 645 million). Ninety-one approvals are projected for that period, of which 75 are IBRD/IDA. Of the 75 IBRD/IDA approvals, 26 are managed by the HNP SB, but 53% of commitments is expected to be managed by the Health, Nutrition and Population School Breakfast programme.
- Helping the private sector is also important. The IFC, the World Bank's private sector arm, has established the Africa Health Sector Initiative: US\$ 250–300 million over five years. These funds will aid the private sector increase access to capital, improving regulatory framework, and provide small loans in medical education, risk pooling, pharmaceuticals, retail operations and service provisions. About 40% is social enterprise or non-profit.

HE Maria Farani AZEVÊDO

**Ambassador, Permanent Representative of Brazil,
Permanent Mission of Brazil to the Office of the United Nations
and other International Organizations, Switzerland**

Previous speakers have already made the point that we are dealing with a widespread global economic crisis. Some will suffer more than others, but all will be affected. There is a general understanding that: economic growth will fall; export revenue will decrease; unemployment will increase; and incomes will fall. Therefore, investment, financing and aid for health may be negatively affected. We have to work to avoid this crisis also becoming a social and health crisis. The event here today inscribes itself in this context, and I want to commend Dr Chan for her initiative: she is always ahead of the curve.

Since this is a health-related panel, I can say that the diagnosis is known. We need to focus on the treatment, or treatments, since the disease is affecting some more than others. Developing countries' health systems, for example, will be affected. And this is because resources in these countries are already scarce. The poorest among the poor, for instance, spend around US\$ 16 per capita on health, while the richest among the rich and industrialized countries spend up to US\$ 2600 dollars per capita.

A recent OECD study points to “strong slowdowns” in seven major economies, as well as in some emerging non-OECD countries, but let me address the case of Brazil. According to this OECD study, the Brazilian economy will suffer some growth deceleration, as opposed to the “strong slowdowns” in other countries. Brazilian exports are diversified in terms of partners and products; the domestic market is large and still has some purchasing power. Credit is still available. The economy has undergone a large period of stability. If things stay the same, Brazil will probably be in a somewhat shaky but manageable situation. Some analysts say that it is still possible for the economy to grow around 3% in 2009, a still healthy figure by Brazilian standards.

Although, Brazil is today undoubtedly more resistant to external shocks than in previous times, we are already being hit by the crisis. We are witnessing lay offs and industry is resorting to collective vacations. But the Government is acting fast to diminish the impact of the crisis and has announced some fiscal measures to stimulate the economy. President Lula da Silva has also announced that our Growth Acceleration Programme will be maintained. This is an ambitious programme which mandates investments of US\$ 270 billion in infrastructure. Out of that amount, almost US\$ 90 billion will be in the social area, particularly in the building of hospitals and the construction of urban and rural sanitation and electrification, which will have positive health effects.

The Brazilian Government firmly believes that health-related activities are important to the economy as a whole. They create jobs, foster innovation and contribute to a virtuous economic cycle, including poverty reduction and social development. The Brazilian commitment to invest in the health sector is a constitutional obligation. The 1988 Constitution establishes that: “... Health is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies ...”. In the face of the financial crisis of the 1990s, this constitutional obligation did not prove to be suffi-

cient. After that dramatic financial crisis, Congress approved a constitutional amendment to guarantee stability and increase resources to the health sector. In times of crisis, of course, investment may fall, but the fact of the matter is that we have learned our lesson and after the crisis of the 1990s, we found ways to bring some predictability to investment in health, which became compulsory. Health care today is universal and free in Brazil. Federal, state and municipal authorities are obliged by law to invest in health. The free services provided by our universal health service range from vaccination to organ and tissue transplants.

In Brazil, investments in the health system are complemented by social policies. Our income-transfer programme (*Bolsa Família*) distributes benefits to 11 million poor families nationwide. To be eligible, mothers must get prenatal care and parents must keep their children in school and vaccinated. Brazil does not have the answer to every challenge in the health area, but we do have several success stories and these experiences are already being made available to other countries in Latin America, Africa and Asia facing similar challenges. Fiocruz, our renowned health institute, whose president is here today (Dr Paulo Buss), is very active, sharing experiences in Africa and elsewhere.

President Lula pointed out recently and I quote: “no country will escape the crisis on its own”. His observation helps me to introduce the concluding part of my remarks: how to mitigate the effects of the financial crisis in the health sector. First, we have to remember, and make governments and civil society very much aware, that investment in health is investment in people. Secondly, cooperation is critical to overcome the crisis and some countries will be hit more than others, so let us share experiences and solutions; we have to be able to find speedy responses to immediate challenges. Thirdly, it is time for solidarity; official development assistance cannot diminish, nor be delayed. These are times when aid is most needed, for aid-dependent countries will be badly hurt. Their national budgets are already strained; remittances (often, the main source of revenue) will diminish as unemployment hits rich countries. Remember: the financial crisis comes in the wake of a food and an energy crisis. These hit poor countries the most. Fourthly, WHO’s role is to monitor the effects of the crisis on health; to increase awareness of the dangers of shrinking budgets and investments in health systems; and to advocate, including to the private sector, more means to invest on health. Above all, WHO’s programmes, in times of crisis, should target the most vulnerable. Fifthly, special attention should be given to fatal diseases; medicines could not fail to be made available to those threatened by death and industries as well as governments should contribute;. We should resort to all means, including existing legal frameworks in the area of intellectual property.

Lastly, we must act on all fronts: national budgets; international resources; official development assistance; innovative sources of financing; coordination between United Nations agencies; cooperation between countries; partnership between industry and governments; and an international pact, be it binding or not, for the maintenance of investments in health should be pursued. Let us take lessons from this crisis and look for ways to reduce dependency and build sustainable health systems.

Dr Manoj KURIAN

**Programme Executive, Health and Healing,
World Council of Churches, Switzerland**

Friends, we are deeply appreciative of Director-General Dr Chan's leadership in calling this critical consultation. We thank you for this opportunity to express some civil society perspectives on the topic and to participate in the ongoing discussions.

The lasting lesson that the global financial crisis will bring to society is the increasing realization of what is of enduring value and the greatest asset that we possess: our people! How economies would fare after the crisis has long past will depend very much on how governments and society as a whole are able to care for the welfare and health of their people during the crisis. Our people are best served when we work together - governments and civil society; from the international, regional, national to the local contexts.

A call to the international community

Today the fabric of human society is stretched thin. A third of the population of sub-Saharan Africa, and more than 20% of the population in South Asia have been going hungry, even before the financial crisis dawned on us. There is absolutely no room for cutbacks on social expenditure. The global financial crisis in the early 1980s and the disastrous consequences of the supposedly correctional measures on the health and welfare of society have made all of us wiser, I believe.

We do not live in isolated communities, but are part of a global village, each one of us a part of one humanity, dependent on one another for our well being. Currently many of the key campaigns to combat diseases and to keep the global public health objectives on track to achieve the Millennium Development Goals are heavily dependent on international cooperation and support. Cutting back on funding will jeopardize ongoing treatment of millions of people affected by diseases such as HIV and tuberculosis. This is not only an infringement of the fundamental rights of these individuals, but it will also potentially open up a Pandora's box of public health disasters. Erratic and incomplete treatments compound the danger of the development of myriad multidrug-resistant strains of pathogenic organisms.

Though societies in wealthier countries have been hard hit by this financial crisis, the world cannot afford a reduction in their current commitments. We are heartened to hear the reaffirmations of the promises of many partners and we look forward to the realizations of these commitments.

A call to governments

The full impact of the crisis is not yet upon us. Past financial crises, the global financial crisis in the early 1980s, the Asian crisis in the 1990s and the Latin American crisis in 2000 have clearly shown us the critical role played by civil society in the recovery of societies. Though these contributions are invaluable, they are not necessarily reflected in the budget lines of governmental health expenditures.

As private out-of-pocket expenditures tends to decline in a recession, societal dependence on private health care declines and is replaced by services that are available at lower cost in the public sector. This is recognized. But what is not always obvious is that, in times of crisis, a significant additional burden is taken on by service providers in the nongovernmental and private not-for-profit sectors, including faith-based organizations, cooperatives and movements such as the Red Cross and Red Crescent Societies, along with the health providers in the government.

Although it is too early to tell, initial reports from several countries indicate reductions in staff and other cost-saving measures by a number of nongovernmental organizations, while demand for services has increased significantly. In some countries, government subsidies to the private not-for-profit sector (including faith-based organizations providing health services) have been diminishing, a pattern that can be further exacerbated given pressures on public sector budgets, in the context of increasing demands.

When crisis stares at communities, civil society is by their side. The cooperatives, the community centres, the mosques, temples and churches do not disappear. They remain, helping communities to cope. There are clear limitations and governments will have to identify with their primary responsibility of making public health a reality. We cannot manage alone; rather we will work shoulder to shoulder with the governments to serve people best. Governments need to recognize the assets and services that civil society provide and see them as part of their national strategy; engage them; assist and resource them; and hold them accountable.

The key role of stimulus packages as a tool to put the economies back on the track to progress has been recognized. But it is important the application of this tool goes beyond infrastructure development. In an environment when people are losing jobs and there are real reductions in wages, these stimulus packages should aim at directly filling the wage gap, taking care so that the most vulnerable in the community can benefit from them. The choice for a mother between spending her last dollar for transportation to collect the monthly medicines and feeding her starving children is no choice at all. Strengthening the public distribution system for food; provision of free or supported transportation to health-care centres; providing support for treatments; removal of user fees – these are examples of direct action which could close the wage gap.

There is ample evidence to show that the proactive policies taken by governments and the critical investments in periods of crisis drew rich dividends for communities. Hence the policies you help formulate now will have profound impacts on societies for years to come.

How are the most vulnerable faring?

The highest reaches of public health and well-being that societies can achieve are based on the firm foundation that the most vulnerable person in each society has access to dignity, respect, love and wholehearted service. In the midst of crisis there can be a tendency to neglect the most vulnerable - people in remote regions; internally displaced people who are not included in official records; communities suffering from ongoing conflicts that we avoid addressing. The welfare of the most vulnerable defies the law of averages and cannot be drowned by numbers. It stands as a poignant indicator of the level of commitment of our societies to justice and equity.

The security of humanitarian and health workers

The most innovative of schemes in the direst of times will succeed only if the workers facilitating it out in the community are valued, affirmed and safe. The promotion of sustainable peace in conflict ridden regions is fundamental and not a luxury, if a healthy society has to be rebuilt.

The level of violence that humanitarian and health workers face is largely invisible to the world. In the year 2008, worldwide, 34 United Nations staff were killed as a result of violence. But this number does not take into account the local staffs who have lost their lives. In Somalia alone, 40 humanitarian workers lost their lives last year, the majority of whom were local staffs. The loss of life is but the tip of the iceberg of molestations, harassments, injury and extreme hardships that health and humanitarian workers face. The investments required for a motivated and secure health workforce should never be underestimated even in the toughest of times.

Hard questions to be answered

While we challenge governments and the international community, we from the civil society working on health issues have to examine ourselves in a forthright and frank manner. As our communities face this global financial crisis, are we working together with the wider civil society? Are we working closely with the governments? Are we aware of the assets that we have and we have influence over? Are we offering these – our institutional, personnel and financial assets – to the service of society in a non-partisan manner?

These questions have to be answered with honesty at all levels and we need to recommit ourselves to address this crisis.

Align assets and act with urgency and synergy

Our people are the greatest asset that society possesses. Ensuring their health and welfare even in the most difficult times takes precedent over other priorities. To achieve this we will have to work together, governments and civil society, from the international, regional, national to the local contexts. Let us be aware of the risks that we face to day; let us appreciate the assets that we all possess; let us align the assets that we have influence over, and act in a sustained and synergistic manner, as a matter of urgency.

Financial crisis and global health – *Background paper*

1. The **financial crisis**, which was triggered by difficulties within the sub-prime mortgage market and which has seen the near collapse of the international banking system, continues to spread. Some countries have already received large-scale emergency funding from IMF, others are in discussions that could lead to this support. Many other countries are known to be facing severe financial problems. The resulting massive reduction in wealth has now tipped several OECD member countries into recession (defined as two successive quarters of negative growth in gross domestic product). World trade is shrinking for the first time since 1980. The recession is not yet global, but a knock-on effect in low-income and middle-income countries is inevitable. Even if its form, magnitude and duration currently remain unclear, many experts are concerned that the world risks the largest economic downturn since the 1930s.
2. In global health there has been significant progress towards achieving the *Millennium Development Goals* but many challenges remain. There have been reductions in child mortality and gains in the treatment and prevention of HIV/AIDS, tuberculosis, malaria, poliomyelitis and neglected tropical diseases. In contrast, there has been little change in maternal and newborn mortality, especially in Africa; nutrition has been relatively neglected; and there remain many countries in which less than half the population has access to adequate sanitation or essential medicines. Several countries, notably in Africa, have taken advantage of economic growth to increase levels of domestic spending on health. Aid for health has more than doubled in recent years, coming both from traditional and innovative sources. The economic consequences of the global financial crisis put these achievements at risk and will jeopardize progress on the challenges that remain.
3. In response to questions raised by Member States and other partners on the impact of the crisis on global health, the Director-General has convened a high-level consultation on 19 January before the opening of the Executive Board session. **The purpose of the consultation**, for which this information note has been prepared, is:
 - (a) to build awareness of the ways in which an economic downturn may affect health spending, health services, health-seeking behaviour and health outcomes;
 - (b) to make the case for sustaining investments in health; and
 - (c) to identify actions – including monitoring of early warning signs – that can help to mitigate the negative impact of economic downturns.

Impact of the crisis on health

4. Although **poor populations** in all countries are likely to be the first and hardest hit by any downturn, it is not just the poorest countries that will be affected by the current crisis. This section briefly examines how different countries are likely to be affected. It then traces, on the basis of past experience, how an economic downturn is likely to have an impact on health.
5. The **pathways** through which a recession in rich economies can affect other countries are becoming evident. Export growth may decline – this is already reflected in a major fall in commodity prices; foreign direct investment is likely to be reduced; sudden and dramatic falls in exchange rates are possible, although not inevitable; access to capital may become more difficult as interest rates and risk premiums rise; remittances may fall; and, most critically for the poorest countries, aid from donors may be significantly delayed or reduced.
6. Even in periods of “global” recession not all parts of the world or even particular regions are affected equally. The 2001–2002 recession had major effects in some Latin American countries. The 1997–1998 recession was felt most strongly in Asia. Some countries start falling into recession early, some move out quickly, while some never suffer negative growth.
7. Many **high-income and upper middle-income countries** will experience negative real income growth and substantial increases in unemployment, with their consequent impact on health. In those countries where the financial crisis has required IMF emergency assistance, the situation is likely to be particularly serious for health service financing, if spending restrictions are imposed during loan repayment. Before the current crisis, many **low- and middle-income countries** were badly affected by increases in food and fuel costs, others prospered during the boom in commodity and oil prices. With a fall in demand, prices have fallen, to the advantage of net importers but to the detriment of those more dependent on export revenues.
8. Current predictions for rates of growth in gross domestic product for **low-income countries as a group** remain relatively optimistic (6.9% for all developing countries, and 4.5% in sub-Saharan Africa). However, these figures disguise major variations between countries. Some major aid recipients may continue to grow, albeit less rapidly, whereas others, including so-called fragile states that already receive less donor support, may be more seriously affected.

Health spending

9. **Total health spending** in countries that have been affected by an economic downturn tends to fall, but not consistently. Some governments have protected health spending or even increased it, but others have done the reverse. Policy in this sphere is thus

vitality important. In contrast to public spending, **private out-of-pocket expenditure** usually tends to decline in a recession, particularly if services are available at lower cost in the public sector.

10. **Informal surveys** suggest that very few health ministries have yet been given any indication from ministries of finance or development partners that health spending will be reduced. In many countries formal announcements await the next budget cycle. Some smaller countries look for economic signals coming from more powerful economies in their region.
11. Reductions in total expenditure will have an impact on the **composition of health spending**. Thus, where indications of impact have been reported, they suggest that salaries will be maintained, but that savings will be found in infrastructure and equipment.
12. Delaying **capital spending** is a common short-term response of governments faced with budget cuts. A logical response in the short term, it can, however, lead to longer-term problems if the downturn is sustained. Reductions in maintenance, medicines or other operating costs related to surveillance or supervision are likely to have a more damaging and immediate effect on service delivery.

Medicines and health-care commodities

13. Where recession is accompanied by inflation and **devaluation of domestic currencies** (e.g. 1997–1998 in East Asia and 2001–2002 in Latin America), the price of imported medicines, raw materials and medical equipment will increase. There is, however, evidence that the rise in cost of care to patients can be controlled, particularly through **generic substitution** or public subsidies.
14. If cost increases are not absorbed, the impact will be reflected in shortages or increased costs of care. With the growing burden of **noncommunicable diseases**, the demand for insulin, cardiovascular medicines and asthma inhalers, for example, is increasing rapidly. Although people can borrow to pay for treatment of acute illness episodes, those dependent on long-term treatment risk progressive impoverishment. Changes in the availability and cost of treatment are likely to happen relatively quickly and can be monitored relatively easily.
15. Some expenditures on medicines may be better protected than others. It is ethically difficult, for instance, to stop **treatment with antiretroviral agents**. If donors do not cut back on expenditure for medicines or on technical assistance yet reduce the overall volume of funds needed for service delivery, medicines may not get to those who need them. Such a situation risks exacerbating the tension between HIV/AIDS treatment and other forms of health spending.

Falling remittances

16. Income from remittances (which at about US\$ 240 000 million in 2007 is more than twice total official development assistance) has held up well through some

past economic downturns. In current circumstances, where the initial impact of the recession has been in the industrialized economies, this may not be the case. There is already evidence that remittance income has started to fall.

17. How much is spent on health is uncertain, although one survey (from Mexico) reported that 57% of remitters said that covering health expenses was the primary purpose of the money sent home. Anecdotal evidence suggests, however, that these monies are often used to meet the cost of long-term or terminal illnesses or even funeral expenses. Thus a decline in remittance income may not be reflected in levels of population health. Nevertheless, these expenses still have to be met. Borrowing locally at high rates of interest can lead to impoverishment or increasing levels of debt.

Reduction in household income

18. The economies of many low-income and middle-income countries have benefited from the **rapid growth of export industries** in areas such as ready-made garments, food and flowers, and business processing. As demand declines in developed economies, job losses are likely with consequences for family income and the ability to pay for health care.
19. Many of the **human consequences of recession are often hidden**. For example, unemployment may erode women's growing economic independence, which will have its own health consequences. Similarly, coping strategies may exacerbate vulnerability (through, for example, increased exposure to HIV). Reduced spending has impacts on health and education, and ultimately on the well-being of families and the development of the community as a whole.

Utilization of health services

20. Decreasing health spending, increased costs of treatment, and reduced family income and/or insurance coverage will affect use of health services and their quality. The most common effect is to **lower demand for private care** with a consequent transfer of demand to the public sector. If public services are also compromised, they may not be adequately equipped to cope, and overall quality may decline. This problem will affect all countries in which publicly-funded services are under pressure. Changes in utilization rates – broadly following this pattern – were documented during the 1997–1998 Asian financial crisis. A decline in the use of services by the poor in these countries was particularly evident.

Health outcomes

21. A significant reduction in spending on life-saving interventions will increase mortality, but data relating changes in mortality to periods of economic recession are scarce and sometimes contradictory. Some examples are, however, unequivocal. The Russian Federation, in the early 1990s, suffered a major increase in adult male mortality. Thailand also recorded an increase in adult mortality for the period 1996–1999.

Peru recorded an increase in child mortality in 1989. Similarly, child mortality rose in Indonesia in between 1996 and 1999 but drought and fires were confounding factors. This last point emphasizes the fact that economic recession is but one influence among many affecting peoples' health.

22. The current food crisis in particular has been estimated as being responsible for pushing more than 100 million people back into poverty – with serious consequences for health outcomes and nutritional status. Shortages of food and consequent malnutrition predispose individuals to disease and thus act in vicious concert with the economic downturn.
23. Some counterintuitive findings come from the United States of America and Europe where recession has been accompanied by falling mortality rates – possibly because of reduction in alcohol use and smoking and more time available for child care. However, this has been observed only during recent, relatively short periods of recession and is unlikely to be found in a sustained downturn. More in line with expectations, a 500 000 person-year study in Sweden showed that men were at risk of increased mortality owing to business recessions (and this in a country with well-resourced welfare policies). Moreover, close associations have been shown between economic hardship and suicide in Japan, New Zealand, the Russian Federation, and the United States of America.

Official development assistance

24. **Official development assistance for health** tends to fall during periods of recession, but this is not always the case. Thus in 1990–1993, according to data from the OECD's Development Assistance Committee, total official development assistance commitments fell, but those for health continued to rise. In 1997–1999 both total and health assistance fell, but rose again within a year, only for health aid to fall again. In 2000–2001 total and health official development assistance both fell, with health assistance the more seriously affected. There is thus no clear pattern emerging from aggregate data.
25. There are however specific instances where official development assistance from **individual donors** has fallen massively (by more than 60%) during recession in a particular country. It is likely too that such assistance may be more seriously affected to some countries than to others.
26. A significant finding, particularly given the importance of maintaining the delivery of basic services, is in the **composition of aid spending**: levels of funding for technical assistance continue to increase during recession, in contrast to aid that is programmable by countries, which falls.
27. On a positive note, leaders in developed and developing countries as well as international financial institutions have made **strong public, political commitments to health and development**. It is widely accepted that health is both an intrinsic good and an investment to reduce poverty. This was not necessarily the case during earlier recessions.

28. OECD and European Union countries have made **pledges not to cut aid**. Groups in civil society will maintain pressure in order to try to hold donors to these commitments. At the same time, despite public statements to the contrary, some donors have already indicated that reductions in aid spending are likely. Furthermore, G8 countries' aid is already lagging well behind the targets they agreed at their summit in Gleneagles, Scotland, in 2005; even before the present crisis, projections suggested a shortfall of about US\$ 34 000 million by 2010.
29. The crisis comes at a time when more actors are involved in the health sector and the range of financing mechanisms is wider. New global health initiatives, philanthropic foundations and a range of innovative financing initiatives that rely on income from investments are likely to be hard hit. Initiatives that tax consumption, such as the levy on airfares, will also be less able to provide counter-cyclical funding than traditional government financiers. On the provider side, more data are needed on the effect of the economic downturn on faith-based and community organizations and other non-state providers of health care.

Mitigating the health impact of the financial crisis

30. This section outlines some basic principles to guide the response to the health consequences of the economic crisis. It sets out areas for action, identifies some elements of best practice and practical advice, and highlights areas in which WHO will offer support.
31. In the face of declining revenues and income, **health should be made as visible as possible**. Health is an entitlement to which people have a basic right, as well as making a significant contribution to economic growth, poverty reduction, social development and human security.
32. Some countries will be more vulnerable to the impact of the crisis than others. It is equally important, however, to take into account the need of **vulnerable populations** – particularly the poorest of the poor – wherever they may live.
33. The financial crisis has provoked an examination of the values that underpin societies. The health response should also aim to be transformative and should be used to promote a greater focus on **social justice**.
34. A key characteristic of the current crisis is the speed with which it continues to evolve and, consequently, the uncertainty facing policy-makers. **Partnerships** will be critical. Rapid assessments, effective communications, exchange of experience, effective and flexible working arrangements will all be essential to success.

Monitoring the impact of the crisis

35. Given the rapid evolution of the crisis and the uncertainty surrounding its impact in different countries, monitoring its effects is a priority.
36. Monitoring should take place at several different levels: (a) changes in employment, housing and income – the most distal causes of ill-health; (b) changes in behaviour relevant to health, including changes in the use of health services (including mental health care) and changes in the behaviours of health workers themselves (including patterns of migration); and (c) changes within the health sector, including the cost and availability of key commodities and treatment.
37. The purpose of monitoring will be to identify the most vulnerable countries and populations – before people are exposed to risks that will affect their health. Many of the most rapidly changing indicators (such as employment and exchange rates) will be monitored by other agencies. Collaboration and rapid communication will therefore be essential. Specific efforts to monitor the impact of the crisis will complement existing, and longer-term efforts to monitor health outcomes.
38. Given the urgency of establishing effective systems and processes for monitoring the health impact of the crisis, **WHO will convene a meeting of relevant experts** as soon as possible following this consultation.

Saving lives and protecting incomes

39. The first priority in any country facing an economic downturn is to protect the lives and livelihoods of those most at risk. In terms of policy actions, **social safety nets** which support the poor will be a priority. The more serious the downturn, the greater the priority to be given in this area. Experience suggests that expanding established programmes for income support may be more effective and achieve more a rapid effect than creating new ones. There is a growing body of experience in the health sector with conditional cash transfers, which provide resources to families conditional upon certain health-related behaviours (e.g. attending clinics for child or antenatal care). In an acute situation, however, unconditional cash transfers can be made faster than conditional ones, and there is some evidence to show that these will be used in ways that promote health. Policies that help to stabilize prices, reduce the cost of buying food, allow the unemployed to maintain health insurance premiums and ensure that children can stay in education will be equally important.
40. **WHO** will work as part of the United Nations team at country level to support a range of initiatives to protect the livelihood and incomes of the poor. **WHO will make available its specific health financing expertise** to countries for advice on approaches to financial risk protection in the health sector.

Increasing the effectiveness of spending for health

41. Economic recession makes the task of defending health budgets more difficult. In countries affected by the financial crisis, recapitalizing banks and other financial institutions may be given priority. In countries affected by economic recession, sectors

that generate employment or increase agricultural production will seek additional funding. Strategies need to take into account spending outside as well as within the health sector.

Increasing the health impact of public spending

42. Where resources for a significant fiscal stimulus are available, countercyclical public spending is seen as vital for reviving the economy. Although the primary aim of such programmes is to create or maintain employment, it is important to seek ways in which they can positively influence health. Rural roads, for example, are an essential component in reducing maternal mortality, and many clinics and rural hospitals would benefit from upgrading.
43. Many countries are dealing with several simultaneous threats to people's health – notably the food crisis, climate change and other environmental problems. Spending in all these areas can positively influence health, providing that health impact is carefully reviewed and understood. Health policy-makers should be assertive in seeking a seat at the table when public spending plans in these areas are being developed.

Increasing the effectiveness of health sector spending

44. Within the health sector ministers and their officials face tough choices. It is always easier, for instance, to cut **running costs** in order to safeguard **salaries**. However, past experience highlights the risks entailed: health spending becomes inefficient as health workers lack supplies; staff become disaffected; shortages of essential medicines lead to public mistrust; and existing infrastructure decays through lack of maintenance. Similar risks to health and the credibility of health services arise when **preventive services** are cut at the expense of **treatment**, or **rural clinics** disadvantaged in comparison to **urban hospitals**.
45. In line with popular wisdom, **every crisis is also an opportunity**. This has been borne out in countries such as Thailand. In 1997–1998 the outflow of physicians from government services to the private sector was reversed, providing an opportunity to introduce necessary reforms. Similarly, in the same region the price increases resulting from devaluation made it possible to introduce medicines policies based on generic substitution. The need for greater efficiency can also facilitate new ways of working, including task-shifting, seeking synergies between different programmes (e.g. tuberculosis and tobacco control) and increasing the use of communications technologies.
46. In many countries **recession has been accompanied by social unrest**. The reality or even the threat of social disruption may thus also act as a spur to social sector and health reform. However, pursuing this line uncritically has its risks. There are many examples where the assumption that acute reductions in public-sector budgets would act as stimulus for a rational or measured process of institutional reform has proven very wrong.
47. **Global public goods**. In times of crisis it is important not to forget the many other threats to health security. Preparing countries to cope with pandemics, food security, war and conflicts and the impact of adverse weather events requires effective **global**

and regional systems of surveillance, coordination and response. It is important that these systems do not fall victim to the economic downturn.

48. At global and regional levels WHO will continue to provide unequivocal and evidence-based support for maintaining, and where possible increasing, financing for health. WHO will also work closely, at their request, with individual countries that are facing particular difficulties, supporting WHO country offices with missions from regional offices and headquarters.¹

Implementing primary health care reforms

49. There is no doubt that **primary health care**, and its central objective of moving towards universal coverage, remains compelling as an approach to health policy at a time of economic crisis. Indeed, as noted above, the advent of a crisis may provide the necessary stimulus to initiate reform.
50. First, primary health care requires a focus on **equity, solidarity and gender**. It reminds policy-makers, for example, that the high burden of maternal mortality is a result of many factors including poor access to care, failure to prevent unwanted pregnancy and women's low status in some societies. All these factors can be exacerbated in a recession.
51. Secondly, primary health care gives direction to work on health systems, reinforcing the idea of solidarity through progress towards the goal of **universal coverage**. This is particularly important given the increasing pressures on public services and the need for ways of reducing exclusion. Pooling risk and resources – central to the notion of universal coverage – not only protects people from catastrophic expenditure, it also facilitates greater allocative efficiency and thus more effective resource use.
52. Additionally, while offering a strong political signal of a country's intent to provide for its people, the concept of universal coverage is still context specific and **contingent on resource availability**. It allows for public debate on what should be included in a benefit package without resorting to the use of selective, or single-purpose programmes.
53. Thirdly, in times of economic hardship a more “joined-up” approach to health and public policy is essential. Health is an outcome of actions across many sectors of society. Primary health care stresses the importance of the **social, economic and environmental determinants of health**, such as the impact of housing, education, employment and nutrition policy; import duties that affect access to essential medicines and technologies; the restriction on the movement of peoples or goods to prevent the spread of epidemics; laws that prevent discrimination against people living with HIV/AIDS; and the major role that clean water, clean air and access to proper sanitation play in protecting health and preventing disease.
54. Primary health care does not focus exclusively on the public sector, but acknowledges the role that **non-state providers** – private, voluntary, faith and community based – play in providing a significant proportion of services in many countries.

¹ The focus of this paper is WHO's provision of support to countries, but many of the issues affect WHO itself. The financial crisis has provoked an examination of how the Organization can increase its effectiveness. Work is in hand to seek efficiencies, to explore new and better ways of working, and to review priorities.

55. Lastly, **participation**, public involvement and transparency are central to the primary health care approach. If the public, civil society and parliaments are involved, decisions on how to make health spending more effective are more likely to be rational and accepted than if they are left to bureaucracies alone.

Protecting aid for health and ensuring it is effective

WHO will continue to make the case to all **donors – traditional and emerging** – that sustaining funding for health is crucial. Many new donors have favoured financing economic infrastructure over social-sector spending. Greater effort is needed to restate the case that a healthy workforce is not only going to be more productive, but that it is essential to achieving a return on donors' investment. In donor countries, sustaining vocal **public support for development aid** is more likely to influence politicians than technical argument alone.

57. Increasing efforts to implement the *Paris Declaration on Aid Effectiveness (2005)* and the *Accra Agenda for Action* (adopted at the third High-Level Forum on Aid Effectiveness – Accra, 2–4 September 2008) will be particularly important at times of economic uncertainty. In particular, aid recipients need predictable and flexible funding that is aligned to national priorities.² Mechanisms that increase uncertainty are not helpful. Many new sources of financing are inherently cyclical compared with traditional forms of official development assistance. Thus revenues from investments funds and taxes on travel will fall during a recession. However, mechanisms such as the international drug purchase facility UNITAID, the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria are significantly lowering prices for specific medicines and vaccines.
58. The focus needs to be maintained on achieving results, but it will be important to interpret the current vogue for **performance-linked funding** with some care. At times of crisis it may be the “poor performers” who need the most help.
59. **Global health funds and programmes** (such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance) may become increasingly important as sources of finance if other forms of development assistance are reduced. Should this be the case it will be important, particularly for the Global Fund, to look at country grants in the light of the need to ensure adequate delivery systems – ones that benefit the health sector as a whole – as well as supplies of medicines for the three diseases. Achievement of the Millennium Development Goals depends on getting the spending balance right between commodities, people and delivery systems.

Working in partnership

60. As noted in the opening principles, all the policy actions recommended in this note require close collaboration between all the actors involved in global health. At a time of scarce resources, the world cannot afford a development system in which duplication and overlap of effort are common. The current circumstances will accelerate the process of **United Nations reform**, and encourage a more rational **division of labour**, based on national needs and aligned to national health-sector plans.

² These issues will be considered in detail by the High Level Task Force on Innovative Financing for Health Systems, whose objective is to explore new sources of funding for health in developing countries.

Moderator • Panelists • Programme

Moderator

Dr Richard HORTON, Senior Editor, *The Lancet*

Panelists

- Dr Andrew STEER, Director-General, Policy and Research, Department for International Development, United Kingdom of Great Britain and Northern Ireland
- Her Excellency Maria Farani AZEVÊDO, Ambassador, Permanent Representative of Brazil, Permanent Mission of Brazil to the Office of the United Nations and other International Organizations in Geneva, Switzerland
- Mr Richard NEWFARMER, Special Representative to the United Nations and the World Trade Organization, the World Bank, Geneva, Switzerland
- Dr Manoj KURIAN, Programme Executive, Health and Healing, World Council of Churches, Geneva, Switzerland

Programme

09:10 Opening comments by the Chairman

09:20 Opening comments by the Director-General

09:30 Introduction by the moderator and introductory comments by panel members

10:00 Moderated discussion among panel members

10:30 Moderated discussion from the floor

12:00 Closing comments from panel members

12:20 Closing comments and conclusions by moderator

12:30 Closure of the consultation by the Chairman



**World Health
Organization**

For more information: www.who.int