



World Health Organization

Geneva

Sustainable Development and Healthy Environments Cluster

Increasing Investments in Health Outcomes for the Poor

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Dr Abusaleh Shariff, Chief Economist, Head, Human Development Division, National Council of Applied Economic Research, India

Mr Ronald Jay Waldman, Deputy Director, Center for Global Health and Economic Development, Mailman School of Public Health and The Earth Institute at Columbia University, United States of America

Professor Jacques van der Gaag, Professor of Economics & Dean, Amsterdam University; Director, Amsterdam Institute for International Development, Netherlands

REGIONAL ENTITIES

Prof. Eric Buch, Health Adviser, New Partnership for Africa's Development (NEPAD), South Africa

Dr Mauricio Alberto Bustamante García, Director, Andean Health Organization (ORAS), Peru

Mr Paul Isenman, Head, Policy Coordination Division, Organization for Economic Co-operation and Development (OECD), France

Ms Sophie Asimenye Kalinde, Chief of Delegation, Permanent Delegation of the Commission of the African Union

Mr Venant Wege-Nzomwita, Counsellor, Permanent Delegation of the Commission of the African Union to the United Nations in Geneva

UNITED NATIONS REGIONAL COMMISSIONS

Mr Kim Ganglip, Expert, Health and Development Section, Emerging Social Issues Division, Economic and Social Commission for Asia and the Pacific (UNESCAP), Thailand

Mr Markus Haacker, Senior Economist, Commission for HIV/AIDS and Governance in Africa, United Nations Economic Commission for Africa

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Ms Marieke Boot, Technical Adviser Health Sector Reform and SWAPs, Reproductive Health Branch, United Nations Population Fund (UNFPA), United States of America

Mr Jay Chaubey, Senior Adviser, Division of Policy and Planning, United Nations Children's Fund, United States of America

Mr Pedro Conceicao, Deputy Director, Office of Development Studies, United Nations Development Program (UNDP), United States of America

Mr Luc Franzoni, Deputy-Director, Geneva Liaison Office, United Nations Development Program (UNDP), Switzerland

Mr Garislav Chkolenok, Senior Scientific Affairs Officer, UNEP, Switzerland

Mr Robert Greener, Economics Adviser, UNAIDS, Switzerland

Ms Juliana Gonsalves, Economic Affairs Officer, Special Programme for Least Developed, Landlocked and Island Developing Countries, UNCTAD, Switzerland

Ms Mina Mashayekhi, Trade Negotiations and Commercial Diplomacy Branch, Division on International Trade in Goods and Services and Commodities, United Nations Conference on Trade and Development (UNCTAD), Switzerland

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Ms Christiane Wiskow, Health Services Specialist, International Labour Office, Switzerland

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Mr Alvaro Bermejo, Head, Health and Care Department, International Federation of Red Cross and Red Crescent Societies

Ms Joy Muller, International Representation Officer, Humanitarian Advocacy Department, International Federation of Red Cross and Red Crescent Societies

Mr Jove Oliver, Communications Manager, Massive Effort Campaign, Switzerland

Dr Mit Philips, Research Centre Brussels, Médecin Sans Frontières, Belgium

Mr Hakan Sandbladh, Senior Officer, Health and Care Department, International Federation of Red Cross and Red Crescent Societies

Ms Nance Upham, President, People's Health Movement, Geneva International, Switzerland

Mr Roy Widdus, Program Manager, Initiative on Public-Private Partnerships for Health (IPPPH), Global Forum for Health Research, Switzerland

Dr Randy Wykoff, Senior Vice President International Operations, Project HOPE – People-to-People Foundation, United States of America

PRIVATE SECTOR

Mr Boris Azais, IFPMA Fellow and Director of External Policy, International Federation of Pharmaceutical Manufacturers Associations (IFPMA), Switzerland (Alternate)

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Ms Anne-Leonore Boffi, Research Assistant, World Business Council for Sustainable Development (WBCSD), Switzerland

Dr Eric Noehrenberg, Director, International Trade and Market Issues, International Federation of Pharmaceutical Manufacturers Associations (IFPMA), Switzerland (Alternate)

PARLIAMENTARIANS

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OTHER PARTICIPANTS

Dr Richard Bumgarner, WHO Consultant, United States of America

Dr Ernst Becher, Consultant on health economics and financing, Professor, American Graduate School of Business, France

Dr Carlos Tiny, WHO Consultant, Sao Tome and Principe

Mrs Asteria Peñaloza, TheBellsConsultants

Mr Jean-Jacques Monot, TheBellsConsultants (Alternate)

WORLD HEALTH ORGANIZATION

WHO Headquarters Participants

Dr LEE Jong-wook , Director-General

Mr Denis Aitken, Director of the Office of the Director-General

Dr Anarfi Asamoah-Baah, Assistant Director-General, Communicable Diseases

Dr Kazem Behbehani, Assistant Director-General, External Relations and Governing Bodies

Dr Jack C. Chow, Assistant Director-General, HIV/AIDS, TB and Malaria

Dr Timothy G. Evans, Assistant Director-General, Evidence and Information for Policy

Dr Kerstin Leitner, Assistant Director-General, Sustainable Development and Healthy Environments

Dr Liu Peilong, Adviser to the Director-General

Dr Joy Phumaphi, Assistant Director-General, Family and Community Health

Dr Catherine Le Galès-Camus, Assistant Director-General, Non Communicable Diseases and Mental Health

Dr Anders Nordström, Assistant Director-General, General Management

Dr Michel Jancloes, Adviser to the Director-General

Dr Jim Kim, Adviser to the Director-General

Mrs Namita Pradhan, Adviser to the Director-General

Dr Ian Smith, Adviser to the Director-General

Dr Robert Beaglehole, Director, ADGO/EIP

Dr Vladimir Lepakhin, Assistant Director-General, Health Technology and Pharmaceuticals

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Dr Eugenio Villar Montesinos, Coordinator, Pro-poor Health Policy

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Dr Sergio Spinaci, Executive Secretary, Coordination of Macroeconomics and Health Support Unit, Sustainable Development and Healthy Environments

Mrs Bernadette Capay, Secretary, Coordination of Macroeconomics and Health Support Unit, Sustainable Development and Healthy Environments

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Dr Silvia Ferazzi, Partnerships and Civil Society Officer, Coordination of Macroeconomics and Health Support Unit, Sustainable Development and Healthy Environments

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Ms Maya Samara, Planning Officer, Coordination of Macroeconomics and Health Support Unit, Sustainable Development and Healthy Environments

Dr Padma Shetty, Technical Officer, Coordination of Macroeconomics and Health Support Unit, Sustainable Development and Healthy Environments

Mrs Hiwot Taffese, Clerk/Secretary, Coordination of Macroeconomics and Health Support Unit, Sustainable Development and Healthy Environments



World Health Organization

Geneva

Sustainable Development and Healthy Environments Cluster

Increasing Investments in Health Outcomes for the Poor

Second Consultation on Macroeconomics and Health

28-30 October 2003, Geneva

ANNEX 2: Agenda & Programme

Tuesday, 28 October 2003 – Preparatory Meeting

Participants: High-level officials from each country, plus WHO country, regional and HQ staff

Venue: World Health Organization, Executive Board Room

8:30 - 9:30 Registration and coffee

9:30 – 10:15 **Welcome Remarks**

Mr Denis Aitken, Director of the Office of the Director-General, WHO

Introduction to the plan for the day

Dr Sergio Spinaci, Executive Secretary, Coordination of Macroeconomics and Health, WHO

Keynote Address:

“Pro-poor Health Reform – Why, What and How?”

Mr Rajiv Misra, Former Health Secretary, Government of India

10:15-10:30 Participants break up into three Working Groups: Venues WG One – EB Room, WG Two - Salle B, WG Three – Salle D

10:30 – 12:45 Working Groups (A detailed agenda for Working Groups is at Annexes A, B, & C)**Working Group One on Thematic Focus One:****How to Improve the Effectiveness of the Health Delivery Systems and Monitor Outcomes?**

Chair: Professor Anne Mills, Head, Health Economics and Financing Program, London School of Hygiene & Tropical Medicine

Rapporteur: Dr Padma Shetty, Coordination of Macroeconomics and Health, WHO

Working Group Two on Thematic Focus Two:**How to Make Health Central in the Country Macroeconomic Framework and Increase Internal Allocation of Resources to Health?**

Co-Chair: Dr Peter S. Heller, Deputy Director of the Fiscal Affairs Department, International Monetary Fund

Co-Chair: Mr Alexander Preker, Lead Economist, Health, Nutrition and Population, The World Bank

Co-Chair: Mr Pablo Gottret, Senior Economist for Health Financing, Health, Nutrition and Population, The World Bank

Rapporteur: Mr Richard Bumgarner, WHO Consultant

Working Group Three on Thematic Focus Three:**How to Increase Predictability of External Funding and Increase Coordination with Partners?**

Co-Chair: Mr Paul Isenman, Head, Policy Co-ordination Division, Organisation for Economic Co-operation and Development (OECD)

Co-Chair: Ms Carin Norberg, Executive Director, Transparency International

Rapporteur: Dr Silvia Ferazzi, Coordination of Macroeconomics and Health, WHO

12:45 – 14:15 Lunch

Tuesday, 28 October 2003 – Preparatory Meeting continued

14:15 – 16:15 Working Groups' discussions continue

16:15 – 16:45 Coffee Break outside EB Room

16:45 – 17:45 Participants re-convene in Executive Board Room for plenary session

Chair - Dr Jim Kim, Adviser to the Director-General, WHO

Working Group Chairs, to summarize the discussions of the three Working Groups

Group discussions and conclusions by Dr Jim Kim

17:45 – 18:30 Rapporteurs of the three Working Groups only: preparation of the report

Wednesday, 29 October 2003

Participants: Country delegations; partner agencies and other participants; WHO staff

Venue: World Health Organization, Executive Board Room

Meeting Convenor: Dr Kerstin Leitner, Assistant Director-General, Sustainable Development and Healthy Environments, WHO

8:15 – 8:45 Registration and Coffee

8:45 – 10:15 Opening Address by Dr LEE Jong-wook, Director-General, WHO

Designation of Chairs by Dr Kerstin Leitner, Assistant Director-General, WHO

Introductory Remarks by Chair of Morning Session:

Mrs Sushma Swaraj, Minister of Health and Family Welfare and

Parliamentary Affairs, Government of India

Keynote Address:

"Health Economics, Growth and Poverty Reduction"

by Professor Lincoln Chen, Kennedy School of Government, Harvard University

Overview of Eastern Mediterranean, African and South-East Asian Regional meetings, by Dr Sergio Spinaci, Executive Secretary, Coordination of Macroeconomics and Health, WHO

10:15 – 10:45 Coffee break

10:45-13:00 **Thematic Focus One : How to Improve the Effectiveness of the Health Delivery Systems and Monitor Outcomes**

Presentation by Professor Anne Mills, Head, Health Economics and Financing Program, London School of Hygiene & Tropical Medicine

Followed by interventions and discussion

Country Presentations

People's Republic of China

Ghana

Followed by interventions and discussion

Summary of the discussion by the Chair

13:00 – 14:30 Lunch

Wednesday, 29 October 2003 continued

14:30 – 15:30 **Introductory Remarks by Chair of Afternoon Session**

Presentation on “What are the Inputs Needed to Achieve MDGs?”

by Professor Jeffrey Sachs, Special Adviser to UN Secretary-General on the UN Millennium Development Goals (MDGs) and Director of the Earth Institute, Columbia University, United States of America

Thematic Focus Two: How to Make Health Central in the Country Macroeconomic Framework and Increase Internal Allocation of Resources to Health

Presentations by Mr Peter S. Heller, Deputy Director, Fiscal Affairs Department, International Monetary Fund and Mr George Schieber, Manager, Health and Social Protection Sector, Middle East and North Africa Region, The World Bank

Followed by interventions and discussion

15:30 – 15:45 Coffee Break

15:45– 17:15 Country Presentations

Ethiopia

Sri Lanka

Followed by interventions and discussion

Summary of the discussion by the Chair

Wednesday, 29 October 2003 – Informal Meeting with Chinese Delegation

Time: 17:30 – 18:30

Participants: All Consultation Participants

Venue: World Health Organization, Executive Board Room

Introductory Remarks by Dr Hendrik Jan Bekedam, WHO Representative, China, Chair of Meeting

Discussion on how China has dealt with recent public health crises.

Thursday, 30 October 2003

Participants: Country delegations; partner agencies and other participants; WHO staff

Venue: World Health Organization, Executive Board Room

Meeting Convenor: Dr Kerstin Leitner, Assistant Director-General, Sustainable Development and Healthy Environments, WHO

8:30 – 8:45 Coffee break

8:45 – 10:15 **Introductory Remarks by Chair of Morning Session****Thematic Focus Three: How to Increase Predictability of External Funding and Increase Coordination with Partners?**

Presentation by Mr Paul Isenman, Head of Policy Coordination Division, Organization for Economic Co-operation and Development (OECD)

Presentation on "Innovative Financing for Health"

by Dr Sally K. Stansfield, Associate Director, Global Health Strategies, Bill & Melinda Gates Foundation

Presentation on "Canada's Foreign Aid Policy for Health"

by Dr Montasser Kamal, Chief, UN Health-Related Institutions Unit United Nations and Commonwealth Division, Multilateral Programs Branch, Canadian International Development Agency

Followed by plenary discussion

10:15 – 10:30 **Coffee Break****10:30 – 12:00** **Country Presentations**

Mozambique

Indonesia

Djibouti

Followed by interventions and discussion

Summary of the discussion by the Chair

12:00 – 14:00 **Lunch**

Thursday, 30 October 2003 continued

14:00 – 15:15 **Introductory Remarks by the Chair of the Afternoon Session**

Summary of consensus on Thematic Foci

Conclusions and Recommendations on Thematic Foci One, Two and Three by:

- Professor Anne Mills, Head, Health Economics and Financing Program,
London School of Hygiene & Tropical Medicine
- Mr Peter S. Heller, Deputy Director, Fiscal Affairs Department,
International Monetary Fund
- Mr Paul Isenman, Head, Policy Coordination Division,
Organisation for Economic Co-operation and Development (OECD)

Followed by interventions and discussion

15:15 – 15:30 **Coffee Break**

15:30 – 17:15 **Consultation Declaration presented by:**

Dr Khandaker Mosharraf Hossain, Chair of the 56th World Health Assembly and Minister of Health and Family Welfare, Government of Bangladesh

Wrap-up on future steps and closing remarks by:

Dr Kerstin Leitner, Assistant Director-General, Sustainable Development and Healthy Environments, WHO



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Geneva

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ANNEX 3: List of Working Group Participants

Working Group I

How to Improve the Effectiveness of the Health Delivery Systems and Monitor Outcomes

Participants List

Chair: Professor Anne Mills, London School of Hygiene and Tropical Medicine
Rapporteur: Dr Padma Shetty, Coordination of Macroeconomics and Health, WHO

Governments

- Angola:** Dr Victor Nzima, Director of Planning, Ministry of Health
- Bangladesh:** Dr Daniul Islam, Second Secretary
Mr Muhammad Abdul Majid, Director-General, Prime Minister's Office
- Botswana:** Mr Mathias Chakalisa, Permanent Secretary for Health, Ministry of Health
- Cambodia:** Dr Lo Veasna Kiry, Deputy Director, Planning and Health Information, Ministry of Health
- China:** Dr Ren Minghui, Deputy Director General, Department of International Cooperation, Ministry of Health
- Ethiopia:** Dr Girma Azene, Director, Planning and Programming Department, Federal Ministry of Health
- Ghana:** Dr Kofi Ahmed, Chief Medical Officer, Minister of Health
Dr Moses Dani Baah, Deputy Minister of Health, Ministry of Health
- Indonesia:** Dr Anhari Achadi, Senior Adviser to the Minister of Health on Health Vulnerable Communities, Ministry of Health

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| Iran: | Mr Ghaempanah Mohamad Jafar, Deputy Minister for Development Management, Resources and Parliament Affairs |
| Jordan: | Dr Anwar Batieha, Secretary General of the Higher Health Council, Ministry of Health |
| Malawi: | Mr Nelson Nixon Kalanje, Director of Planning, Ministry of Health and Population |
| Mozambique: | Dr Humberto Cossa, National Director of Planning and Cooperation, Ministry of Health |
| Myanmar: | Prof. Mya Oo, Deputy Minister of Health, Ministry of Health |
| Nicaragua: | Lic. Eliseo Araúz Palacios, Director General de Planificación y Desarrollo, Ministerio de Salud |
| Nigeria: | Mr Shehu Sule, Director of Health Planning and Research, Ministry of Health |
| South Africa: | Dr Percy Mahlati, Senior Technical Adviser to the Office of the Director-General of Health, Ministry of Health |
| Sri Lanka: | Dr Reggie Perera, Secretary, Ministry of Health, Nutrition and Welfare |
| Tanzania: | Mrs Regina Kikuli, Head of Budget and Planning, Ministry of Health |
| Thailand: | Dr Amnvay Gajeena, Director, BPS/MOPH |
| Uganda: | Mr Mwesigwa Rukutana, Minister of State for Finance, Planning and Economic Development in Charge of General Duties, Ministry of Finance, Planning and Economic Development Dr George Bagambisa, Planning Commissioner, Ministry of Health |
| Viet Nam: | Prof. Pham Manh Hung, Vice Minister, Ministry of Health |

WHO

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| Headquarters: | Dr David B. Evans, Director, Global Programme on Evidence for Health Policy (GPE/EIP) Dr Robert Beaglehole, Director, ADGO/EIP Dr Dan Bleed, Medical Officer, Stop TB Dr Patrick Kadama, Adviser, EIP Ms Lin Yang Lin |
| Eastern Mediterranean Regional Office: | Dr Hussein Salehi, Regional Adviser, WHO/EMRO |
| China : | Dr Hendrik Jan Bekedam, WHO Representative |
| Myanmar: | Dr Agostino Borra, WHO Representative |
| Viet Nam : | Mrs Heather O'Donell, Technical Officer, Health Systems Development, WR Office |
| Yemen : | Dr Hashim Ali E. El-Mousaad, WHO Representative |

Other Organizations

Andean Health Agency/ Organismo Andino de Salud (ORAS):

Dr Mauricio Alberto Bustamante Garcia, Secretario del ORAS-CONHU

Institute for Global Health, University of California, San Francisco:

Dr Carol Medlin, Policy Adviser and Senior Researcher

Centre for Poverty Reduction and Income Generation, Pakistan:

Dr Mushtaq A. Khan, Director

Global Alliance for Vaccines and Immunization (GAVI):

Dr Mercy Ahun, Principal Officer

TheBellsConsultants: Ms Renée Asteria Peñaloza

People's Health Movement, Geneva International: Ms Nance Upham, President

Global Forum for Health Research: Ms Veloshnee Govender, Public Health Specialist

International Federation of Pharmaceutical Manufacturers Association:

Mr Boris Azaïs, IFPMA Member and Director of External Policy

Permanent Mission of Nicaragua: Patricia Gawpbell

Norwegian Agency for Development Co-operation (NORAD):

Dr Sigrun Møgedal, Senior Health Adviser

Working Group 2

How to Make Health Central in the Country Macroeconomic Framework and Increase Internal Allocation of Resources to Health

Participants List

Co-Chairs: Dr Peter S. Heller, Deputy Director, Fiscal Affairs Department, International Monetary Fund
Mr Alexander Preker, Lead Economist, Health, Nutrition and Population, World Bank
Mr Pablo Gottret, Senior Economist, Human Development Program, World Bank

Introduction: Dr Michel Jancloues, Adviser to the Director-General, WHO

Rapporteur: Mr Richard Bumgarner, WHO Consultant

Governments

Angola: Dr Pedro Kiala, Director of Cabinet for the Population Survey, Ministry of Planning

Argentina: Dr Ginès González Garcia, Minister of Health, National Ministry of Health

Bhutan: Mr Daw Tenzin, Secretary, Planning Commission

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| Botswana: | Mr Mathias Mandlebe, Deputy Secretary of Economic Affairs, Ministry of Finance and Development Planning |
| Cambodia: | Mr Ieng Sunly, First Deputy Director, Budgeting Department, Ministry of Economy and Finance |
| China: | Dr Li Yin, Deputy Director-General, Ministry of Health Mr Dezhi Yu, Deputy Director-General, Department of Planning and Finance, Ministry of Health |
| Estonia: | Mr Erki Must, Adviser to the Minister, Ministry of Social Affairs |
| Ghana: | Mr Kwaku Agyeman-Manu, Deputy Minister of Finance and Economic Planning, Ministry of Finance and Economic Planning |
| India: | Ms Sujatha Rao, Personal Secretary, Government of Andhra Pradesh Mr Rajesh Bhushan, Director, International Health, Department of Health, Ministry of Health and Family Welfare |
| Indonesia: | Prof. Bambang Bintoro Soedjito, Deputy Minister for Local Acting and Regional Department, Ministry of National Planning |
| Iran: | Mr Koorosh Taherfar, Senior Officer, Ministry of Economic Affairs |
| Jordan: | Ms Hala Lattouf Bsisa, Secretary General, Ministry of Planning |
| Kenya: | Mr Stephen Wainaina, Chief Economist, Ministry of Planning and National Development |
| Malawi: | Lures Kalinonhe, Development and Aid Management Officer |
| Mozambique: | Dr Jose Sulemane, National Director of Planning and Budget, Ministry of Planning and Finance |
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| Pakistan: | Dr Abdul Majid Rajput, Chief, National Health Policy Unit, Ministry of Health Mr Javed Sadiq Malik, Secretary, Planning and Development, Ministry of Finance |
| Peru: | Dr Álvaro Vidal Rivadeneyra, Señor Ministro de Salud, Ministerio de Salud |
| Philippines: | Ms Erlinda M. Capones, Director, National Economic and Development Authority |
| Sri Lanka: | Dr Patricia Alailima, Director-General, National Planning Department, Ministry of Finance and Planning |
| Sudan: | Dr Mohamed Hassan Awad, Director of Health Economics Unit and Chairperson, Secretariat of CMH |
| Thailand: | Mr Boonyong Vechamanesri, Deputy Secretary-General, National Economic and Social Development Board |

WHO

Headquarters: Dr Eugenio Villar Montesinos, Evidence and Information for Policy (EIP)
Dr Charu Garg, EIP
Dr Ke Xu, EIP

Western Pacific Regional Office: Dr Dorjsuren Bayarsaikhan, Technical Officer

South East Asia Regional Office: Mr Bhupinder Singh Lamba, Sustainable Health Policy Officer, CMH Focal Point

African Regional Office: Dr Benjamin Musembi Nganda, Regional Adviser, African Region, Poverty and Ill Health

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Estonia : Dr Jarno Habicht, WHO Liaison Officer

Ethiopia : Dr Tefera Wonde, Senior Policy Adviser

Indonesia : Dr Sarah Barber, Health Policy and Systems

Peru : Dr Luis E. Velásquez, Representante Interino de la OPS/OMS

Philippines : Dr Jean-Marc Olivé, WHO Representative

Sudan : Dr Guido Sabatinelli, WHO Representative

Other Organizations

United Nations Children's Fund:
Mr Jay Chaubey, Senior Adviser, Division of Policy and Planning

National Council of Applied Economic Research, India:
Dr Abusaleh Shariff, Chief Economist, Head, Human Development Division

The World Bank:
Mr George Schieber, Health and Social Protection Sector Manager, Middle East and North Africa Region

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Philippines Mission: Maria Teresa C. Lepatan, Minister

Working Group 3

How to Increase Predictability of External Funding and Increase Coordination with Partners

Participants List

Co-Chairs: Paul Isenman, Head, Policy Coordination Division, Organisation for Economic Co-operation and Development (OECD)
Carin Norberg, Executive Director, Transparency International

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Rapporteur: Dr Silvia Ferazzi, Coordination of Macroeconomics and Health, WHO/HQ

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Jordan: Dr Riyad Okour, Director of Health Economics, Ministry of Health

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Nepal: Mr Bijay Raj Bhattarai, Secretary, Ministry of Health

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Dr Tolu Fakeye, Deputy Director of International Health, Ministry of Health

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| Rwanda: | Mr Leonard M. Rugwadiza, Expert on Macroeconomics and Health, Ministry of Finance and Economic Affairs |
| Senegal: | Dr Birahim Diongue, Coordonnateur de la Cellule de Planification, Ministère de la Santé |
| South Africa: | Dr Thuthula Balfour, Head of International Health Liaison, Department of Health, Ministry of Health |
| Sri Lanka: | Mr N. Pathmanathan, Deputy Secretary to the Treasury, Ministry of Finance |
| Sudan: | Mr Mohamed A. Falza, Minister of Finance and Economic, Ministry of Finance and National Economy |
| Tanzania: | Mr Silvery B. Buberwa, Director of Social Services, Ministry of State, President's Office |
| Thailand: | Mrs Saichai Limtrakool, Foreign Relations Officer, International Health Group, Bureau of Policy and Strategy, Ministry of Public Health Mrs Rossukon Kangvallert, Chief of Health Policy Group, Bureau of Policy and Strategy, Ministry of Public Health, Nonthaburi |

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Barbados: Mrs Veta F. Brown, Caribbean Program Coordinator

India: Mr Rajiv Misra, Consultant

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Nepal: Dr Klaus Wagner, WHO Representative

Papua New Guinea: Dr Salik Govind, Programme Management Officer

Other Organizations

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Harvard Centre for Population and Development Studies:

Dr Catherine Michaud, Senior Research Associate

Organismo Andino de Salud (ORAS):

Dr Mauricio Alberto Bustamante García, Director

United Nations Development Programme (UNDP):

Mr Luc Franzoni, Deputy-Director, Geneva Office



World Health Organization

Geneva

Sustainable Development and Healthy Environments Cluster

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ANNEX 4: Summary of Working Group Sessions

Working Group I: How to Improve the Effectiveness of the Health Delivery Systems and Monitor Outcomes?

Chair: Professor Anne Mills, London School of Hygiene and Tropical Medicine

Rapporteur: Dr Padma Shetty, Coordination of Macroeconomics and Health, WHO

Working Group I of the 2nd Consultation of Macroeconomics and Health shared and discussed country experiences and objectives in improving the effectiveness and efficiency of health systems and in monitoring outcomes for more effective management. Three main areas framed the discussions: 1) Setting national health priorities; 2) Institutional and organisational constraints and opportunities; and 3) Monitoring outcomes. The key issues identified by countries during Working Group discussions are summarized below.

To adequately set **national health priorities**, countries identified the following issues as most important for successful advancement of the process:

- Before priorities can be discussed, there must be a realistic assessment of the components of the health delivery system. How is health care delivered to the citizens? What is the mix of private and public sector services? Who are the vulnerable groups?
- Priority setting is an interministerial government-led process that begins with political commitment for health and recognition of the linkages between poverty and health. Countries felt that national health priorities must include sustaining quality and demand for health care.
- Priority setting is needed at all levels and is the foundation for accountability among policy-makers and providers. It must be a concerted effort that encompasses the various sectors that affect health (eg. education and water), requiring a greater acceptance that health is affected by the actions taken in other sectors and that, in turn, success and productivity in these sectors are influenced by the health of the population.

- In a resource-constrained environment with competing priorities and mixed public and private health provision, governments must focus on ensuring the local delivery system reaches the poorest groups with priority interventions.
- A strong evidence base and information system are required to provide data for priority setting. Data should include information on vulnerable groups and on cost-effective interventions appropriate to the local situation. Priority-setting tools should reflect a realistic assessment of the data available. Related to this, there is a need for increased expertise and analytical skills to analyse the data.

When discussing the components of a **more effective health system**, countries identified the following issues as most important for successful advancement of the process:

- The key challenge is improving access to services at the community level and, specifically, access for poor and marginalized groups. The mixed nature of health care delivery and financing requires emphasis on district-level planning and monitoring and local analyses of financing and barriers to access and quality (eg. impact of user fees, supplies and management mechanisms to support peripheral units, etc.). Each country has to address how it can establish an optimal mix of fixed and outreach services to ensure access at the community level and how groups that are not effectively reached can be targeted.
- Many countries identified human resources as the single most critical system-wide constraint. There is a need to address public sector reform needs and macroeconomic policies at the national and international levels that contribute to the inadequate human resource capacity in the health sector. There is a need to increase the number, correct the maldistribution, and improve the skills of health care human resources. Innovative strategies are required to retain health workers in country and to combat attrition, especially due to illness (i.e. HIV-AIDS).
- Health systems must be designed to reward good performance at all levels and to promote management capabilities. A supportive work environment and job satisfaction are important incentives to deliver quality health services and results. The distortion of incentives and salaries among public, private and NGO sources must be addressed.
- Social mobilization is vital and basic to accountability between providers, politicians and patients. More work is need regarding the interface of supply and demand and the balance of preventive and curative services. The roles of local organizations and NGOs in improving access to and financing of care should be assessed and optimized.

While discussing the components of **effective mechanisms for monitoring outcomes**, countries identified the following issues as most important for successful advancement of the process:

- A commitment has to be made to invest in information systems and quality data for monitoring and evaluation, utilizing simple, reliable indicators and recognizing the importance of such a mechanism for policy formation, outcome-oriented management,

and tracking of performance at all levels. National institutions and academia should be strengthened to increase data collection and analysis capabilities at the local level to inform decision-making.

- Countries need to avoid uncoordinated creation of new multiple information systems for different diseases/programmes and global initiatives. To do this and to overcome existing fragmentation, country leadership is essential to ensure an integrated approach.
- Decentralization and the existence of both public and private providers require that there be access to information and monitoring of outcomes to ensure accountability at all levels. Private sector data must be made accessible since it is an important provider of care to the population. There needs to be an increased emphasis on mutual accountability amongst all stakeholders.

Working Group 2: How to Make Health Central in the Country Macroeconomic Framework and Increase Internal Allocation of Resources to Health

Co-Chairs: Dr Peter S. Heller, Deputy Director, Fiscal Affairs Department, IMF
Mr Alexander Preker, World Bank

Mr Pablo Gottret, World Bank

Rapporteur: Mr Richard Bumgarner, WHO Consultant

Introductory remarks by Dr Michel Jancloes, Adviser to the Director-General, WHO

Working Group 2 of the 2nd Consultation of Macroeconomics and Health shared and discussed the country experiences and objectives to make health central to development and increase resources allocated to health. Three main areas framed the discussions: 1) Review multisectoral coordinating mechanisms that can best integrate pro-poor health investments into national development plans and achieve health objectives; 2) Identify options for generating and reallocating internal resources for increased health expenditures; 3) Report, discuss and possibly prioritize options on how public and private partnerships and external partnerships can improve health outcomes for the poor.

Reviewing the process to **integrate pro-poor health investments into national development plans**, countries identified the following issues as most important for successful advancement of the process:

- This CMH follow-up meeting has offered an extraordinary opportunity for dialogue between the international health community, ministries of finance and of planning, and ministries of health. It signals the importance of their working together to develop an evidence base for policy-making.
- Improving health sector performance not only requires investments in the health sector, but also policies to improve access to education, clean water and sanitation infrastructure, and to influence household behaviour in a number of ways (better

nutrition, cessation of tobacco use, etc). This underscores the importance of a multisectoral approach in considering how to improve health outcomes and a prioritized increase in expenditure across sectors.

- Countries must be the principal drivers in choosing the mix of government policies for improved health, taking account of the specific nature of the health problems confronted, how resources for health are financed and provided, and if domestic resource mobilization alone can finance necessary spending for health. For the poorest countries, the PRSP process is a principal modality for forging consensus on the prioritization of resources across and within sectors. For middle-income countries, alternative modalities to the PRSP must be devised to achieve coherence in priority-setting in the health sector.
- Countries need ambitious goals, particularly for countries heavily afflicted by HIV/AIDS, malaria, tuberculosis, high rates of child mortality, and smoking-related illnesses. This requires creative thinking on how to do things differently, solve problems, and scale up health systems of limited capacity in order to be able to absorb increased resources. Answering the challenge of expanding the number of health personnel, particularly of paramedical staff, will be critical. But ambitious objectives must be tempered and based on realistic fiscal frameworks. It is not sensible to build a health budgetary program on resources that do not exist or are vulnerable to withdrawal.

While discussing the options for **generation and allocation of domestic resources for health**, countries identified the following issues as most important for successful advancement of the process:

- Strengthened domestic resource mobilization is essential, both for demonstrating a government's policy commitment and to graduate from dependency on external resources. This may require both tax reform and increased revenue efforts. In particular, countries should explore win-win taxes, such as on tobacco products, thus reducing future adverse health outcomes and freeing household resources for more desirable outlays on nutrition and education.
- Domestic resource mobilization can also come about through:
 - Reallocation of expenditures from non-productive uses in the budget;
 - Reallocation of expenditures within the health budget to more effective and efficient purposes and modes of delivery;
 - Seeking lower-cost forms of intervention and treatment (e.g. use of generic drugs); and
 - Realizing higher efficiency in resource use (e.g. procurement reform).
- Macro stability is an absolute prerequisite for achieving real economic growth; prevention of financial crises is critical to ensure stable financing of social sectors. Governments can work with international financing institutions (IFIs) to ensure informed policy choices, and devise macroeconomic strategies that can support enhanced absorption, including

sustainable programs to scale up human resources in the health sector. There are efforts to develop a financing facility in the IMF to deal with exogenous shocks faced by the poorest countries.

- Government health spending needs to be focused on the poor. Increased spending not perceived as focused on the health problems of the poor is not likely to achieve a sustainable flow of external donor support. There is a need for attention to modalities to ensure that the poor, in accessing health care facilities, are not impoverished by catastrophic illness episodes.
- And domestic resource mobilization efforts can be facilitated if donor resources are translated into effective programs. Sector Wide Approaches and untied budget support can facilitate the maximization of gains possible from a given flow of external resources. Good governance—transparency and financial accountability—is critical to ensure continue sustained donor support.

In discussing the **involvement of public and private partnerships and external partners**, countries identified the following issues as most important for successful advancement of the process:

- In many poor countries, formulating an equitable and effective health sector strategy will depend on determining how to best incorporate the private sector's predominant role in both the financing and provision of health services. This includes identifying the role for enhanced external resources. Where out-of-pocket expenditures constitute a large share of total national health spending, governments need to assure that these funds maximize health outcomes and are used for risk-pooling schemes that protect households from impoverishment.
- For the poorest countries, even the most efficient use of domestic resources will not be enough. Sustained and predictable external assistance to support well-formulated programs is vital. The focus should be on cost-effective interventions that go through existing channels and target the poor in priority areas. The strong imperative for donors is to finance health through grants and debt relief. Loans for recurrent costs invite fiscal unsustainability and future debt bailouts. Resources must be managed through the government's budget to avoid duplication and lack of transparency.

Thinking ahead. The inevitable drivers of future disease burdens and health service demands are clear:

- Demographic change, including ageing populations, even in the poorest countries
- Urbanization, HIV/AIDS, TB, and malaria and other communicable diseases
- Rising risk exposure driving more death and illness from noncommunicable diseases.

There is indeed a risk that ageing populations, and the increased burden of noncommunicable diseases may create pressures for fiscal spending on some health needs that may crowd out spending on the poor.

Working Group 3: How to Increase Predictability of External Funding and Increase Coordination with Partners?

Co-Chairs: Mr Paul Isenman, Head of Policy Coordination Division, Organisation for Economic Co-operation and Development (OECD)

Ms Carin Norberg, Executive Director, Transparency International.

Rapporteur: Dr Silvia Ferazzi, Coordination of Macroeconomics and Health Support Unit

Introductory remarks by Dr Jim Kim, Adviser to the Director-General, WHO

Working Group 3 of the 2nd Consultation of Macroeconomics and Health shared and discussed country experiences and objectives in increasing the quantity of external resources for improved health outcomes and improving the predictability, effectiveness, and coordination of aid. Three main areas framed the discussions: 1) The flow of development assistance: Assessing recent trends and how to increase funding; 2) Making donor funding mechanisms more efficient; and 3) Realistic choices for coordination with partners.

In assessing recent **development assistance trends and how to increase funding**, countries identified the following issues as most important for successful advancement of the process:

- It was noted that Official Development Assistance (ODA) grew for the first time in 2002 (while Development Assistance for Health (DAH), also including private funding, had increased more steadily since 1998) with the largest growth recorded in HIV/AIDS interventions. CMH seems to have had an impact in this (the Global Fund to fight AIDS, Tuberculosis and Malaria was established following the publication of the CMH Report).
- Data on external assistance often are not available to countries and cannot therefore be adequately monitored by them. Countries expressed the need to be regularly informed of both disbursements and commitments. It was suggested that WHO continue its collaboration with OECD to put in place a system to track and monitor on a continuous basis the flow of Development Assistance for Health (how much, to what purpose and where) and provide this information to countries.
- Since budgetary decisions on use of external assistance are made on the basis of commitments, countries looked forward to a more timely translation of donors' commitments into disbursements. They also expressed the need for identifying effective steps to make aid flows more predictable, as any investment in health can only yield benefits in the medium-and long-term. Some suggested that to achieve predictability greater emphasis should be on multilateral assistance and multi-year commitments.

In discussing the **efficiency of donor funding mechanisms**, countries identified the following issues as most important for successful advancement of the process:

- Common criteria for reporting on health outcomes need to be identified to avoid the overburden on recipient governments due to multiple and fragmented requests by donors. The "health metrics" approach was identified as a promising mechanism to help countries build uniformity in analysing and tracking data.
- However, on average, in-country capacity to track, monitor and evaluate data on national outcomes of investments in health, including from external assistance, is weak: investment should be made to strengthen this capacity from the national down to the district level.
- Countries felt that external resources are still too focused on disease control, or "crisis management", at the expense of investment to strengthen health systems. This can have the effect of diverting attention from the long-term and critical issue of system capacity. Related to this point, external assistance should include a preliminary analysis of its potential effectiveness based on the existing health systems, and support should be ensured to build the recipient country's capacity.
- On the issue of additionality, it was stressed that external resources for health should not substitute domestic investments. On the other hand, a macroeconomic framework more flexible and sensitive to the need for investment in health and social sectors should be applied by ministers of finance and the International Monetary Fund. External assistance for health should be in the form of grants, less conditional, more innovative and follow more closely government priorities. On the recipient countries' side, national priorities should be more pro-poor and transparent, to ensure that funding gets to the targeted beneficiaries. National priorities should also be innovative in promoting public goods (experiences were presented of effective promotion at the regional level).

In the discussion of **realistic choices for coordination with partners**, countries identified the following issues as most important for successful advancement of the process:

- Assistance needs to have a broader inter-sectoral scope and include support to crucial health-related sectors such as education and water and sanitation, and taking gender into account.
- Several participants expressed the important role that technical support by international organizations plays in this context, and were reassured of the continued commitment of WHO in focusing on action at country level, as expressed by the introductory speech in the morning and in other interventions during the day.
- Several countries reported on their ongoing work in ensuring harmonization of external assistance and internal allocation of resources in various forms: dialogue with donors for support in programme approach or budgetary support (vs. project approach) to better involve a broader range of donors in a more coordinated manner; ad hoc consultative processes, such as aid coordination groups and steering committees to monitor poverty reduction strategies. Country experiences were mentioned where donors were in favour of this approach, and proposed them themselves. The OECD presentation stressed

efforts made following the "Rome Declaration" of February 2002 to harmonize donor procedures in that direction (full text of the presentation is in the annexes to this report).

- Some countries commented that exercises such as the CMH Consultation were useful mechanisms to facilitate South-to-South information sharing on national experiences with health investments and development assistance.
- A point raised and further strengthened in the plenary was the link to the Millennium Development Goals (MDGs), namely the question of what flows of assistance are needed and can be expected to help countries to meet the MDGs when countries pledge their commitment to them.



World Health Organization

Geneva

Sustainable Development and Healthy Environments Cluster

Increasing Investments in Health Outcomes for the Poor

Second Consultation on Macroeconomics and Health

28-30 October 2003, Geneva

ANNEX 5: Consultation Papers

Pro-Poor Health Reforms-Why, What and How

By Rajiv Misra

I. Introduction

Wide-ranging reforms in the health sector have been aggressively promoted by multilateral institutions, particularly the World Bank, in the last two decades in the developing and transitional economies. The record of these efforts, especially in respect of the poor, has been mixed. In many cases, the benefits did not really reach the poor, and in some, they seem to have been adversely impacted. Examples of the latter include indiscriminate privatisation, introduction of cost recovery without safety nets for the poor and hasty decentralisation. The focus of many of these efforts was not necessarily the health of the poor, but macroeconomic stabilisation and fiscal compression. Part of the problem was a serious misunderstanding of the role of the state in the wake of economic liberalisation and euphoria about the markets following the collapse of the socialist model. However, there is now a clearer perception of the central role of the state in the health sector in general and in protecting the vulnerable population in particular. The World Development Report 1993, devoted exclusively to health, set the ball rolling by defining the role of the state in providing public goods, merit goods and provisioning essential health services. The World Development Report 1997 greatly helped to clear the air by squarely placing the responsibility for protecting the vulnerable on the state. Finally, the World Health Report 2000 brought out forcefully the stewardship role of the state in steering the health system.

Despite the recognition of the central role of the state in health, doubts still persisted about its importance in the context of development and poverty alleviation. The Millennium

Development Goals (MDGs), adopted by the Millennium Summit of the United Nations in September 2000, put the health of the poor in the forefront of the global battle against poverty and disease, and thus represents an unprecedented global consensus on the subject. The WHO Commission for Macroeconomics and Health (2001) represented a pioneering effort to understand the linkages between economic growth and poverty on the one hand, and health status on the other. It not only underscored the importance of investments in health for economic growth and alleviation of poverty, but also laid out a blueprint for both the developing countries and the donor community to move forward towards the achievement of the MDGs.

What poor countries need urgently is not only greater investment in health along with wide ranging systemic reforms, but also that these specifically target the poor. As we shall see subsequently, investments made ostensibly for the poor have often been misappropriated by the rich. And even donor agencies have often shied away from investing in the backward areas on account of poor governance, weak health infrastructure and consequently higher risk of failure. Needless to say, the poor generally lack political influence and are unlikely to receive the desired attention without a special focus. This paper attempts to present the rationale (why), the main ingredients (what) and the methodology (how) of pro-poor health reforms based largely upon the experience in India with very diverse health outcomes in different states ranging from Kerala at one end, comparable to the high-performing middle income countries, and UP and Bihar on the other, only slightly above the level of Sub-Saharan Africa. The CMH arguments establishing linkages between investments in health and economic growth and poverty are not repeated as they are well covered by other background papers.

Why?

The case for a pro-poor approach in respect of a basic human right like health could be strongly made purely on ethical and moral considerations. Many have argued that by trying to justify investments in the health of the poor on economic arguments, we are diluting the moral argument-health being a desirable end in itself and pursued not only for its contribution to economic welfare. Nevertheless, the compelling case made out by the CMH for investments in health, especially of the poor, on macroeconomic considerations will, hopefully, persuade those who hold the purse strings (finance and planning ministries and donor agencies) to give this matter greater attention. But there are other equally strong arguments in favour of special focus to the health of the poor as discussed below.

1. The poor are subjected to a disproportionate, and to a large extent avoidable, burden of disease (BOD) from pre-transition diseases (infectious diseases, perinatal and maternal conditions and nutritional disorders). The BOD in low - and middle-income countries on this account was estimated at 44% as against 7% in high-income countries (World Health Report 1999). All these conditions are capable of being controlled very cost-effectively with relatively simple and easily available technologies. Investment in the health of the poor could,

therefore, not only yield quick results but also maximise the returns on such investments. **If the world desires to move ahead rapidly towards the MDGs, the poor would be the best place to direct the efforts.** Besides the pre-transition diseases, the new pandemic of HIV/AIDS is causing unimaginable consequences in the poorest regions of the world. A recent World Bank study (2001) in India has also shown the poorest quintile to be having almost double the exposure to lifestyle risk factors like tobacco use and smoking as compared to the richest 20% of the population. The poor are often concentrated in backward and remote areas having very weak infrastructure, degraded environment, poor sanitation, lack of access to safe drinking water, which combined with under-nutrition and poor hygiene makes them highly vulnerable to ill health. The tables below bring out clearly the striking disparities in health status among different income groups in India.

Table I : Health Status Indicators – Comparison Between the Poorest and Richest Quintiles of the Population, India, 1992-93

| | <i>Poorest 20 %</i> | <i>Richest 20 %</i> | <i>Poor / Rich Risk Ratio</i> |
|---|---------------------|---------------------|-------------------------------|
| Infant Mortality (Deaths under 12 months per 1000 births) | 109.0 | 44.0 | 2.5 |
| Under 5 Mortality (Deaths under 5 years per 1000 births) | 155.0 | 54.0 | 2.8 |
| Childhood Underweight (Percent below -2 sd z-score, weight/age, children under 4 years) | 60.0 | 34.0 | 1.7 |
| Total Fertility Rate (Births per woman age 15-49 years) | 4.1 | 2.1 | 2.0 |

Source: Gwatkin et al, Socio-Economic Differences in Health, Nutrition, and Population in India, 2000. HNP Poverty Thematic Group of the World Bank, based on NFHS, 1992-93.

Reproduced from India: Raising the Sights – Better Health Systems for India's Poor, World Bank, 2001

Reproduced from : India Health Report, Oxford University Press, 2003.

Table 2 :
Health Outcomes According to Standard of Living, India 1998-99

| Standard of living index | Infant Mortality (per 1000 births) | Under Five Mortality (per 1000 births) | Total Fertility Rate | Children Underweight (% below -2 SD) | Children with anemia (%) | Children with acute respiratory infection in past 2 weeks (%) | Children with diarrhea in past 2 weeks (%) | Anemia among women (%) |
|--------------------------|------------------------------------|--|----------------------|--------------------------------------|--------------------------|---|--|------------------------|
| Low | 88.8 | 130 | 3.37 | 56.9 | 78.7 | 21 | 19.9 | 60.2 |
| Medium | 70.3 | 94.6 | 2.85 | 46.8 | 73.5 | 19.4 | 19.7 | 50.3 |
| High | 42.7 | 51.5 | 2.1 | 26.8 | 67.3 | 15.7 | 16.1 | 41.9 |
| Low/High Ratio | 2.08 | 2.52 | 1.6 | 2.12 | 1.17 | 1.34 | 1.24 | 1.44 |

Source: National Family Health Survey 1998-99 (IIPS 2000), Reproduced from India: Raising the Sights – Better Health Systems for India's Poor, World Bank, 2001

Reproduced from : India Health Report, Oxford University Press, 2003.

Although significant progress has been made in monitoring of health status by income groups in India by national surveys in the last decade, the information still remains limited. A better source of information is the status of Scheduled Castes (SC) and Scheduled Tribes (ST), which are socio-economically the most backward sections of society eligible for affirmative action under the Indian Constitution. A comparison of the infant and child mortality levels in these groups with the general population brings out clearly the wide disparity in health status.

Table 3:
Health Indicators among SC/ST and Others (Rate per 1000)

| Mortality Indicators | SC | ST | Others |
|--------------------------|-------|-------|--------|
| Neo-Natal | 53.2 | 53.3 | 40.7 |
| Post Neo Natal | 29.8 | 30.9 | 21.1 |
| Infant <1 year | 83 | 84.2 | 61.8 |
| Under 5 Years | 119.3 | 126.6 | 82.6 |

Source: National Family Health Survey II.

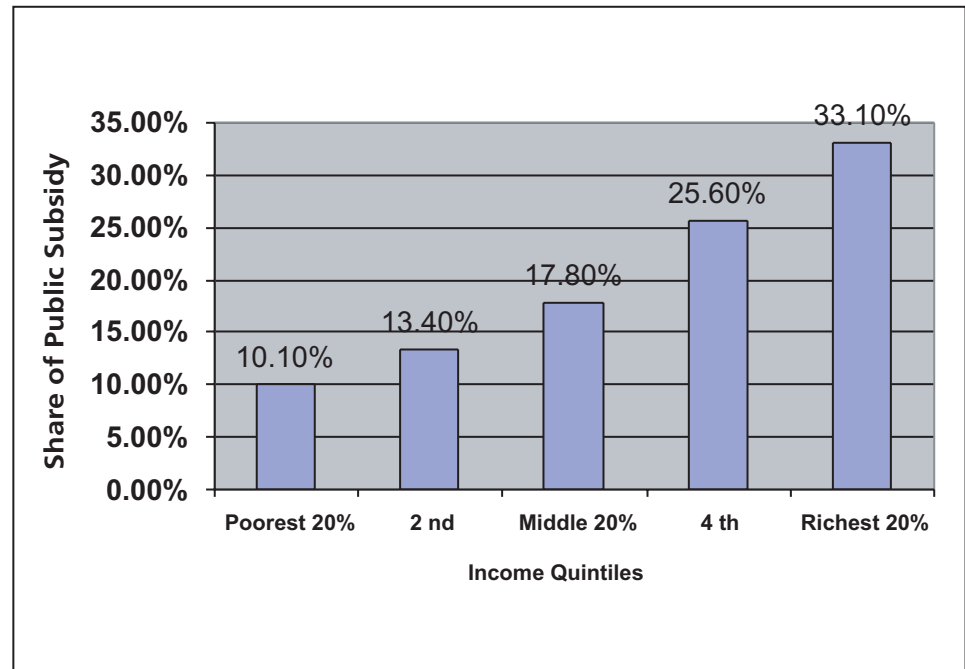
Reproduced from : India Health Report, Oxford University Press, 2003.

Therefore, if global health is to be improved quickly, there is no alternative but to concentrate on those that carry the maximum burden – the poorest sections of society.

2. The poor suffer much higher mortality and morbidity due to lack of access to both public health and medical services. A recent benefit incidence analysis done by the National Council

of Applied Economic Research (NCAER) shows that even public subsidies in health have been disproportionately utilised by the rich.

Figure 1 Share of Public Subsidy for Curative Care Benefiting Income Groups



Source: Who Benefits From Public Health Spending In India, unpublished paper, NCAER, 2000

Reproduced from : India Health Report, Oxford University Press, 2003.

The private sector is expectedly concentrated in more developed areas, which offer better commercial prospects. The poor thus have very limited access to the qualified private sector due both to locational disadvantages and financial constraints. A large number in India have no alternative but to depend on unqualified providers – often with disastrous results. The low literacy levels, poor health information and often persistence of traditional beliefs and superstitions compounds the problem by making the poor ill-equipped to make rational choices in health related matters.

3. The employment of the poor is, by and large, in the informal unorganised sector, making it difficult to organise any risk pooling arrangements, like health insurance. They are thus subject to the most regressive method of health finance – fee for service paid as out of pocket expenses – a major contributing factor in perpetuation and aggravation of poverty. A recent World Bank (2001) study on India concludes that out-of-pocket medical costs (estimated to be more than 80% of the total medical expenditure) alone may push 2.2% of the population below the poverty line each year.

4. The neglect of the poor is leading to unacceptable imbalances in development within the country as well as within each state – a major source of social tension and unrest. Disaggregated data on health status of the backward and remote areas is not available but the comparison of health facilities utilisation statistics between a relatively prosperous state, like Punjab and a backward state like Bihar brings out the huge distortions quite clearly. While the poor suffer a higher burden of disease, their poor utilisation of medical facilities is clearly due to lack of access and financial constraints. While all groups have lower utilisation in Bihar as compared to Punjab, the contrast is more marked in the poorest (Q1), where the utilisation is around four fold higher in Punjab both in outpatients and hospitalisation. Only a very concentrated effort on backward and remote areas inhabiting the poor can correct these imbalances and distortions.

Table 4: Rate per 1000 of Treatment during last 15 days

| State | POP<BPL In millions | %BPL Families | QI | QV | Total |
|------------|------------------------|------------------|-----------|-----------|-----------|
| Bihar | 49 | 55 | 14 | 36 | 24 |
| Punjab | 25 | 12 | 63 | 94 | 72 |
| All | 320 | 36 | 28 | 61 | 42 |

BPL = Below Poverty Line; Q = Quintile; All = the whole country

Source: 52ND NSSO From Benefit Incidence Analysis (BIA) Study of NCAER, 2000

Reproduced from : India Health Report, Oxford University Press, 2003.

Table 5: Rate per 100,000 of Hospitalisation

| State | POP<BPL in millions | %BPL Families | QI | QV | Total |
|------------|------------------------|------------------|------------|-------------|-------------|
| Bihar | 49 | 55 | 198 | 1728 | 722 |
| Punjab | 25 | 12 | 754 | 2998 | 1622 |
| All | 320 | 36 | 563 | 3447 | 1653 |

Source: 52nd NSSO From BIA Study of NCAER, 2000

Reproduced from : India Health Report, Oxford University Press, 2003.

It would thus be seen that the argument for a pro-poor focus in health investment extends far beyond macroeconomic and ethical arguments. It is not possible to make an impact on the health status of the population in a poor country without addressing the areas and the populace where most of the disease burden exists. Also, addressing the major causes of morbidity and mortality among the poor – the so called pre-transition diseases – is the most cost effective solution giving the maximum and the most rapid return on health investments. Also, since the maximum problem resides in backward and remote areas where the majority of the poor live, the only way to promote balanced and harmonious development is by concentrating on the upgradation of such areas – an absolute must for political stability in the long run. **Investment in the health of the poor is thus not only good economics but also good politics.**

What?

1. The CMH deserves to be congratulated on bringing home one long-obscured truth before the world that no system can be expected to deliver without a minimum of financial resources. Unfortunately, the minimum level of financial support is rarely in evidence among low-income countries. The average per capita public spending is estimated at \$ 6 in the least developed countries and \$13 in other low-income countries by the CMH. In India, the latest estimate by the World Bank (2001) is just \$ 3-4 per capita at 1993-4 constant prices. The CMH also conducted detailed exercises to estimate the cost of the essential services, which the state must provide and came up with a range from \$30-\$45 per capita. At current levels of expenditure, the resources devoted to health in most low-income countries would fall woefully below this target. The CMH must get full credit for bringing these harsh truths before the international community, as prior to this report, the focus was primarily on what the WDR 93 termed as greater allocative and technical efficiency. It is nobody's case that there isn't misallocation of resources or that the available resources could not be more efficiently employed in the poor countries. Certainly there is considerable room for improvement in that direction and that the same deserves urgent attention. However, that problem is relatively small compared to the gross inadequacy of financial resources. **The bottom line, therefore, is that public investments in health have to be raised significantly before any impact on the health outcomes can be expected.** A vigorous and sustained effort to mobilise resources both by developing countries themselves and by the donor community would need to be made on the lines suggested by the CMH, and the bulk of these additional resources would have to be invested in interventions that principally target the poor.

2. Every reform effort invariably comes up against vested interests, which try to create political roadblocks. The political leadership is understandably against taking political risks of antagonising any section of the population unless the political benefits clearly outweigh the risks. Therefore, where a significant political advantage can be seen by infusion of substantial additional resources, the political leadership would be willing to support reform even though

it involves antagonising some sections. In the early nineties, a number of categorical programmes supported by the World Bank had brought to light serious systemic problems at the state level, which were impeding the success of these as well as other programmes. But the proposals for reform never found a receptive audience till the introduction of the State Health System Projects. Despite the wide-ranging reforms contained in the projects, the states were most eager to take them up because the substantial investment in upgradation of infrastructure promised significant political benefits. **The additionality of resources is thus a necessary sweetener for reforms.**

3. The foremost priority is to have a universal health services delivery system including both public health and basic health care performing efficiently. This has been given different names at different times from Health for All in Alma Ata Declaration to 'essential health services' in WDR 93, and to 'close to client services' in the CMH. They basically mean the same thing with minor shifts of emphasis. As highlighted by the Working Group 5 of CMH, the foremost priority should be local health delivery structure, well equipped and staffed with motivated health workers, categorical programmes to provide technical and financial resources, and effective management with a well integrated surveillance and monitoring mechanisms. The primary and secondary level services must incorporate an effective referral system for more serious cases. The health delivery systems are most dysfunctional and inefficient in the backward and remote areas having poor governance and infrastructure, and therefore foremost attention deserves to be devoted to these areas. This is also necessary for removing the developmental imbalances referred to earlier.

4. The other priorities flow from the rationale for pro-poor reforms discussed in the earlier section. The conditions causing the maximum disease burden on the poor need to be tackled first. These are HIV/AIDS, infectious diseases, maternal and perinatal conditions, micronutrient deficiencies and tobacco related illnesses. Besides, the poor need to be provided easy access to health services and protected against the financial costs of serious illness either through direct provision of services by the state or through appropriate risk pooling arrangements, like health insurance. Eventually, the reduction of out of pocket expense as a source of health finance should be a principal objective in any reform exercise. Recently Mexico announced a universal health insurance programme, which sought to reduce drastically the current level of out of pocket expenditure (around 50%). In the case of India with over 80% out of pocket expenses, even reaching a level of 50% appears a far cry.

5. The complementary and synergistic development of other health related sectors like education, sanitation drinking water supply, nutrition and environment is equally important. The development of institutional mechanisms for coordination and convergence between these sectors both at the policy-making level as well as at the cutting edge is the key to achieving this objective. This is critical for the poor as the deficiencies in related sectors often negate the gains made in the health sector.

6. A sensitive and yet a very important question in all reform processes is the quality of governance. Normally in discussions of health-related reforms this issue is not brought up, as it is an all-encompassing problem affecting all activities of the government and not health alone. Yet it is too important an issue to be swept under the carpet: the success of the entire reform effort hinges on it. This is particularly so as poor governance affects the poor much more. Their lack of both political influence and awareness makes them easy targets for exploitation and neglect by unscrupulous functionaries. It has been a common experience of backward and remote areas that much of the funds for the welfare of the poor are siphoned away by corrupt officials. Obviously, it is not possible to change the administrative and political milieu of a country as the same depends on so many factors outside the purview of any health reform programme. **However, an effort to inject accountability and transparency and reduce the avenues for political and bureaucratic malfeasance and corruption should be an integral part of any such exercise.**

How?

No generalisation can be made, or indeed even attempted, about the process of reform, which has necessarily to be country specific. Each country, and in some cases each region, would need to determine the precise modalities of implementing the aforesaid reforms taking into account, inter alia, the socio-economic, political and cultural milieu, the level of development, the availability of financial resources and the capacity of the health infrastructure. It is neither possible nor even desirable to try to fit reforms all over the developing world in 'one size fits all' formula. We cannot even think of attempting such an exercise for a large and very diverse country like India, what to say of the world at large with its infinite diversity of political, cultural and economic situations and health problems. The maximum that can be attempted globally is the identification of a set of guiding principles and essential elements, which should underpin the process of reform.

The principal actors in the reform movement have necessarily to be the developing countries themselves as they bear the primary responsibility for the welfare of their citizens. However, with their limited financial and technical resources, their efforts would require sustained and generous help by the international community, as brought out very forcefully by the CMH. The MDGs represent a new awareness and an unprecedented international consensus, but the same has yet to be effectively translated into significantly higher commitments of financial assistance or new mechanisms for coordinated international action with the sole exception of the Global Fund for AIDS, Tuberculosis and Malaria (GFTAM). **As pointed out earlier, the reform process cannot survive without substantial increase in donor assistance, which needs to be insulated from the usual fluctuations arising out of regime changes and economic prospects in industrialised countries.** The political and economic factors influencing the aid climate in the donor countries are beyond our control. However, two steps could greatly improve the sustainability of external assistance and minimise its volatility. First, aggressive and sustained

global advocacy of the importance of supporting pro-poor health reforms-and the CMH has already laid out all the arguments in its favour: secondly, the channelling of aid for this effort primarily through multilateral institutions (WHO, World Bank, GFTAM) to minimise the possibility of shifting political preferences influencing the quantum of assistance. Side by side, international agencies need to provide technical support to the developing countries to the extent necessary, both for the formulation of the investment and reform package and guiding and monitoring its implementation, and the WHO is ideally situated to play a leadership role in this behalf. The extent of this support would naturally vary widely on the level of development and in-house technical expertise available in each country. **It is, however, most important that the external technical and financial support should not in any way compromise the ownership of the reform process in the host country- it should not only be entirely domestically owned and driven but also seen to be so.**

Notwithstanding the country specific nature of the process, an attempt has been made to list out some of the essential and critical elements to facilitate discussion:

1. First and foremost is the generation of awareness and political support in the developing countries for health in general and for pro-poor reforms in particular. As of today, there is appalling indifference and absence of informed debate on health issues, which is reflected in the abysmally low financial allocations. The need of the hour is aggressive and sustained advocacy involving political institutions, media, and the civil society. The campaign necessarily should be totally non-partisan with a view to develop a political consensus. The advocacy campaign might need external financial and technical support.

2. The mobilisation of domestic resources would depend largely on the strength of the political support generated by the advocacy campaign. It must be recognised that the developing countries are facing varying degrees of fiscal constraints and there is strong competition to health for the available funds. It has often been argued that the resources should be found by increasing taxes, reducing subsidies, privatisation of public sector enterprises and reallocating resources from items like defence. First of all, all these prescriptions are not necessarily desirable, and even where that is so, they are often politically infeasible. It would therefore, be idle to place too much reliance on mobilisation of additional resources from these measures although their validity in many cases is not disputed. The promotion of these solutions should be tempered by the realisation that even in the mature western democracies, there are severe political limitations to some of the suggested measures, e.g. the huge subsidies on agriculture. While some reallocation of resources can be attempted, it will always remain vulnerable to fiscal crises, political upheavals and other competing claims. Investments in health can produce results only in the long and medium term. Therefore, the stability of financial support is critical. Each country will have to find ways of protecting health outlays from financial crises and political upheavals. The earmarking of funds and imposition of dedicated levies is one possible solution of promise to this vexed problem. In India, the best-performing sector in the recent

past has been the upgradation and building of new highways, which is largely financed out of a cess on petroleum products – an assured and growing source of revenue. Dedicated levies on alcohol and tobacco are obvious candidates for consideration.

3. The success of the health system depends largely on people's participation and involvement. **The challenge is to develop a participatory system in which the community has a sense of belonging and ownership without the state losing technical control and stewardship.** It can be attempted through decentralised institutions of local self-government, wherever possible. It is important to ensure that the health workers feel accountable to the community they serve and important health related decisions are taken in consultation with the beneficiaries. The bottom line is that a top down approach is unlikely to work. In the state of Kerala in India, where the responsibility for the health system at the primary and secondary level has been transferred entirely to the local elected bodies, the improvement in efficiency is significant. For instance, the local community has solved the chronic problem of shortage of health personnel by hiring staff on contract. They have mobilised funds for repair of buildings, purchase of equipment and have greatly improved the supervision and accountability of the health workers. Part of the success of this effort is due to very elaborate preparation for the transfer of responsibilities including the extensive training of elected leaders.

4. The institutional capacity in the health ministries and subordinate offices for planning, analyses and monitoring is often very weak, and expertise in critical areas, like public health, epidemiology, health economics and finance are either totally lacking or highly deficient. **What is needed is a culture of evidence-based and well-informed decision making.** There is often no institutional arrangement for interaction between researchers and decision makers both in setting the research agenda and utilisation of research outputs. Similarly the arrangements for monitoring and evaluation are generally deficient. The development of these essential capacities would require sustained effort and external technical help, which is critical to the success of the reform effort.

5. There is a growing private sector in most developing countries, which is not generally involved in the achievement of national health goals. It must be recognised that the state alone would not be able to achieve the desired goals without the active involvement and support of the private sector. Public-private partnerships need to be promoted not only in respect of public health interventions, but also for provisioning health services for the poor. Also the private sector, particularly non-profit would need to be encouraged to set up services in under-served and backward areas with attractive incentives. The cooperation of the private sector in adoption of agreed treatment protocols for important infectious diseases (like TB), preventing indiscriminate use of anti-microbials, and epidemiological surveillance, is critical.

6. A credible and dependable system of identification of the poor for the purpose of targeting special concessions and facilities needs to be put in place. This is not an easy task as

the experience in India suggests. The introduction of transparent criteria and subjecting the selection to scrutiny by village councils (Gram Sabha) comprising all adults, has generally proved effective in preventing irregularities. **Special monitoring of health outcomes in designated backward areas and disaggregated data on health status at different income levels is critical to monitoring the impact of reforms on the poor.** External technical help, wherever required, would need to be provided to develop these instruments.

7. The key to the success of any health - related programme is the quality and commitment of the health workers, particularly at the cutting edge. A careful assessment of manpower requirements, identification of current deficiencies, and the planning of remedial measures would be a critical element of the exercise. **Health workers need to be motivated to work in remote and difficult areas by generous compensation combined with transparent and attractive incentives.**

8. Finally, the systemic constraints impeding efficient delivery of interventions and optimal utilisation of services would need to be identified and a detailed blueprint drawn up for their time bound elimination. The objective identification of these constraints could be facilitated by surveys and analyses by agencies independent of the government. The exercise would require many reforms in management systems to improve accountability, efficiency and transparency.

9. The development of a strategic framework and an investment plan including clearly targeted pro-poor interventions and reforms, would require detailed work by expert groups with oversight of key ministries like finance, planning and health, support of international agencies (WHO, World Bank) and other important donor agencies for health. The CMH had suggested constitution of national commissions on macroeconomics and health co-chaired by the ministers of finance and health. Each country could devise a mechanism suitable to its own situation as long as it is capable of completing the challenging task in a time bound manner. Already the process has been initiated in several countries.

Conclusion

Pro-poor reforms in health are desirable not only from a moral and ethical standpoint, they are indeed the best strategy for rapid improvement in health outcomes and progress towards MDGs besides maximising returns from investments in health. They could also contribute significantly towards balanced, harmonious and participatory development as well as empowerment and well-being of the poor. The need of the hour is generation of political will both in the developing countries and the donor community in favour of a strong and sustained effort in this regard. This could be achieved through an international compact – the main objective of this consultation. The world shall be watching eagerly and expectantly for the outcome.

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Development Assistance for Health (DAH): Recent Trends and Resource Allocation

Catherine Michaud, MD, PhD

This paper complements the CMH working paper “Development Assistance for Health: Average Commitments 1997-1999”. The first part reviews trends in development assistance for health (DAH) provided by bilateral and multilateral agencies; the European Community (EC); the Global Fund to fight AIDS, malaria and tuberculosis (GFATM); and grants provided by the Bill and Melinda Gates Foundation (BMGF). Together these sources provide an estimated ninety percent of total DAH. The second part presents a detailed analysis of geographic allocation of funds and for major components of interest, namely AIDS, malaria and tuberculosis. The last part discusses the major implications of key findings.

I. TRENDS IN DEVELOPMENT ASSISTANCE FOR HEALTH BETWEEN 1997 AND 2002

This period corresponds to a period of decline in overall ODA coupled with a new understanding of the importance of health as a major determinant of economic growth.

Clear targets have been set as part of the Millennium Development Goals (MDG) to assess progress. The report of the CMH provided estimates of the substantial increase in DAH that would be needed to have a significant health impact. The first question therefore is “how far have we advanced towards a substantial increase in DAH”?

• Total ODA begins recovery in 2002

After a long period of decline in total official development assistance (ODA) during the past decade, the OECD reported a real increase of 5% in ODA provided by members countries of the OECD’s Development Assistance Committee (DAC) from 2001 to 2002. The total amounted to \$57 billion and hopefully signals the beginning of a recovery from the steady decrease of total ODA during the 1990s to an all time low in development assistance over the past three years. In 2002 total ODA increased from 0.22% to 0.23 % of combined gross national income (GNI). This is still far from the target of 0.7% of GNI set years ago.

Health ODA fared better than total ODA. The share of total bilateral ODA allocated to the health sector (including health and population) increased from 3.8 percent in 1990 (\$2.2 billion) to 6.8 percent in 2002 (\$2.9 billion). In spite of this steady increase, bilateral health ODA had not quite caught up in 2002 with its peak value of \$3 billion in 1995.

• Total development assistance for health (DAH) increased between 1998 and 2002

Data sources

When assessing volume and trends of DAH, an important distinction has to be made between commitments and actual disbursements. Disbursements in a given year capture actual expenditures incurred that year, whereas commitments are usually made for a period of 3-5 years by most agencies. Typically there is a lag time between the time of commitment and actual disbursements of those funds. Unfortunately few agencies readily provide both commitments and disbursements. Most agencies included in this review provided commitments only, with the exception of UN agencies (WHO and UNICEF). The World Bank and more recently the GFATM track both components. Data sources and available datasets are provided below (Table I).

Table I: Main data sources and data types

| Funding sources | Data sources | Data type |
|-----------------------------|----------------------------------|-------------------------------|
| Bilateral agencies | OECD: CRS and DAC (1) | Commitments |
| | USAID Congressional reports | Commitments |
| Multilateral agencies | WHO Detailed expenditure reports | Disbursements |
| | UNICEF Agency database | Disbursements |
| | World Bank Agency database | Commitments and disbursements |
| | IADB Agency database | Commitments |
| Other multilateral agencies | AfDB and AfDF OECD: CRS | |
| | EC Agency database | Commitments |
| | GFATM Data included in website | Commitments and disbursements |
| BMGF | Data included in website | Commitments |

1) The OECD provides data on the sectoral allocation of ODA for bilateral agencies only in DAC tables. The Creditor Reporting System (CRS) complements the DAC and captures detailed commitments to recipient countries. Reporting from bilateral agencies has improved overtime and is now almost complete. Commitments made by development banks have been and UN agencies have been added in recent years, with different levels of completeness.

This brief overview of available data sources points to a major shortcoming of current estimates, which is that they include a mix of commitments (for most agencies) and disbursements for WHO and UNICEF. The implications of this will be discussed in the third part of this report.

Key findings

Total DAH from major selected sources increased by \$1.7 billion - from \$6.4 billion on average between 1997-1999 to \$8.1 billion in 2002. Most of this increase was due to new funds committed by both public and private sources to the Global Fund to fight AIDS, tuberculosis and malaria (GFATM) (Table 2).

**TABLE 2: RECENT TRENDS IN DEVELOPMENT ASSISTANCE FOR HEALTH (DAH)
SELECTED MAJOR SOURCES OF FUNDS
USD (thousands)**

| | 1997-1999 average | 2002 | 2003 |
|------------------------------|----------------------|----------------|---------|
| Bilateral agencies | 2,559.8 | 2,875.2 | |
| USAID | 920.8 | 1,134.9 | 1,474.0 |
| Multilateral agencies | 3,401.5 | 4,649.2 | |
| UN SYSTEM | 1,575.5 | 2,036.3 | |
| WHO | 864.2 | 1,140.5 | |
| Regular Budget | 406.1 | 461.1 | |
| Extrabudg. Contributions | 458.1 | 776.5 | |
| PAHO (own funds) | 84.3 | 93.4 | |
| UNAIDS | 58.2 | 91.9 | |
| UNICEF | 275.8 | 391.0 | |
| UNFPA | 293.0 | 319.5 | |
| DEVELOPMENT BANKS | 1,522.0 | 1,405.5 | |
| World Bank | 1,124.9 | 983.0 | 1,171.8 |
| IDA | 713.5 | 536.4 | 586.2 |
| IBRD | 411.4 | 446.6 | 585.5 |
| IADB | 245.7 | 205.0 | 0.0 |
| ADB (1) | 287.7 | | |
| AfDB | 151.4 | 217.5 | |
| OTHER MULTILATERAL | 304.1 | 1,207.4 | |
| EC | 304.1 | 244.5 | |
| GFTHMT | 0.0 | 962.8 | 979.2 |
| Private non-profit | | | |
| BMGF | 458.0 | 595.9 | |
| Total DAH | 6,419.3 | 8,120.3 | |

(1) Was not included in totals (pending update) to increase comparability of total DAH

Bilateral commitments increased only slightly over the past five years from 2.6 to 2.9 billion, and have not yet reached peak commitments made in 1995. Trends have varied in individual agencies. The most significant increase in commitments was made by the United States from \$920 million for the period 97-99 to \$1.5 billion in 2003. These amounts do not include an additional \$300 million committed to the GFATM and other multilateral agencies (Table 3)

TABLE 3: RECENT TRENDS IN DEVELOPMENT ASSISTANCE FOR HEALTH (DAH) – BILATERAL AGENCIES
USD (thousands)

| Bilateral agencies | 1997-1999 average | 2002 | % total |
|---------------------------|------------------------------|----------------|----------------|
| United States | 920.8 | 1,134.9 | 39.5% |
| United Kingdom | 286.3 | 318.2 | 11.1% |
| Japan | 359.9 | 308.5 | 10.7% |
| Norway | 56.4 | 147.2 | 5.1% |
| Netherlands | 101.4 | 136.9 | 4.8% |
| Germany | 184.3 | 122.5 | 4.3% |
| France | 128.4 | 111.8 | 3.9% |
| Sweden | 79.1 | 104.5 | 3.6% |
| Australia | 79.6 | 97.0 | 3.4% |
| Canada | 28.7 | 88.4 | 3.1% |
| Belgium | 60.5 | 68.4 | 2.4% |
| Spain | 74.8 | 67.7 | 2.4% |
| Denmark | 49.0 | 40.1 | 1.4% |
| Switzerland | 17.9 | 31.2 | 1.1% |
| Italy | 21.6 | 27.5 | 1.0% |
| Ireland | 10.4 | 25.7 | 0.9% |
| Finland | 17.2 | 23.8 | 0.8% |
| Portugal | 8.7 | 7.8 | 0.3% |
| Greece | 5.8 | 5.5 | 0.2% |
| New Zealand | 3.3 | 4.2 | 0.1% |
| Austria | 49.0 | 3.5 | 0.1% |
| Luxembourg | 16.7 | | 0.0% |
| Total | 2,559.8 | 2,875.2 | |

UN agencies increased funding from 1.6 to 2 billion since 1997. The most notable was the increase in WHO extrabudgetary contributions, which almost doubled over the past five years – from \$460 million to \$780 million.

The rapid increase in IDA and IBRD commitments made by the World Bank during the 1990s has now stabilized around 1 billion per year.

The Gates Foundation, which increased rapidly since it was established in 1994 to \$460 million on average between 1997 and 1999, and \$ 600 million in 2002. Cumulative commitments since inception were equal to \$3 billion by October 2003.

• **The largest increase in funding was allocated to fighting AIDS in SSA**

Most major funding sources in the public and private sectors increased funding for HIV/AIDS, particularly in SSA (Table 4)

**TABLE 4: RECENT TRENDS IN DEVELOPMENT ASSISTANCE FOR HEALTH (DAH) FOR HIV/AIDS – SELECTED MAJOR SOURCES OF FUNDS
USD (millions)**

| | 1997-1999 average SSA | Total | 2002 SSA | Total |
|-------------------|--------------------------|--------------|--------------|--------------|
| USAID | 55.1 | 91.3 | 103.4 | 300.5 |
| World Bank | | | | |
| IDA | 5.0 | 144.4 | 285.8 | 314.6 |
| IBRD | | | | 20.9 |
| BMGF | | | 60.9 | 81.5 |
| Sub-total | 60.1 | 235.7 | 450.1 | 696.6 |

The Global Fund to fight AIDS, tuberculosis and malaria allocated 56 percent of total commitments to HIV/AIDS; 27 percent to malaria; and 15 percent to tuberculosis. The largest share of funds was allocated to SSA. Amounts actually disbursed so far are modest (\$150 million by September 2003) but are projected to increase rapidly. The estimated total amount committed in the first three rounds of proposals would lead to funding increasing by approximately 1 billion each year – or a cumulative budget of 1 billion the first year to reach 5.1 billion the fifth year.

The United States was the largest donor for HIV/AIDS in 2002. It committed \$790 million for HIV/AIDS. This was \$475 million more than the next largest donor and 50 percent of all amounts budgeted by all donors (US at G8 2003). The USAID HIV/AIDS budget in Africa increased from \$ 55 million on average in 97-99 to 193.4 million in 2002 (63 percent of total for HIV/AIDS). Uganda, Zambia and Kenya were the largest recipients of USAID commitments (\$ 20 million; \$18.5 million; and \$17.2 million respectively).

According to the Creditor Reporting System (CRS) on-line database, commitments from all other bilateral donors increased from \$205.3 (period average 97-99) to \$294.5 in 2001. The UK was the next largest donor and committed \$157.9 million in 2001.

UNICEF increased funding for HIV/AIDS in recent years to 9% of its total budget in 2002 (Annual Report 2002).

• Funds provided to RBM more than double WHO funds for malaria in SSA

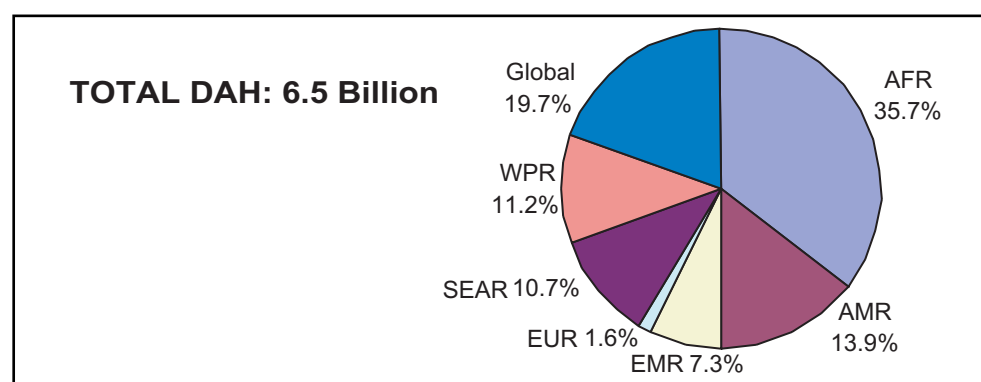
The partnership to roll back malaria (RBM) more than doubled total funding provided by WHO for malaria in SSA. It added \$ 6.4 million to the \$ 2.5 million allocated to malaria by other funds in 2002.

II. ALLOCATION OF DAH BY REGION AND MAJOR COMPONENTS IN 2002

Bilateral agencies, WHO, UNICEF, the AfDB/AfDF, the IADB, the World Bank, the EC, GFATM, and the BMGF provided detailed information on the allocation of ODH to recipient countries and major components of particular interest, namely HIV/AIDS, tuberculosis and malaria, and were included in this analysis. Together these agencies provided \$ 6.5 billion in 2002.

The largest share of funds was allocated to support country and regional activities (\$5.2 billion). The remainder (\$1.3 billion) was allocated to inter-regional and global activities. Regions included in this analysis were the six main WHO regions – Africa (AFR); the Americas (AMR); Europe (EUR); Eastern Mediterranean (EMR); South-East Asia (SEA) and Western Pacific (WPR). More than one third of all funds (36 percent) were allocated to Africa; 22 percent to Asia (SEA and WPR); 14 percent for the Americas; 7 percent to EMR and less than 2 percent to Europe (Table 5).

TABLE 5
OVERALL DISTRIBUTION OF ODA - SELECTED MAJOR SOURCES 2002



SELECTED SOURCES: BILATERAL AGENCIES, WHO, UNICEF, WORLD BANK, IADB, AFDB/AFDF, GFATM, BMGF (for which detail allocation was available)

The \$1.25 billion allocated to HIV/AIDS, malaria and tuberculosis represented approximately one fifth of total DAH for the selected sources combined. The allocation of the remainder 80 percent would of course be of great interest as well, but was outside of the scope defined for this study. The largest share was allocated to HIV/AIDS (14 percent) and approximately 3 percent to both malaria and tuberculosis.

The allocation for each component, however, varied significantly between regions. The largest share for HIV/AIDS (56 percent) and for malaria (69 percent) were allocated to Africa, and the largest for tuberculosis to the Western Pacific (62 percent) (Table 6).

TABLE 6: DISTRIBUTION OF ODA MAJOR COMPONENTS - SELECTED MAJOR SOURCES 2002
USD (thousands)

DAH per capita was equal to \$ 3.3 in Africa; \$ 0.8 in the Americas and \$ 0.77 in the Eastern

| | Total DAH | SUB-TOTAL (AIDS, malaria, tuberculosis HIV/AIDS MALARIA TUBERCULOSIS) | | | |
|-------------------------------|------------------|---|----------------|----------------|----------------|
| | | | | | |
| TOTAL REGIONAL FUNDING | 5,183,497 | 1,072,736 | 752,421 | 140,398 | 179,918 |
| AFR | 2,292,677 | 550,892 | 417,545 | 96,658 | 36,689 |
| AMR | 895,970 | 111,389 | 88,685 | 10,703 | 12,000 |
| EMR | 466,096 | 13,499 | 5,551 | 7,541 | 407 |
| EUR | 101,719 | 117,139 | 107,026 | 1,698 | 8,415 |
| SEAR | 684,631 | 77,899 | 57,816 | 9,223 | 10,860 |
| WPR | 717,060 | 190,619 | 64,548 | 14,524 | 111,547 |
| Global | 1,266,959 | 11,249 | 11,249 | | |
| GLOBAL FUNDING | 1,266,959 | 126,298 | 79,684 | 17,790 | 28,824 |
| TOTAL | 6,450,457 | 1,247,738 | 879,607 | 158,187 | 209,944 |
| Percent Distribution | | | | | |
| | Total DAH | SUB-TOTAL (AIDS, malaria, tuberculosis HIV/AIDS MALARIA TUBERCULOSIS) | | | |
| TOTAL REGIONAL FUNDING | 5,183,497 | 20.7% | 14.5% | 2.7% | 3.5% |
| AFR | 2,292,677 | 51.4% | 55.5% | 68.8% | 20.4% |
| AMR | 895,970 | 10.4% | 11.8% | 7.6% | 6.7% |
| EMR | 466,096 | 1.3% | 0.7% | 5.4% | 0.2% |
| EUR | 101,719 | 12.0% | 15.7% | 1.4% | 4.7% |
| SEAR | 684,631 | 7.3% | 7.7% | 6.6% | 6.0% |
| WPR | 717,060 | 17.8% | 8.6% | 10.3% | 62.0% |
| GLOBAL FUNDING | 1,266,959 | 10.0% | 6.3% | 1.4% | 2.3% |
| TOTAL | 6,450,457 | 19.3% | 13.6% | 2.5% | 3.3% |

Mediterranean region; \$ 0.41 in South East Asia and the Western Pacific regions.

Finally the allocation of DAH per capita varied by country within regions (Table 7 and Table 8). The ten countries that received the largest DAH per capita from all sources combined were in Africa (7 countries) and in the Americas (3 countries).

TABLE 7: TOP TEN COUNTRIES RECEIVING MOST DAH FROM SELECTED MAJOR SOURCES 2002 (I)

| WHO region | population | Country Name | DAH per capita USD | DAH total (000s) | DAH HIV/AIDS | DAH Malaria total | DAH Tuberculosis total |
|------------|------------|--------------|--------------------|------------------|--------------|-------------------|------------------------|
| AMR | 6,154 | El Salvador | 28.0 | 172,187 | 500 | 0 | 250 |
| AFR | 8,976 | Zambia | 16.7 | 150,222 | 25,933 | 5,978 | 27 |
| AFR | 1,695 | Namibia | 12.7 | 21,445 | 4,287 | 41 | 15 |
| AFR | 1,268 | Gambia | 12.2 | 15,488 | 47 | 57 | 6 |
| AMR | 2,560 | Jamaica | 11.9 | 30,368 | 12,728 | 0 | 4,009 |
| AFR | 9,240 | Senegal | 11.7 | 107,986 | 6,001 | 2,726 | 1,000 |
| AMR | 6,316 | Honduras | 9.6 | 60,820 | 3,888 | 220 | 650 |
| AFR | 5,937 | Benin | 7.3 | 43,250 | 2,861 | 1,564 | 3 |
| AFR | 6,565 | Burundi | 7.0 | 45,902 | 189 | 437 | 2,019 |
| AFR | 2,108 | Leshoto | 6.6 | 13,926 | 1,239 | 0 | 0 |

(I) Countries with a total population of less than 1 million were not included

TABLE 8: TOP FIVE COUNTRIES RECEIVING MOST DAH FROM SELECTED MAJOR SOURCES 2002, BY REGION

| WHO region | Population (000s) | Country Name | DAH per | | DAH HIV/AIDS | DAH Malaria total | DAH Tuberculosis total |
|------------|-------------------|----------------------------------|------------|------------------|--------------|-------------------|------------------------|
| | | | capita USD | DAH total (000s) | | | |
| AFR | 8,976 | Zambia | 16.7 | 150,222 | 25,933 | 5,978 | 27 |
| AFR | 1,695 | Namibia | 12.7 | 21,445 | 4,287 | 41 | 15 |
| AFR | 1,268 | Gambia | 12.2 | 15,488 | 47 | 57 | 6 |
| AFR | 9,240 | Senegal | 11.7 | 107,986 | 6,001 | 2,726 | 1,000 |
| AFR | 5,937 | Benin | 7.3 | 43,250 | 2,861 | 1,564 | 3 |
| AMR | 6,154 | El Salvador | 28.0 | 172,187 | 500 | 0 | 250 |
| AMR | 2,560 | Jamaica | 11.9 | 30,368 | 12,728 | 0 | 4,009 |
| AMR | 6,316 | Honduras | 9.6 | 60,820 | 3,888 | 220 | 650 |
| AMR | 8,142 | Bolivia | 6.4 | 52,362 | 4,496 | 600 | 831 |
| AMR | 4,938 | Nicaragua | 6.0 | 29,496 | 674 | 0 | 0 |
| EMR | 27,867 | Morocco | 4.7 | 129,734 | 53 | 0 | 130 |
| EMR | 17,488 | Yemen | 2.6 | 45,037 | 138 | 247 | 27 |
| EMR | 21,923 | Afghanistan | 1.8 | 39,709 | 0 | 371 | 1,403 |
| EMR | 9,672 | Somalia | 1.8 | 17,475 | 0 | 90 | 191 |
| EMR | 3,236 | Lebanon | 1.3 | 4,279 | 297 | 0 | 20 |
| EUR | 3,839 | Bosnia Herzaegovina | 1.9 | 7,388 | 0 | 0 | 0 |
| EUR | 4,669 | Kyrgystan | 1.9 | 8,921 | 650 | 10 | 19 |
| EUR | 3,133 | Albania | 1.1 | 3,384 | 1,422 | 0 | 0 |
| EUR | 5,006 | Georgia | 0.7 | 3,275 | 1,100 | 10 | 2,417 |
| EUR | 23,942 | Uzbekistan | 0.6 | 14,377 | 4,009 | 0 | 2,365 |
| SEAR | 2,064 | Bhutan | 6.0 | 12,405 | 112 | 51 | 493 |
| SEAR | 28,385 | Nepal | 1.5 | 41,708 | 7,452 | 699 | 1,285 |
| SEAR | 18,639 | Sri Lanka | 0.7 | 13,087 | 51 | 5,287 | 2,890 |
| SEAR | 126,947 | Bangladesh | 0.6 | 80,779 | 3,452 | 0 | 600 |
| SEAR | 45,059 | Myanmar | 0.6 | 28,123 | 228 | 260 | 188 |
| WPR | 4702 | Papua New Guinea | 3.8 | 17821 | 0 | 171 | 149 |
| WPR | 5297 | Lao People's Democratic Republic | 3.4 | 17988 | 577 | 37 | 5 |
| WPR | 10945 | Cambodia | 2.7 | 29866 | 12531 | 1360 | 213 |
| WPR | 74454 | Philippines | 1.9 | 139960 | 2001 | 2915 | 2485 |
| WPR | 78705 | Viet Nam | 1.6 | 129165 | 32734 | 279 | 74 |

III. IMPLICATIONS OF KEY FINDINGS

The analysis of recent trends and allocation of DAH from major donors conveys mixed messages.

- There is no doubt that DAH fared much better than other sectors during the 1990s, maintaining a relatively steady level at a time when total ODA plummeted;
- The geographic allocation of DAH from all sources has been responsive to real needs, at least for HIV/AIDS, malaria and tuberculosis;
- The report of the CMH has led to the development of the Global Fund to fight HIV/AIDS, malaria and tuberculosis, and sparked increased commitment towards tackling major health problems in several developing countries;
- The allocation of funds – mostly commitments – increased by \$1.7 billion over the past five years;
- Political commitment is much higher than ever before: the President of the United States made the commitment to provide \$15 billion over the next five years to fourteen countries plagued by AIDS in Africa and the Caribbean (Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia).
- Yet, recent increases in DAH, although encouraging, fall short of meeting real needs.

It appears that things are moving in the right direction, although may be not quite as fast as would have been desirable. Are they really? Should the message provided at the end of the CMH follow up meeting be that all that is needed is to keep going and increase funding levels?

One major shortcoming of the analysis presented in this paper is that it combined commitments and disbursements as though they were comparable. They really are not, and this points to a fundamental issue, which is the pace at which funds committed are being disbursed. An increase in total disbursements of \$1.7 billion would have a totally different meaning than the same increase in commitments. It means that it will take several years before committed funds will actually be spent, and thus represents a much smaller increase in DAH than first appears.

This very issue lies at the core of the current difficulties encountered by the GFATM in receiving pledges needed to ensure sufficient funds in the future. The decision made just a little over a week ago by trustees of the GFATM to reduce the number of yearly funding cycles in order to ensure that the funds would not run out before projects funded in the first three rounds have been completed raises real concerns.

One key question that would be well worth discussing during this meeting, is the extent to which substantial increases in funds committed to countries in greatest need can be absorbed at the country level. It is quite striking that even though pledges reached 2 billion,

only \$ 150 million dollars has actually been disbursed to countries, two years after the GFTM was established. What are major limiting factors to a more rapid disbursements of funds? Is the lag time between commitments and disbursements increasing with increased commitments – or is it decreasing ? What are the major limiting factors , and what could be done to address those? There is no doubt that all stakeholders need to work much more closely together to identify and overcome major roadblocks to scaling up investments to improve health among the poor, as was recommended by the CMH.

Links between Macroeconomics and Health: Relevance to the South East Asian Region¹

Abusaleh Shariff, Ph.D²

Executive Summary

Introduction

Healthier the economy of a state, healthier are its citizens is an off-repeated point of view. The other side of this chicken and egg conundrum is highly positive spin-offs of investment in health on economic development. Importantly, the fact that health gains can be achieved through efficient allocation of available, often inadequate, resources in emerging economies will enhance economic prosperity does not generally accord policy attention. Historically, important breakthroughs in public health, disease control and appropriate nutritional intake have given rise to great takeoffs in economic development. This was evident during the rapid growth of Britain during the Industrial Revolution, of Japan in the 20th century and East Asia in the 1950s and 1960s.

This study analyses the links between Health and Macroeconomics for ten countries in the Southeast Asian Region (SEAR), namely Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand. While there are wide variations in the levels of economic and human development, their commonality lies in common health problems with differences apparent in socioeconomic, epidemiological and demographic transitions. The whole of the region is characterized by prevalence of the diseases of the poor, such as tuberculosis, malaria, sexually transmitted diseases, skin infections and common blindness and the newly emerging HIV/AIDS. Many countries, notably the South Asian economies, have high gender biases in access to health care, and the women and children face high risks due to the lack of and poor quality reproductive health, immunization and family planning services. This region has the dubious distinction of having the highest incidence of anemia amongst women and malnutrition amongst children in the world, including the African continent.

Objectives

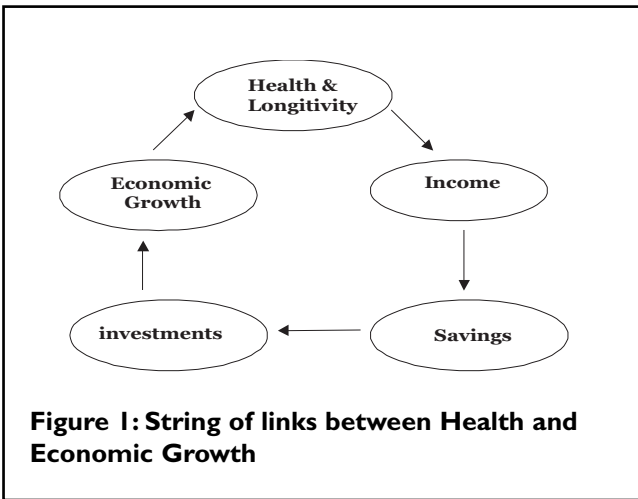
This study highlights the importance of monetary and physical investments in primary and reproductive health, mass education and poverty alleviation programmes. It attempts to establish links between macroeconomic growth and health spending, identify mechanisms to enhance health coverage of the poor, and to explore effects of globalization and multilateral trade agreements such as TRIPS on the availability of drugs amongst the poorer nations.

1. A note prepared for presentation in the 'Ministerial Consultation on Macroeconomic and Health' organized by the World Health Organization, 28 - 30th October 2003, WHO Headquarters, Geneva.

2. Chief Economist, National Council of Applied Economic Research, New Delhi, India. The opinions expressed in this document are the author's own and not of the institution he represents nor of the WHO Regional Office for Southeast Asia. The author wishes to acknowledge the high quality research assistance of Kavery Ganguly, Anoop Satpathy, Saswata Ghosh, Jaya Koti and Girish Khulbe.

Health and Macro-Economic Links

In order to place the argument of health being more of a cause rather than an effect of economic development, this study brings together compelling empirical evidence from the SEAR. At the outset it is important to note that there exist considerable differences in the disease profiles between the rich and the poor nations of the world, and between the rich and poor often within the same country. The burden of morbidity from a number of

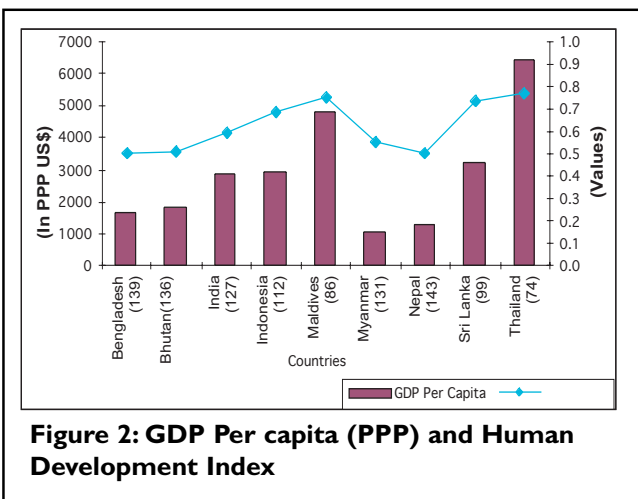


untreated, debilitating but rarely fatal diseases in developing countries, including sexually transmitted infections, tuberculosis, malaria and HIV/AIDS, has a substantial impact on economic productivity. The commonly used indicator of well-being - life expectancy at birth – appears inadequate to highlight the costs associated with morbidity. Instead, ‘Disability Adjusted Life Years’ (DALYs) is a better measure albeit the difficulty in estimation at the national and sub-national levels.

Disease burden slows the economic growth that is presumed to solve the health problems. Disease

reduces the number of years of healthy life years. A society afflicted with high infant mortality lacks secure knowledge of children’s longevity, witnesses higher rates of fertility, and experiences “quantity-quality” trade off in child rearing. Disease burden, apart from its effects on individual worker productivity, diminishes the return to business and infrastructure investment.

Southeast Asian Region (SEAR) is one of the poorer parts of the world, having huge deficits in many human development parameters and low levels of human development Index (HDI)



values. For example, about 80 per cent of the population in Bangladesh, Bhutan and Nepal and about 60 per cent in India are found to have a per capita per day income of less than 2 dollars a day. Two-dollar-a-day poverty is also as high as 40 per cent in Sri Lanka and 30 per cent in Thailand. All countries, excepting Thailand and Sri Lanka, have HDI values below 0.7 Nepal and Maldives below 0.5. Even Thailand and Sri Lanka have values about 0.75 that are not high in terms of global perspective.

However, as has already been mentioned, in spite of the commonality of health problems there remains noteworthy difference in terms of health parameters and the effort of institutional mechanisms to attain a

better health standard. The proportion of women facing high levels of anemia ranges

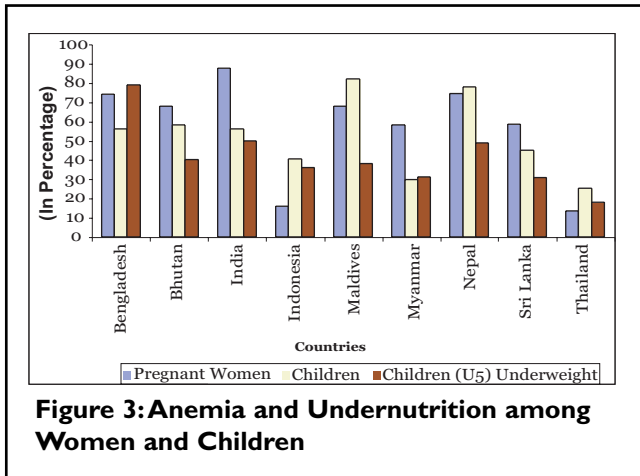


Figure 3: Anemia and Undernutrition among Women and Children

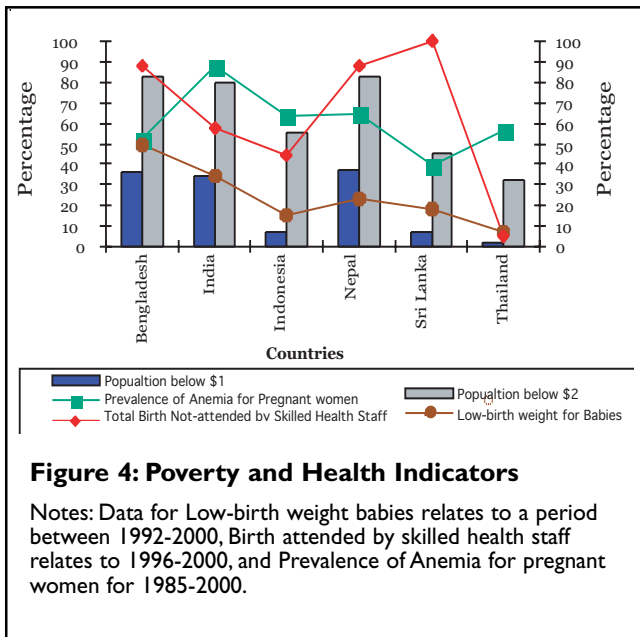


Figure 4: Poverty and Health Indicators

Notes: Data for Low-birth weight babies relates to a period between 1992-2000, Birth attended by skilled health staff relates to 1996-2000, and Prevalence of Anemia for pregnant women for 1985-2000.

Public Health Expenditures

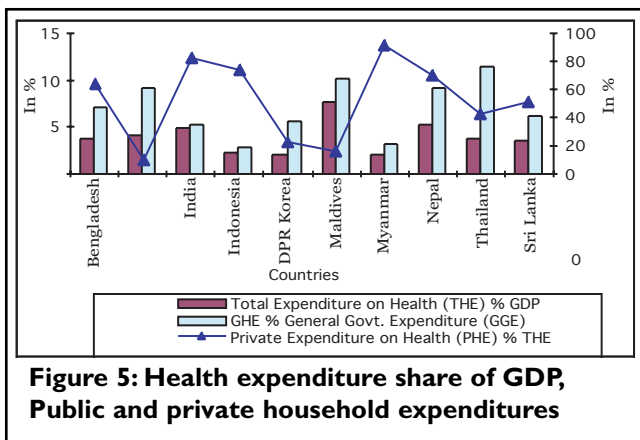


Figure 5: Health expenditure share of GDP, Public and private household expenditures

between 50 to 80 per cent, with highest levels in India, Indonesia, Bangladesh, Nepal and Bhutan. Sri Lanka has the lowest level, yet above 40 per cent of its pregnant women suffer from anemia. Low birth weight is a problem in South Asian part of the region, excepting Sri Lanka. While Thailand has better coverage in terms of birth attendance by skilled health staff, but a large proportion of birth in Bangladesh, Nepal, India and Indonesia occur in the absence of skilled health staff.

Most countries in SEAR confront periods of macroeconomic imbalances, such as rising inflation, imbalances in aggregate demand and supply and foreign exchange crisis. In order to deal with financial crises, many have resorted to structural adjustment and policy reforms that have entailed a substantial departure from the past economic practices. The consequential reduction in public resources, fiscal squeeze and budget cuts in social sectors, such as health, primary education, poverty alleviation and social protection programmes, both at the national and state (local) levels has been the rule of the day. In low-income economies, fiscal squeeze and budget cuts in social and poverty alleviation sector expenditures has diminished accessibility by the poor to basic health and essential clinical services, elementary education and social protection flows. This has considerably reduced the ability of the poor citizens to cope with the period of stress arising out of illness.

Economies constituting the SEAR spend a considerably lower percentage of their GDP on health. For example, only Maldives, a small country, spends up to 7.6 per cent of its GDP. Countries with large populations, such as India, Bangladesh, Indonesia and Myanmar, spend 4.9, 3.8, 2.2 and 2 per cent of their respective GDPs. However, there is a substantial qualitative difference across countries as to the structure of expenditure and source of funds. Over 77 per cent of expenditure in DPR Korea, 83 per cent in Maldives and 90 per cent in Bhutan is undertaken by their respective governments

whereas, the public expenditure in Myanmar is less than 10 per cent of the total expenditure. The share of public expenditure in India, Indonesia and Bangladesh is 18 per cent, 26 per cent 36 per cent, respectively.

Household (Private) Health Expenditures

Structure of household health care expenditures provides the rationale for a strong governmental interventionary measure. Individuals and households spend substantially on physician's fees, purchase of drugs and transport. Health spending of an outpatient visiting a private practitioner always outweighs the spending at a government facility. A study undertaken in the States of Tamil Nadu and Karnataka reveals that only about 10 per cent of outpatients to a private doctor spend less than US\$ 2 (Rs. 100) as against almost 55 per cent of outpatients at a government facility.

Similar expenditures according to land size classifications also highlight precarious conditions of those who are landless, marginal and small farmers. It is also observed that the backward classes identified as the SCs and STs and the religious minorities also pay out a substantial part of their income on health higher than that spent by the other privileged classes.

BOX I

High Out-of-Pocket Expenditures on Health:

India Case Study

India has a population of over one billion and two-thirds are living in rural areas. The national and state governments have made a commitment through the Indian

constitution to provide basic services, such as health care, elementary education, drinking water and sanitation, to the masses. In spite of the popular claims by the government of providing free and cheap health services, it is found that people spend considerable amounts as out-of-pocket expenditures to seek health care. In absolute terms, high-income group spend substantially on medical treatment. In relative terms, the poor spend a disproportionately higher share of household income on similar treatments (See Figure 5 and 6). In the recent years, owing to the adoption of the structural adjustment programs adopted by the national governments, there have been severe cuts in public expenditure on health services. Although this provides opportunities for the private sector to thrive, it has adversely effected the poor disproportionately. About 20 per cent of people are classified as 'poor belonging to lower segments of below the poverty line'. They have an average per capita income of Rs 1050 per year and spend just about 20 per cent of this household income on purchase of medicine and payments to physicians. Another about 6.5 per cent of this income on an average is spent on providing primary education to

the school going children. This puts extraordinary difficulty for the poor to lead a decent life.

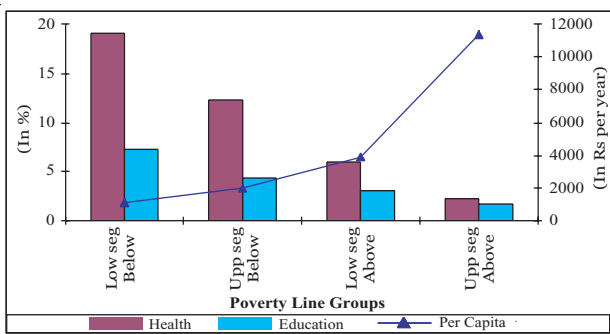


Figure 6: Share of Household Income spent on Health and Education by Poverty Groups in India, 1994

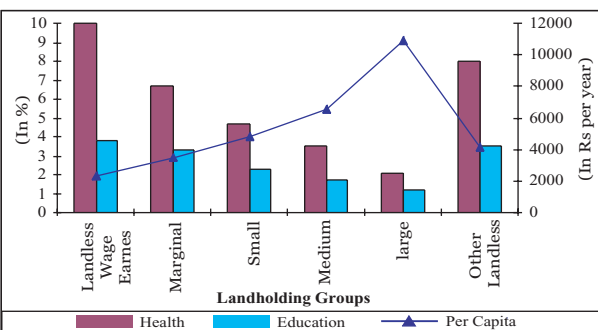


Figure 7: Share of Household Income spent on Health and Education by Landholding Groups in India, 1994

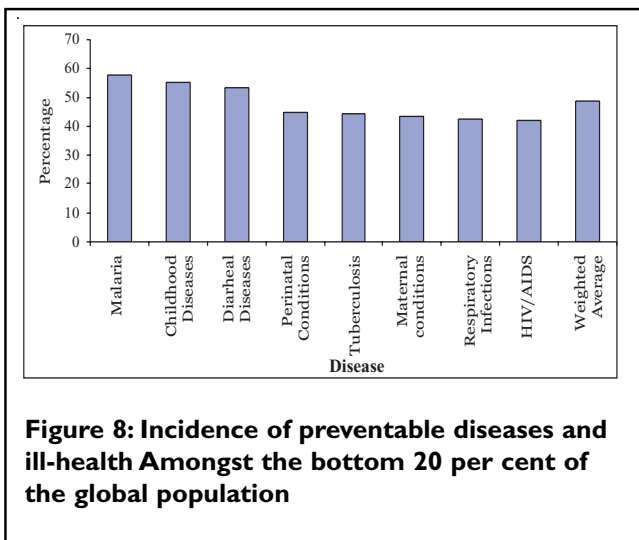
Public Expenditures Imperative

In arguing for a greater governmental role in the health sector one need not be oblivious to the fact that the much sought after expenditure on health can't be marshaled by the poor economies on their own. A vicious cycle comes into operation as poor health standards

retard economic development and the resultant low income pushes the economy limiting expenditures on health. However, a virtuous cycle sets in motion when non-governmental organizations and the local bodies act in tandem with the national governments.

Donor assistance must be viewed as an add-on that acts as a catalyst in supporting domestic resources and as a bridge for the gap between the amount required to finance the health services and the available resources, rather than as a replacement for the domestic resources. Countries that suffer from high disease burden can ill-afford the luxury waiting until economic growth generates enough domestic savings and raises household incomes. The high-income donor countries have an important role to play in helping low-income economies achieve their health objectives and bridge the existing gap in health financing. In the era of globalisation, such a cooperative venture provides a win-win scenario.

Under the World Trade Organisation (WTO regime), the TRIPS seem to have initially gone against the interests of the developing countries so far as the domestic prices of medicines and drugs have increased disproportionately compared with national price indices. Of late, the WTO negotiations are undergoing enormous changes as can be seen in its provisions for the poor countries to override the patents of multinational drug companies and outsource cheaper generic drugs that are not manufactured within the country.

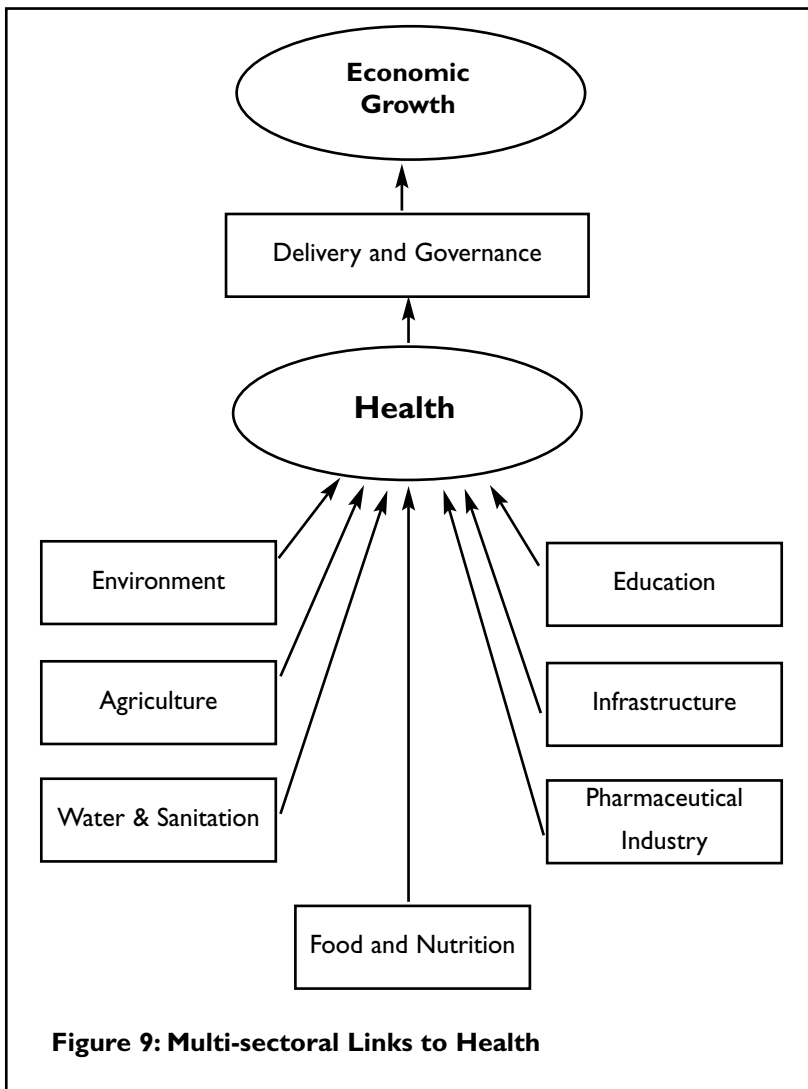


In its advocacy for the improvement in health access to the poor, this study underlines the following mechanisms: improved efficiency of investment, reduction of urban bias in health care delivery, decentralization of health services and community health financing. In its commitment to increase the resources to the health sector, the highest priority has to be given to raise the utilization of key health services by the poor. Improved efficiency of investment in health sector is attained with evolution of implementative platforms, institutions, procedures and inventory control system that bring about transparency and accountability. The choice of western allopathic health care as the

dominant practice in the SEAR has favoured urban and centralized delivery. Furthermore, emphasis on curative and hospital care has accentuated such an urban bias. It is noteworthy to mention that reduction in rural-urban gap in health care is a pre-requisite for better health standards in SEAR. There is a need for public investment in building rural health posts and primary health centres in order to provide elementary clinical services, preventive care, immunizations and reproductive care services by trained dedicated staff.

Multi-Prong Strategic Public Investments Promote Health

Most of the countries in SEAR, emphasize primary care and rightly so. Health indeed is a net result of the influences of a number of non-health factors that are crucially linked with each



other. It is therefore essential to ensure that people have access to clean drinking water; improved sanitation and hygienic living conditions, reduced levels of pollution and so on. Health and environment are linked inextricably with each other and in turn are affected and influenced by other external factors. For instance, development projects meant to bring socio-economic and health-related benefit to the community at large are associated with unintended impacts that amplify existing hazardous conditions in the countries of the SEAR. Together with achievements in the health sector, it is also essential to ensure that the people have access to other basic needs particularly adequate food and nutritious diet. Hence public investments in agricultural sector clearly deserves urgent attention in most of the SEAR, especially so in South Asia. Education and health are considered as assets for promoting economic development. Education itself has an essential impact on the health of

individuals. It results in increased awareness among masses, which is one of the most effective means of controlling the spread of diseases, speaking broadly. Apart from this aspect, education also improves the quality of life, which has a positive impact (through individual efforts) on improving the health standards (See Figure 7 for schematic inter-sectoral linkages affecting health and economic growth.

Decentralisation creates the possibility of mobilizing additional resources for the health services at the local level. It addresses better the needs of the locality and promotes efficiency and public accountability. Community groups, such as village health committees, youth clubs, mothers' clubs, and village development committees, can be actively involved in providing health care when they are supported to identify their own local needs and are equipped with both financial as well as non-financial resources. Community based schemes are in operation in SEAR – village health care post in Bangladesh, model village in Bhutan and Sri Lanka, mother's club in Nepal and integrated health post and village maternity post in Indonesia - which need to be emulated across the region.

The poor in the South-East Asia lack savings and access to credit, face trouble in financing even routine outpatient care in primary health facilities and are either compelled to ask for help from family and friends, sell their assets, or manage without needed health care. Private insurance can play a significant role but collection of premium payment is difficult as most of the labour force in the region is engaged in agriculture or informal sector work. In such a situation, the risk-pooling needs of the general population can be met by encouraging the systematic expansion of mandatory social health insurance coverage. Governments of Thailand and Indonesia are actively developing and testing ways to extend social health insurance coverage to previously uncovered groups.

This study presents the centrality of health in economic development by providing empirical evidence and establishing a multi-sectoral linkage to health in promoting economic development all routed through accountable governance and efficient delivery mechanisms.

Strategic Vision

- Better health conditions of a society and its labour force are essential to enhance the rate of economic growth of an economy. History is witness to the fact that important breakthroughs in public health, disease control, improved nutritional intake and behavioural changes with respect to hygiene, sanitation and drinking water have given rise to great take-offs in economic development. The most durable resource is the capital invested in nurturing human development.
- One may find a unique situation in which the poor are most affected by the high incidence of morbidity – a condition known as ‘selectivity bias’. This raises important questions that policy reforms must address, which fall in the realm of equity and human rights, promoting anti-policy sentiments.
- It is not prudent to expect that economic development will automatically take care of improvements in citizens’ health in a society afflicted with high disease burden. The nature of disease and its distribution amongst poorer economies are such that nations can hardly attain a level of prosperity to address health and nutrition issues, raising serious concerns of ensuring equity and accessibility. Often, the excess disease burden of the low-income countries is a result of a small number of identifiable conditions, which can be addressed by a set of affordable and low cost health interventions. In this context understanding the multi-sectoral interactive links of health with environment, water, sanitation, public hygiene, and food and nutrition is important.
- The health spending in practically all nations in SEAR is insufficient and also requires correction in its structure. Health spending as a percentage of GDP ranges from 7.6 percentages in Maldives and 5.2 per cent Nepal to a very low of 2 per cent in Myanmar. Countries with large population such as India, Indonesia and Bangladesh spent 3-4 per cent of their respective GDPs on health sector. Out of such expenditures, the households themselves undertake major portion out-of-pocket. For example, the household expenditures on health care is 70-80 per cent in India and Bangladesh and 90

per cent in Myanmar, thus the respective governments are contributing meager amounts as a share of total health expenditures. Given the huge population base, the public expenditures turn out to be pitifully too low in per capita terms, while most of this amount also is spent on maintaining over-sized bureaucracy and administration, leaving little amounts for actual transfers in the form of health gains.

- There is strong urban bias in public health provisioning structures in all countries of the region, so is the bias towards curative and high specialty services. Thus, primary health care, health care of the people living in rural and remote areas, people who are poor, reproductive health of adolescent and women in reproductive ages, preventive health care for children and health provisions of the old are the worst affected. All the above adverse biases in health services, strongly affects the quality of future labour force.
- In catering to the health needs of the hitherto unreached poor population of the SEAR, the governments apart from increasing health sector spending should improve efficiency of investment by evolving implementative platforms, institutions, procedures and inventory control systems that bring transparency and accountability. The disease burden lies disproportionately on the poor that is preponderantly rural. In order to reduce the rural-urban gap in health care there is a need for public investments in building rural health posts /sub-centres and primary health centres and provisioning of elementary clinical services, preventive care, immunization and reproductive care services by adequately trained dedicated staff. All the countries of the region suffer from lack of dedicated female core of physicians in the public programmes. This is one of the serious constraints in extension of reproductive health services in countries such as India and Bangladesh.
- In an era of globalization, any co-operative venture in the health sector provides a win-win situation. Donor assistance needs to be taken as an add-on rather than a replacement of domestic reserves for narrowing down the difference between the amount required to finance the health services and the available resources.
- Decentralisation, apart from creating the possibility of mobilizing additional resources, is responsive to local needs and allows local people to participate in programme implementation. Community groups, such as village health committees, youth clubs, mothers' clubs, village development committees, need to be actively involved in providing health care.
- Unmet demand for risk pooling services can be met by promoting private insurance. But since most of the labour force is engaged in the informal sector, governments must enhance and expand mandatory social health insurance coverage, until the time the private sector innovates to reach out to this sector. However, it is not conceivable that the public policy can relinquish or reduce its commitment to the provisions of mass health of the citizens in the respective countries in the near future. Coordinated efforts by government, professionals, corporate sector and a participating vigilant civil society can rid the SEAR region of its excess disease burden and health problems.

Macroeconomics and Health in Context: Background Summary for Participants

I. Introduction

The challenge of positioning health central to development

Health is a prerequisite to having an enjoyable and productive life. Effective interventions and preventive measures to reduce mortality are available today. Societies that have been able to adequately provide these interventions have significantly higher average life expectancies than those who have not. Due to financial constraints and institutional and organisational weaknesses in the health systems, least developed countries and other low income countries have had a particularly difficult time in scaling-up such measures. Though the benefits of good health are shared by all sectors, the onus of increasing access to health care falls to the health sector. The health sector in most countries attempts to develop strategies that combine long-term and short-term goals for health. Experience informs us that placing health in the development agenda requires an integration of successful disease-specific initiatives with system support, maintenance of a broad range of partnerships, and long-term policy reform, across sectors. In most developing countries, however, these linkages between health and poverty have not been fully appreciated and, therefore, health has not been adequately inserted into poverty reduction strategies.

In addition expanding the availability of important preventive and treatment measures, countries are currently faced with the need for a coherent strategy to coordinate health priorities with the numerous development initiatives and health financing mechanisms, including Poverty Reduction Strategy Papers (PRSPs), Heavily Indebted Poor Countries (HIPC) initiatives, Global Alliance for Vaccines and Immunisations (GAVI), and Global Fund for AIDS, TB and Malaria (GFATM). The effective integration of health and health-related investments into these processes is needed for reaching Millennium Development Goals (MDGs) and national health objectives.

The commitment

Governments and the international community have this most important responsibility of protecting the right to health, especially among the poor. By adopting the health-related Millennium Development Goals, countries have expressed the commitment to do this. Thus health outcomes have begun to be recognized as highly relevant to reduce poverty. We know that we can prevent the vast majority of diseases affecting the poor. We know ill health is pushing the poor deeper into poverty and that health must be part of the strategy to reduce poverty. Now, countries want to move forward and are looking for an effective strategy for the better use of resources for health, recognizing the local challenges and conditions that are perpetuating disease and poverty.

In the past, declarations of high-level political commitment have failed to result in concrete actions. For example, in the Abuja Declaration (27 April 2001), African heads of state committed to allocate at least 15% of their annual budget to the health sector. The countries are not on track to meet this goal. To be successful, political and policy leaders must commit to pro-poor health reform, to scale-up effective and cost-effective interventions and to increase the capacity of health and health-related sectors to efficiently utilize additional investments.

The gap

Developing countries and development partners have not converted commitment to invest more in health into sustained, coordinated actions. The toll from preventable diseases continues to be staggering and the poor and marginalized are disproportionately affected. The key constraints to reach the poor are well known. To reduce financial constraints, investments in health of the poor must be scaled-up significantly as calculated by the Commission on Macroeconomics and Health (CMH), increasing both national and foreign financing. Least developed countries are more dependant on external investments when compared to middle income countries. The latter should be mostly focused on prioritizing interventions and improving efficiency.

Removing financial constraints will not be sufficient. Health systems have numerous obstacles to the scaling up of interventions. The so-called absorption capacity of the health sector is underlying the need of improve management of the health delivery system, especially deployment of human resources.

2. Mobilizing coordinated actions

Through the efforts of governments and health partners, there have been well-documented successes in categorical programs in certain parts of the world, such as polio eradication and TB control. In the last five years, important partnerships for disease specific programmes have formed, such as the Global Alliance for Vaccines and Immunization (GAVI), Stop TB, Roll Back Malaria and the Global Fund for AIDS, TB and Malaria.

Control of other diseases, however, continues to be elusive even with increased political and financial commitment. Recently, the United Nations community acknowledged the failure of adequate global provision of anti-retroviral treatment of HIV/AIDS and called for more money and political will to ensure that 3 million HIV-positive people in the developing world have access to anti-retroviral medications by 2005. In other countries, non-communicable diseases have become the most important cause of preventable mortality.

3. The Macroeconomics and Health process

About 40 countries have begun the follow-up work to the CMH Report, guided by the overarching objectives of achieving better health for the poor, increasing investments in health overall, and progressively eliminating non-financial constraints. Countries are driving

the process. Recognising the diversity of health, economic, and social situations, placing health in macroeconomics context must accommodate the health priorities, opportunities and obstacles unique to each country. Specifically, governments must assess their health priorities and evaluate the cost of providing necessary interventions to the poor, in light of the financing mechanisms available internally and externally and the constraints experienced within the institutions.

The work demands a multisectoral approach. The implementation of any reform must take into account the cross-sectoral interaction of risk factors for disease. Without the complementary improvement of other sectors such as education, water and sanitation, and environment, countries will be unable to optimize investments in health or achieve national health objectives.

Political commitment to action

What is known is that political commitment must originate from the highest levels of government. At the national level, a health compact reflects the strong support of the ministries of finance and planning, along with the ministry of health, civil society, donors, development partners, private sector, NGOs and others for the insertion of health investments into the national macroeconomic agenda. The pact would put into motion the super-sectoral oversight of pro-poor policy reforms and allow input and discussion by all stakeholders. In some countries attending this consultation, a National Commission on Macroeconomics and Health has been created to exercise the political oversight of the process. In others, different mechanisms have been identified. Still other countries have expressed the willingness to start analytical studies to better understand the level of financial commitment and the type of reforms necessary for a successful process.

Countries need to take inventory of the ongoing mechanisms and funding initiatives to which investments in the health or health-related sectors can be linked. This includes functioning sectorwide processes such as multi-year national health plans that are periodically updated and budgeted and poverty reduction processes such as PRSPs and Heavily Indebted Poor Countries (HIPC) initiatives, for insertion of increased and more efficient spending on essential health or health-related services.

To move forward countries in collaboration with global partners will have to:

- Analyse country health, social, and development situation, establish national goals based on this analysis and generate strategic options for the allocation of internal resources and increasing the effectiveness of health care delivery at the local level
- Develop a sequenced approach to identifying and addressing institutional and organizational obstacles to efficiently utilizing resources and to the widespread provision of essential health interventions to the poor.

- Ensure accountability and transparency by developing a mechanism of monitoring inputs and outcomes so that management decisions can be effectively made at the local and central levels.

4. The 2nd Consultation on Macroeconomics and Health

This Consultation will provide the unique forum joining together high-level health, finance, and planning decision-makers to work towards a health compact, setting in motion the strategic policy and technical actions that will be needed across sectors. This process will be supported and facilitated by WHO at the country and regional levels and will require broad coordination among development partners and all stakeholders that are committed to improving the lives of the poor.

During the Consultation, countries will continue and build upon the work that they had begun at the 1st Consultation on National Responses to the CMH report (June 2002) and at local and regional levels. This will be the first opportunity for ministers of health, finance, and planning to come together to discuss the issues and challenges with each other and with WHO, development partners, donors and others. What are the challenges that countries face in positioning health centrally in development strategies? What types of support will the countries need in developing and implementing a long-term health investment strategy? How can WHO best collaborate at the regional and country levels?

WHO resources at country, regional and headquarters levels can be used by the countries to link up with the technical expertise needed for carrying out situational assessments, to generate strategic options for improving the efficiency of health systems, and to identify new tools for health financing and costing of expanded services for the poor.

This is a forum in which countries can share their experiences in the Macroeconomics and Health process and the opportunities and challenges that they have faced in positioning health at the centre of development. Countries will define concrete mechanisms to set national health priorities and to specify the process towards developing a Health Investment Plan. This process will include the identification of coordinating mechanisms that can oversee progress on planning long-term investments, sequencing pro-poor health reforms and making the necessary analyses on strategic choices, financing options and human resources.

Countries will also be able to identify how WHO and other partners can coordinate their activities to support health investments in an effort to achieve MDGs.

The Consultation will commence with the assembly of three Working Groups which will participate in a structured discussion under three thematic foci: 1) How to Improve the Effectiveness of the Health Delivery Systems and Monitor Outcomes; 2) How to Make Health Central in the Country Macroeconomic Framework and Increase Allocation of Resources to Health; and 3) How to Increase Predictability of External Funding and Increase Coordination with Partners, which correspond to CMH Working Group reports 5, 3 and 6,

respectively. These three foci will be carried forward and will be the foundation for the subsequent days of the Consultation. The following pages provide a summary of the issues relevant to the three foci as well as potential questions to guide discussion.

5. Summary of Working Group Issues

Working Group I: How to Improve the Effectiveness of the Health Delivery Systems and Monitor Outcomes

Overview based on the work of CMH Working Group 5

- In a costing analysis done by WG5 for 83 countries with per capita GNP below \$1200, the spending required to ensure necessary strengthening at all levels of the health system would be 40-52 billion dollars annually by 2015.
- There are a limited number of diseases that account for most of the avoidable mortality among the poor in developing countries.
- Each country, based on their social and development situations, will have their own health priorities, which will change as countries develop economically.
- Interventions exist that are effective in treating and preventing the priority conditions but are not currently available or accessible to most of the poor. Based on health priorities, countries need to determine the range of interventions and the sequencing of expanded coverage and introduction of new interventions.
- Numerous institutional and organisational barriers exist at all levels to expanding health care access to the poor. These constraints have been placed in three broad categories including constraints on demand, constraints on delivery, and overall strategic constraints. Barriers are financial and non-financial in nature, but all prevent the efficient absorption and utilization of funds.
- Essential elements of systemic reform include a local health care delivery structure that is well-equipped and staffed with effective, motivated health workers, categorical programs to provide technical and financial resources, and effective management with a well integrated surveillance and monitoring system.
- Need development of mechanisms to monitor the effective use of resources at local and central levels

Issues for deliberation

- What tools and resources are available for collecting epidemiological data and costing expansion of coverage of priority interventions? To what extent is data able to be disaggregated by income groups so that disease impact on the poor is better described?
- What are the realistic choices on allocation of funds for improving health if the increase

in additional resource mobilization is not realized? What technical support can countries expect from WHO and other partners in doing this?

- What are the most important constraints in the health system (e.g., adequately trained staff, poor management, medication supply, access to facilities, political instability, corruption, poor governance)?
 - Which constraints are susceptible to short term financial solutions?
 - Which constraints will require more long-term strategies?
 - How will sequencing of reforms be determined?
- What are options for monitoring systems and what outcomes could be monitored? How will these outcomes translate into action by decision-makers at the local level?
- What resources and tools can WHO provide to assist countries in terms of surveillance, health information systems, costing tools, and in progressively implementing institutional reforms?

Working Group 2: How to Make Health Central in the Country Macroeconomic Framework and Increase Internal Allocation of Resources to Health

Overview based on the work of CMH Working Group 3

- The CMH suggested that most countries with low levels of public health spending could raise 1-2% of GDP more for health.
- Investments in health should be geared towards attainment of specific national and global health objectives, especially for the poor, and linked to ongoing poverty reduction initiatives
- Countries need to match methods of financing to its population groups, using general budgetary revenue to fill in gaps in providing public goods and essential health care and subsidize the poor.
- A coherent strategy to integrate health care for various population groups can increase spending on health, facilitate the pooling of risks, improve quality, and achieve gains in efficiency and quality – as well as provide the framework for discussion with civil society, the medical professions, NGOs and donors.
- Current social, political and fiscal policies contribute to the inefficiencies of health sector expenditures and reallocation of funds from “unproductive expenditures”, such as revenues lost through tax concessions and investment incentives, may provide additional resources for the health sector.
- Community financing schemes could improve coverage for excluded populations, ensure ownership of health care provision, and decentralize health care responsibilities. Such

schemes should be supported with training and management techniques by government, donors, and NGOs.

- Explore Public–Private partnerships as approaches to increasing access to health care. Currently, significant financing for health comes from out-of-pocket payment by poor families. Options for decreasing financial risk for the poor and increasing equity in access to health care must be explored.

Issues for deliberation

- What are the available health financing mechanisms in each country?
 - General and ear-marked taxes, Social insurance, Private insurance, Community financing, Users' fees, etc.
- How can the financing mechanisms be reconciled with national health goals, the country's capacity to raise additional funds, and the socioeconomic make-up of the population? How can economic policy be made more conducive to greater allocations to health?
- Acknowledging that mobilization of additional resources may be limited, what are the opportunities for achieving greater efficiency in the resources currently allocated to the health sector? What are the social, political, and economic constraints (policy and institutional) to efficient health investments? How can resources be reallocated from “unproductive expenditures” to health and health-related sectors?
- What are the options for institutional mechanisms to ensure a multi-sectoral approach to the production of health outcomes. How will this be linked to the work of development partners, private sector and NGOs? Who should be the principal advocates for health within the government and lead the development of the health investment plan?
- What are potential ongoing sectorwide initiatives that are available for insertion of increased and more efficient spending health, linked to achieving national goals and MDGs?
 - Sector Wide Approaches to Health Development (SWAPs), Periodic multi-year national health planning and budgeting, Poverty Reduction Strategy Papers (PRSPs), Heavily Indebted Poor Countries (HIPC) Initiatives, etc.
- What are the respective roles of public and private sector in financing and delivery of health care services? How can countries align the goals of the private sector to national and global health objectives?
- What are the alternate financing options for middle income countries, such as expansion health delivery outsourcing and encouraging competition by private providers?
- What role can National Health Accounts play in monitoring the health expenditures and their efficiency? How can this inform policy?

Working Group 3: How to Increase Predictability of External Funding and Coordination with Partners

Overview based on the work of CMH Working Group 6

- WG6 estimated that donor assistance should increase to \$27 billion annually by 2007 and \$38 billion annually by 2015.
- The trends in development assistance to countries and where these resources have been targeted within the health system needs to be assessed.
- Donors and countries should apply more comprehensive and results-oriented approaches to development assistance, with a sharper focus on poverty reduction.
- Disease-control programmes and global health initiatives should redirect emphasis from global or regional targets to allow more flexibility in priority-setting at the country level.
- The variety of financing mechanisms can bring about inefficient, unpredictable allocation of resources, leading to the reduction of the impact of external funding
- Improved harmonization and convergence of initiatives will require partners to reform funding mechanisms and project objectives to be more responsive to local needs. Countries would benefit from the increased flexibility of targeting resources to diseases of the poor
- Effectiveness of this assistance can be limited under stringent technical and reporting requirements and can put undue pressures on limited human resources and institutional capacity. Monitoring should be based on sectoral performance.

Issues for deliberation

- What trends in the flow of development assistance have we seen over the last few years?
- How can we harmonize external partner objectives with national health priorities?
- What is the best strategy to coordinate the activities and objectives of the numerous donors and development partners at all levels? How can developing countries be assured that external assistance will be available to support a viable investment plan comprised of needed systemic reforms and domestic mobilisation of resources?
- How can we limit donor conditionalities that put undue pressures on limited human resources and institutional capacity in countries?
- What proportion of development assistance should be used for global public goods, including technical and managerial knowledge goods?
- How can country level stakeholders maintain ownership over health initiatives while ensuring accountability to donors?
- What are options to address country-level constraints to the use of donor funds such as insufficient number of or inadequately trained professional staff and managers or weak or absent monitoring and reporting systems?
- Are there examples of effective donor coordination mechanisms in countries?

Mobilization of Domestic and Donor Resources for Health: A viewpoint

Jeffrey D. Sachs, Director of the Earth Institute, Columbia University

The state of health in the world's poorest countries is more than a human tragedy. It is an economic catastrophe. Millions of impoverished people die every year of conditions that can be readily prevented or treated with existing technologies. These tragic deaths—and the enormous economic and social costs associated with them—reflect the basic fact that essential life-saving health services are out of reach of hundreds of millions of the world's poor. Without extending these life-saving interventions, poverty is likely to be exacerbated and to be passed to the next generation, with enormous and pervasive economic costs.

In graduate school I was taught that poor people live "on the edge of survival." This is not exactly right. Poor people are not living on the edge of survival; they are falling right over the edge, and by the millions. We're living in a world where millions of people are dying every year because they are too poor to stay alive, in the midst of the greatest affluence and technological capacity in the history of the world. The premature mass deaths of the poorest of the poor are absolutely unnecessary, absolutely avoidable.

To address this global tragedy, the Commission of Macroeconomics and Health (CMH) was launched in 2000 by the World Health Organization to analyze the impact of health on development and to examine ways in which health-related investments could address the crisis of mass premature death and thereby spur economic development. The Commission focused its work on the world's poorest people, in the world's poorest countries, to develop specific recommendations that would save lives, reduce poverty, and spur economic growth through a scaling up of investments in the health sector of these countries.

The findings of the Commission are both stark and encouraging. First, it will take a lot of money and much more political and organizational effort than has been seen in the past generation to accomplish the tasks at hand. Second, the Commission called for greater policy efforts in the low-income countries, from which, with the needed political leadership, budgetary resources for public health might rise by perhaps 1% to 2% of GNP during the period to 2015. For a poor country at US\$ 300 per capita, that would be US\$ 6 per person per year in health spending, important but far from enough to ensure widespread access to essential health services. This suggests that donor funding will indeed be needed to close the gap. The Commission found that donor support should rise from the current level of around \$3 billion per year for health in low-income countries to around \$27 billion by 2007.

This added donor funding needs to be put in perspective. \$27 billion amounts to around 0.1% of donor GNP—one penny for every \$10 of income. This modest sum, if matched by the

increase within the low-income countries themselves, we provide enough financing to avert around 8 million deaths per year by the end of this decade. The reduction in human suffering would be enormous. The economic gains would also be striking, around the order of US\$ 360 billion per year during the period 2015-2020, several times the costs of scaling up the health interventions themselves.

The message, in essence, is that today, for the first time in history, the world has the capacity to end the suffering and death of millions every year, suffering and death that are the consequence of absolute poverty. Ministries of health, international organizations, and leaders in the cause of global health will be in the front lines in overcoming these health crises, fighting a lack of attention and political will, and the lack of adequate financial commitment from the rich world. Many people think it naive to believe in the possibility of seriously addressing absolute poverty in our generation. But it can be done. The CMH put the price tag on what it would cost to meet these health challenges, and demonstrated rigorously and shockingly how little it would take to overcome the current crisis and despair.

The future depends wholly on our choices. Whether we are able to appreciate the extent of our wealth and its ability to solve problems, whether we are able to recognize our common stakes, whether we are able to bring to bear our vast scientific knowledge and whether, therefore, we are able to get the job done. This is a question of human choice, not simply a matter to forecast. We will need all hands to succeed.



World Health Organization

Geneva

Sustainable Development and Healthy Environments Cluster

Increasing Investments in Health Outcomes for the Poor

Second Consultation on Macroeconomics and Health

28-30 October 2003, Geneva

ANNEX 6: Press Release

Press Release WHO/82 • 29 October 2003

HEALTH AND FINANCE MINISTERS TO ADDRESS NEED FOR WORLDWIDE INCREASE IN HEALTH INVESTMENT

Geneva - Ministers of Health, Finance and Planning from 40 developing countries will come together with development partners at WHO headquarters from 29 to 30 October to address the need to significantly increase investments in health. This is the first time that the World Health Organization (WHO) has hosted a meeting so widely attended by non-health officials, underlining the urgency of building national capacity to absorb increased health funding.

“This meeting signifies real political commitment from the highest levels of government and donor representatives. Let us capitalize on this unique opportunity to recognize health as a critical investment and together develop a common understanding of how countries and their partners can transform these commitments into immediate actions. We must choose to make equitable and efficient health investments a reality,” said WHO Director-General Dr LEE Jong-wook.

This meeting comes nearly two years after the launch of the 2001 Report of the Commission on Macroeconomics and Health (CMH), which recommends that by 2007, donors should increase assistance for health to US\$ 27 billion. The Commission also calls for more budgetary resources for public health from both developed and developing countries, and more political and organizational effort than has been seen in the past decades to achieve real improvements in health.

Two years on, the world still has not shown determination to increase investment in health to the levels needed to measurably impact major diseases that affect the world's poor. A recent study* has shown that the total development assistance for health from major selected sources increased by US\$ 1.6 billion, from an average of US\$ 6.1 billion (1997-1999) to US\$ 7.7 billion (2001). Most of the increase in funding was allocated to fighting HIV/AIDS in sub-Saharan Africa. Although these recent increases in assistance for health are encouraging, they still fall short of meeting real needs.

“On taking office, I declared the target of ‘3 by 5’ – to have 3 million people with AIDS in developing countries on treatment with antiretrovirals by the end of 2005. Only 300 000 are on treatment at the moment. To achieve ‘3 by 5’ and other health priorities we need considerably more funds than those currently available. If we do not increase resources for health and target these resources to activities that will have the greatest impact, we stand to lose millions of men, women and children to disease. This also means trapping individuals and families in poverty and disillusionment,” said Dr Lee.

During the meeting, the combined work of countries, WHO and partners will be to develop concrete plans for increased health investment in countries. Continued global leadership and follow-up from the development community, combined with inter-ministerial collaboration is needed: first, to increase resources for health from domestic resources, debt relief and development assistance for health, and second to eliminate health system and institutional constraints, enabling greater absorption of increased resources. This will be critical for pursuing country action to reach the ‘3 by 5’ and other health targets.

“We need country-specific blueprints for making real increases in health investment. Developing countries and their partners need to collectively and quickly do much more, for health and global stability. This meeting can identify ways to make this happen,” added Dr Lee.

National Macroeconomics and Health activities are ongoing in the countries participating in the Consultation: From Africa: Angola, Botswana, Congo, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Senegal, South Africa, Uganda, United Republic of Tanzania. From the Americas: Argentina, Brazil, Mexico, Nicaragua, Peru and the Caribbean Community including Haiti. From the Eastern Mediterranean: Djibouti, Iran (Islamic Republic of), Jordan, Pakistan, Sudan, Yemen. From Europe: Azerbaijan and Estonia. From South East Asia: Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand. From the Western Pacific: Cambodia, China, Philippines and Viet Nam.

* Development Assistance for Health (DAH): Recent Trends and Resource Allocation

Dr Catherine Michaud, Senior Research Associate, Harvard Center for Population and Development Studies

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All WHO Press Releases, Fact Sheets and Features as well as other information on this subject can be obtained on Internet on the WHO home page <http://www.who.int/>.



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Annex 7: Media coverage: Extracts from articles in international press

List of articles:

- **Voice of America News:** Developing Countries Discuss Urgent Health Issues at WHO Meeting, 30 October 2003
- **The Financial Times :** Ghana and the Commission on Macroeconomics and Health: The economic paradox of Ghana's poverty, 10 November 2003
- **The Scotsman :** WHO: Health and Finance Ministers to Address Need for Worldwide Increase in Health Investment, 29 October 2003
- **Bua News (Pretoria):** Health Ministers Get Together in Geneva, 29 October 2003
- **Tribune de Genève :** OMS Réunion sur les politiques de la santé, 29 octobre 2003
- **Le Vif – L'Express:** Il faut 27 milliards de dollars pour les pays pauvres (OMS), 29 octobre 2003
- **Télévision Suisse Romande (TSR) :** Investissements dans la santé: les pays pauvres ont besoin de plus, 29 octobre 2003
- **Xinhua General News Service:** Ministers to meet in Geneva to increase health investment, 29 October 2003
- **Jeune Afrique - L'Intelligent:** Ingérence économique, 31 octobre 2003
- **Angola Press Agency:** Country Attends WHO Meeting, 31 October 2003
- **Pharma Marketletter:** WHO-hosted LDC investment meeting to urge more for HIV/AIDS drug treatment, 29 October 2003
- **Express Healthcare Management:** Need for world wide increase in health investment to be addressed, 30 October 2003
- **The Press Trust of India,** 29 October 2003

Extracts from articles

Voice of America News:

Developing Countries Discuss Urgent Health Issues at WHO Meeting 30 October 2003

Byline: Lisa Schlein, Geneva

USA: The article quotes that "Ministers of Health, Finance and Planning from 40 developing countries are meeting at the World Health Organization to explore ways of increasing investments in the health sector.... A report commissioned by the World Health Organization two years ago, finds disease, and in particular HIV-AIDS, is crippling economic development in Africa and other high-risk countries. "

The article continues by quoting the Minister of Finance and Development Planning of Botswana, Baledzi Gaolathe, who stresses that "the situation of disease and poverty will get worse if nothing is done. "We are here because there is an outcry that the health situation in Africa leaves much to be desired," he said. "And, the concern is that perhaps we are not investing enough. So, we are here to actually determine whether, in the case of Botswana, are we investing enough or not and to learn from other experiences." "One of the most important areas of prevention (for HIV/AIDS), which I should mention, is the one of preventing a mother to child transmission" says Baledzi Gaolathe. In addition, the Botswana Finance Minister says his government is providing free anti-retroviral treatment to all people infected with HIV-AIDS.

The Voice of America News reports that..... "At this meeting, the World Health Organization is negotiating an agreement with 20 member states to come up with a plan to increase investments in the health sector by the end of 2004. WHO says more work will be done in trying to raise interest in the private sector to become involved in this critical public health issue."

The Financial Times : Ghana and the Commission on Macroeconomics and Health

Headline: The economic paradox of Ghana's poverty

10 November 2003

Byline: Michael Weinstein

The writer of the article is director of programs at the Robin Hood Foundation and senior fellow at the Council on Foreign Relations and presents two propositions for the economic paradox of Ghana's poverty : ... "Proposition one: Ghana represents sub-Saharan Africa's best chance to grow out of poverty. Proposition two: Ghana cannot grow out of poverty - at least not on its own. Behind those two propositions lies an ugly reality. Western leaders like to preach that if poor countries move decisively to competitive markets, they can lift their citizens out of poverty. Not so. Countries in sub-Saharan Africa that make every smart

economic move will almost certainly remain crushingly poor unless there is much more help from the rest of the world," the article quotes.

The writer then continues to document his propositions by emphasising that "Ghana is largely free of the civil strife that plagues many of its neighbours. It is also a fully fledged, multi-party democracy, where power peacefully shifted a couple of years ago by secret ballot from an autocrat to the opposition party. President John Agyekum Kufor oversees a relatively corruption-free, hard-working administration..... "Also, Ghana enjoys the benefits of a relatively good education system, sources of foreign exchange earnings - primarily from gold and cocoa - and a majestic beachfront that cries out for tourist development. "Civil peace, democracy, waterfront, exports: these are tickets for economic success. But in Ghana, these tickets go unpunched. Living standards are only marginally higher than they were decades ago. So what is the problem? Professor Sachs provides a compelling explanation: in sub-Saharan Africa, poverty breeds poverty. That may sound obvious, even circular. In fact, it is nearly profound."

Michael Weinstein continues his article by explaining this apparent paradox..... "To see why this basic idea is often ignored, take out your old economics textbook. You will find that it assumes that investments in poor countries produce more profit per dollar invested than do investments in rich countries..... Textbook models also often assume that people living in poor countries save more of every dollar they earn than do people living in rich countries. The combination of high savings rates, high rates of return on investment and large potential inflows of foreign capital can ignite a self-reinforcing cycle of investment, growth, more investment and more growth," the writer adds.

".....But, Prof Sachs points out, countries can be too poor and too disadvantaged to grow, no matter how enlightened their policies. Without a healthy population, developed harbours, roads and other infrastructure, foreign investors will stay away. And the poor people themselves can be too poor to save a dime, if all income gets spent on life's necessities. In sub-Saharan Africa, the cycle of disease, low domestic savings, poor infrastructure and no foreign investment produces self-reinforcing poverty, not growth."

The article presents data from WHO's 2001 Report of the Commission on Macroeconomics and Health that states that Ghana and other countries in the malarial zone needed to spend about \$35 or \$40 per person a year just to meet the essential health need of their population. It quotes that Ghana can afford only about \$10 and that the country needs an extra \$30 per person for 20m people, just to keep Ghanaians fit to work. "But that's a half-billion dollars that Ghana does not have to spend on health care or other basic needs. Its people are living on less than a dollar a day. They cannot, willy-nilly, hand over about a month's earnings for health or anything else." Michael Weinstein reports.

This article concludes that....." Ghana and other poor sub-Saharan countries do not, and cannot, make it on their own. They need financial infusions from the west for health care and other basic investments that would set the stage for growth. Given an initial boost, Ghana's

pro-growth attributes could take over. But Ghana needs that boost. If the west, smugly clinging to nostrums of boot-strap capitalism, sits back and watches Ghana fail, its neighbours will fail as well. Ghana is one of sub-Saharan Africa's best shots at success. Ghana's shot at success will remain remote until rich countries come to its rescue ".

The Scotsman:

WHO: Health and Finance Ministers to Address Need for Worldwide Increase in Health Investment

29 October 2003

Wiesbaden, Germany: This article reports about WHO's Consultation on Macroeconomics and Health and that this is the first time that the World Health Organization (WHO) has hosted a meeting so widely attended by non-health officials, underlining the urgency of building national capacity to absorb increased health funding.

"This meeting signifies real political commitment from the highest levels of government and donor representatives. Let us capitalize on this unique opportunity to recognize health as a critical investment and together develop a common understanding of how countries and their partners can transform these commitments into immediate actions. We must choose to make equitable and efficient health investments a reality," said WHO Director-General Dr LEE Jong-wook.

The article specifies that during the meeting, the combined work of countries, WHO and partners will be to develop concrete plans for increased health investment in countries."Continued global leadership and follow-up from the development community, combined with inter-ministerial collaboration is needed: first, to increase resources for health from domestic resources, debt relief and development assistance for health, and second to eliminate health system and institutional constraints, enabling greater absorption of increased resources. This will be critical for pursuing country action to reach the "3 by 5" and other health targets."

"We need country-specific blueprints for making real increases in health investment. Developing countries and their partners need to collectively and quickly do much more, for health and global stability. This meeting can identify ways to make this happen," added Dr Lee.

Bua News (Pretoria):**Health Ministers Get Together in Geneva****29 October 2003****Byline: Candace Freeman**

Pretoria, South Africa: The article states that Ministers of Health, Finance and Planning from around the world came together with development partners at the World Health Organization (WHO) headquarters in Geneva to address the need to significantly increase investments in health.

It reports that WHO Director-General Lee Jong-wook said in a statement that the meeting signified real political commitment from the highest levels of government and donor representatives. Delegates at the meeting aimed to develop concrete plans for increased health investment in countries.

Tribune de Genève:**OMS Réunion sur les politiques de la santé****29 October 2003**

Geneva, Switzerland: The Tribune de Genève reports: "Le directeur général de l'Organisation mondiale de la Santé (OMS) a ouvert aujourd'hui à Genève trois jours de travaux avec 40 ministres de la santé et des finances des PVD (dont treize pays africains) ainsi que des représentants des pays donateurs. Ces consultations ont pour but de développer les infrastructures de santé dans les pays pauvres."

Le Vif – L'Express:**Il faut 27 milliards de dollars pour les pays pauvres (OMS)****29 octobre 2003**

Geneva, Switzerland: Le Vif-L'Express reports: "Il faut 27 milliards de dollars par an d'ici 2007 pour éviter huit millions de morts dans les pays en développement (PVD). Actuellement, les pays donateurs consacrent 7,7 milliards par an à la santé des pays pauvres, une somme insuffisante, a indiqué mercredi l'Organisation mondiale de la Santé (OMS). Le directeur général de l'OMS, le Dr Lee Jong-wook, a ouvert mercredi à Genève trois jours de travaux avec 40 ministres de la Santé et des Finances des PVD (dont treize pays africains) ainsi que des représentants des pays donateurs."

Télévision Suisse Romande (TSR):**Investissements dans la santé: les pays pauvres ont besoin de plus****29 octobre 2003**

Geneva, Switzerland: TSR reports: "Il faudra 36 milliards de francs par an d'ici 2007 pour éviter huit millions de morts dans les pays en développement (PVD). C'est sur ce constat que s'est ouverte à Genève une réunion sur les investissements dans la santé. "

Xinhua General News Service:**Ministers to meet in Geneva to increase health investment****29 October 2003**

Geneva, Switzerland: This article announced the Consultation, reporting: "Ministers of health, finance and planning from 40 developing countries are meeting at the World Health Organization (WHO) headquarters here Wednesday to address the need to significantly increase investments in health." It quoted Dr LEE Jong-wook, WHO Director-General: "We need country-specific blueprints to realize real increase in health investment. Developing countries and their partners need to collectively and quickly do much more," and "this meeting can identify ways to make this happen."

Jeune Afrique - L'Intelligent:**Ingérence économique****31 octobre 2003****Byline: Juliette Bastin**

Reporting on the Consultation, Bastin writes: "Pour tenter d'atteindre l'objectif fixé par la commission, il convient donc d'établir " des schémas nationaux spécifiques ". Objectif, pour les pays en développement (PED) : s'appuyer sur leurs ressources et sur l'aide internationale pour renforcer les moyens consacrés à la santé. Mais aussi affecter une partie de l'allègement de la dette aux systèmes sanitaires. Cette ambition nécessite une étroite collaboration entre les ministères des Finances et de la Santé. Cette incursion de l'agence onusienne dans le budget des États est une petite révolution. Qui fait définitivement de la santé la condition sine qua non du développement. "

Angola Press Agency :
Country Attends WHO Meeting
31 October 2003

Luanda, Angola :The article reports that "an Angolan delegation has participated, for three days, in Geneva, Switzerland, in a meeting of the World Health Organization (WHO) intended to discuss issues related to the investments in the health sector in undeveloped countries.

The Angolan delegation, headed by the Vice-Minister of Planning, Mr Eduardo Severim de Morais, was integrated by the Vice-Minister of Finance, Mr Arlindo Sicato, and top officials of both Ministries.

The article goes on to state: "Two years have gone, the WHO complains that the donors have not given proof of their determination in developing the investments in the health sector and to lead them to levels that have a true impact on big diseases which affect the poor people. According to a recent study, the total aid from the donors for the development of the health sector in developing countries increased only for the fight against AIDS in the Sub-Saharan Africa, still not covering the real needs of the developing countries."

Pharma Marketletter:WHO-hosted LDC investment meeting to urge more for HIV/AIDS drug treatment
29 October 2003

Pharma Marketletter reports: "Ministers of health, finance and planning from 40 developing countries are meeting with development partners at the World Health Organization headquarters in Geneva, Switzerland, October 29-30, to address the need to significantly increase investments in health.

This is the first time that the WHO has hosted a meeting so widely attended by non-health officials, underlining the urgency of building national capacity to absorb increased health funding, says the Organization."

The article goes on to quote Dr LEE Jong-wook, the WHO Director-General: "The meeting 'signifies real political commitment from the highest levels of government and donor representatives,' said WHO Director General Lee Jong-wook.

"On taking office, I declared the target of 'three by five' to have 3 million people with AIDS in developing countries on treatment with antiretrovirals by the end of 2005. Only 300,000 are on treatment at the moment," said Dr Lee. "To achieve 'three by five' and other health priorities we need considerably more funds than those currently available. If we don't increase resources for health and target these resources to activities that will have the greatest impact, we stand to lose millions of men, women and children to disease," he added.

"We need country-specific blueprints for making real increases in health investment. Developing countries and their partners need to collectively and quickly do much more, for health and global stability. This meeting can identify ways to make this happen," said Dr Lee.

Express Healthcare Management :

Need for world wide increase in health investment to be addressed

30 October 2003

Express Healthcare Management reports: "Ministers of Health, Finance and Planning from 40 developing countries will come together with development partners at WHO headquarters from 29 to 30 October to address the need to significantly increase investments in health. This is the first time that the World Health Organisation (WHO) has hosted a meeting so widely attended by non-health officials, underlining the urgency of building national capacity to absorb increased health funding.

"This meeting signifies real political commitment from the highest levels of government and donor representatives. Let us capitalise on this unique opportunity to recognise health as a critical investment and together develop a common understanding of how countries and their partners can transform these commitments into immediate actions. We must choose to make equitable and efficient health investments a reality," said WHO Director-General Dr LEE Jong-wook.

The article explains that this meeting comes nearly two years after the launch of the 2001 Report of the Commission on Macroeconomics and Health (CMH), which recommends that by 2007, donors should increase assistance for health to US\$ 27 billion. The Commission also calls for more budgetary resources for public health from both developed and developing countries, and more political and organisational effort than has been seen in the past decades to achieve real improvements in health.

The article quotes Dr Lee Jong-Wook: "We need country-specific blueprints for making real increases in health investment. Developing countries and their partners need to collectively and quickly do much more, for health and global stability. This meeting can identify ways to make this happen," added Dr Lee.

**The Press Trust of India :
Macroeconomics and Health Meeting**

29 October 2003

New Delhi : India and other developing countries on Wednesday came together at a meeting hosted by the World Health Organisation to address the crucial issue of enhancing investments in the health sector.

The two-day meeting, that began on Wednesday at Geneva, is being attended by Ministers of Health, Finance and Planning from 40 developing countries along with development partners.

India is represented by Health Minister Sushma Swaraj along with officials.

The meeting is focussing on developing concrete plans for increased health investment, a World Health Organisation release said.

"This meeting signifies real political commitment from the highest level of government and donor representatives... we must choose to make equitable and efficient health investments a reality," WHO Director General Dr Jee Jong-wook said.

"We need country-specific blueprints for making real increase in health investment. Developing countries and their partners need to collectively and quickly do much more for health and global stability. This meeting can identify ways to make this happen," Lee said.

He said currently only 300,000 people with AIDS are on treatment with anti-retrovirals due to dearth of funds.