Fourth Meeting of
The Commission on Macroeconomics and Health

Addis Ababa, 6-8 March 2001

Executive Summary

1. High visibility in Africa of Health in the Development Agenda

The timing and venue of the 4th meeting of the CMH were deemed to be particularly appropriate in the context of Africa's recent proactive efforts in giving health pride of place in the development agenda. The UNECA health-focused Forum "Leadership to overcome HIV/AIDS" held in December 2000, the HIV/AIDS Summit to be held in Abuja from 21 to 24 April 2001 and the meeting of Ministers of Finance scheduled for 8 to 19 May, in Algiers, to inaugurate the New Global Compact for Africa all attest to the high visibility given to health in the broader macroeconomic scenario. Taking its lead from the International Development Goals' strong emphasis on health, African Heads of State are treating health as the key to economic growth and in this context are assessing what they can do for themselves and what can best be done in partnership with others.

The Ethiopian experience

In this vein, two complementary presentations at the CMH meeting, on the health systems in Ethiopia highlighted progress achieved in recent years in increasing health coverage from 43% to 52% in the country which it is believed to be due to a twenty-year health sector development strategy formulated by the Government of Ethiopia that follows a series of five-year investment programmes for implementation. This strategy involves two levels of partnership: (a). The Federal Government and the Regional States. (b). the Government of Ethiopia and its donor partners. AND (c). the involvement of NGOs, and the private sector. However, resource availability has not matched planned activities and innovative measures are being sort to obtain additional health financing from old and new partners. The Ethiopian experience provides a strong case whereby **without a substantial increase in donor support progress in health care delivery will be slow and achievements limited.**

Findings from the meeting in Bellagio

Still within the African context, the recent Special Meeting of Working Group 1 and the CMH on "Priorities for Health Investment in Africa" which took place in Bellagio from 12-16 February 2001, provided the opportunity for the Commission to dialogue with African policy makers and stakeholders in order to understand fully, problems, priorities and policies required for effective poverty reduction and health improvements. Findings from the "Bellagio" meeting itself and the ensuing debate in Addis on the Report brought up some key contentious areas which kept reoccurring throughout the Meeting and which provided valuable pointers to what the Commission should reach a position on. First and foremost the importance of **good governance** was underlined. This was seen as the cornerstone for attracting much needed funding.

In line with the argument put forward by the renowned economist David Dollar in his book "Making Aid Effective "development assistance in countries with poor governance and where ineffectual policies are in place, will have little or no impact". The CMH through the work of Working Group 6 is providing the added value of defining the levels of donor assistance needed and of outlining the most effective delivery mechanism for donor aid to ensure country ownership, transparency and accountability. Discussions at the meeting opened up the whole issue of donor fatigue, of the need to produce convincing evidence-backed numbers of the amount required and in which forms aid should be granted with a view to ensuring **country ownership, transparency, and public health efficiency.** Working Group 6 is working closely with Working Group 3 which is focusing on the **mobilization** of domestic resources for health. The latter was deemed by representatives of African governments at the Bellagio meeting to be of prime importance in the overall picture of drawing on more resources for health. In general, it was felt that funds released as a result of the HIPC initiative amounting to approximately $70 million a year for health were deemed inadequate unless matched by donor assistance. This was explained by the reality of a low-income country with only $15 per person annually to not possessing the financial wherewithal to finance health systems by themselves. Nevertheless domestic resource mobilization can still play a key part in the overall health investment scenario. The recent HIPC assistance initiative resulting in an average cash flow to the budget of affected countries of approximately 2% has freed resources for pro-poor programmes. It is argued, however, that although the $70 million freed a year as a result of the HIPC initiative falls short of the estimates required to make a difference, it nevertheless is a step in the right direction in that it demonstrates international goodwill and gives operational meaning to the whole question of country ownership.

2. Recent health-related initiatives

Encouraged by a growing international consensus on the importance of health to development and by the window of opportunity provided by the HIPC initiative, G8 meetings and increased cash flow for health-related initiatives, the UK government has set in motion a project entitled "Health in Developing countries". The premise for the project is that the scale and effectiveness of existing interventions for HIV/AIDS, TB, Malaria and Communicable Diseases of childhood is inadequate. What is being called for is step change in the global response. Key aspects of the project will focus on policy measures to achieve large health improvements; arrangements for a global health fund; identification of capacity constraints which need to be addressed for scale up and of ways to involve, to a greater extent, developing countries in the process and outcome. A parallel initiative entitled the Ottawa Fund which is the outcome of a partnership between DFID, USAID, CIDA and the EC aims for a **streamlined and efficient transfer of commodity support to developing countries**. **Commodity support** covers not only the supply commodities but also resources for their purchase, technical assistance and provider support necessary to ensure that the commodities are well used, and provide support to developing countries to enhance their own commodity supply systems. The focus is on priority diseases with support channelled in ways which strengthen health systems and are in support of other planning and poverty processes at country level (e.g. SWAp, PRSP, national planning cycles). This initiative aims to reduce the transaction costs for recipient countries.

3. Determinants of Health

Working Group 1 is focusing on health as an investment good and on evidence showing the extent to which it is predictive of economic growth. However, it was felt that there was a need to examine the broader determinants of health such as (income, water, sanitation, education, the health sector) in order to provide convincing air-tight arguments for the Final Report that health is the **key** to development and not just a contributing factor.

4. The CMH and its position on"Globalization"

It was felt that the CMH should take a firm stance on the issue of globalization – whether in fact Globalization can be made work for the world's two billion poorest and on the specific issue of IPRs and the TRIP's agreement. A CMH position will need to be reached on whether amendments in the TRIPs provisions to suit the needs of developing countries is recommended or whether it is possible to work within the existing framework for TRIPS and still serve the interests of the poor. In the event that a review of the TRIPs agreement is to be sought, policy decisions will need to be reached on the issue of compulsory licensing and on how it can work to the benefit of developing countries in a post-TRIPS's period. Thus a clear stand is required on the impact of TRIP's. Recommendations would have to cover the key **issue of access** to essential medicines to the poor, namely of expensive drugs needed for the treatment of HIV/AIDS such as HAART. The cost of HAART treatment currently runs at $10,000-$15,000 per annum - which puts it out of reach of the poor affected. The need was discussed at the meeting to set in motion a large scale strategy to introduce HAART into African and make it accessible both in terms of availability and of affordability. Thus, a clear stand is required on the impact of TRIPs on domestic market conditions, on R&D, on prices, on generic substitutes, on the need for compulsory licensing, and how countries which do not have local manufacturing capacity could gain from the compulsory licensing provision. Working Group 2's work on patent systems and amendments will help define WG4's final analysis of the TRIPs agreement.

Questions that will need to be answered are the relative merits of globalization, i.e. raised incomes in some countries; facilitation of the transfer of medical technology and adoption of new information technologies; on the adverse impact of globazation, i.e. mobility of skilled personnel and the brain drain from developing to developed countries. Can privatization of health care help offset the adverse effects of health sector globalization such as the bran drain? The main problem associated with the brain drain factor is associated with lack of financial incentives to attract health professionals to rural areas for instance and to train new recruits to the public health sector such as doctors and nurses. Whilst more money is seen to be the main solution to the problem other considerations were mentioned at the meeting such a stable political and social environment (i.e. salaries actually paid on time to health professionals).

5. How can the CMH get the research agenda moving in terms of global public goods

One of the biggest challenges facing the CMH will be to attempt to reverse the present imbalance in funding for health research which weighed heavily in favour of the diseases "of the rich" with only 10% of international research on health focused on diseases which

affect 90% of the world's population. Furthermore, there is an urgent need to strengthen the research capacity of low-income countries which in some instances has gone backwards as opposed to simply stagnating. This refers again to the issue of good governance. Redressing the health research imbalance can best be achieved by providing an analysis of the cost of failing to invest in health research that address problems of the poor and by providing incentives to research institutes, pharmaceuticals companies and local industries to invest in research of diseases of a less lucrative clientele.

6. The CMH's position on the HIV/AIDS pandemic

It was felt that in view of the all-pervasive nature of the HIV/AIDS pandemic (noticeably in Sub-Saharan Africa) merited that it be given special consideration, over and above other targeted diseases, in the CMH Final Report. At present this global threat is aggravated by a lack of a treatment strategy to deal with the problem and by an inadequate political response and donor investment commitment. The possibility of making available the $10,000 a year treatment of the highly active anti-retroviral thereby (HAART) to Africa and on a large scale needs to be co-ordinated and paid for by the international community. At present, IPRs mean that this effective drug in the treatment of HIV/AIDS is not an option for the poor. In addition, support needs to be provided to prevention strategies which are meeting with a high degree of success, i.e. in Uganda and in Thailand. The CMH in order to be heard needs to provide cost estimates on the economy if HIV/AIDS pandemic is not curtailed. For instance, it has been estimated that the South African economy would be 17% smaller in 2010 than it would have been without AIDS by which time the disease will have cost the country about $22 billion.

7. Health Financing

It was felt that the Commission in its Final Report should come up with practical and attainable scenarios with regard to health financing, i.e. private financing: out of pocket contributions; (private) voluntary insurance versus public financing: General revenue taxation; social (mandatory) insurance, usually by way of pay roll tax. As a country's income increases, the percentage of pre-paid health expenditures rises and out-of-pocket payments decrease. With the exception of the US, high-income countries have universal (mandatory) public finance. Available evidence suggests that mandatory public finance is more efficient as well as being more equitable.

8. How much will it all cost?

A major challenge facing WG5 is to arrive at an accurate costing of health investment taking into account realistic overheads for human resource inputs. This costing will be complemented by a realistic estimate of the **health and economic returns** that a committed global public health effort would provide. It is hoped that donor assistance would commit to funding realistic salaries of health workers in order to reverse the extent of the brain drain. It was felt that the Commission should outline the mechanics of donor assistance needed - in terms of **how much** donor assistance is required, **how** it should be channelled, to which areas, **how** it can be accounted for whilst ensuring country ownership. The **real question** however is one of scale.

Increased capacity absorption

A major challenge confronting Working Group 5 will be to reach an accurate estimate of the absorption capacity of the health system. For instance, in South Africa the Department of Health failed to spend last year 28% of its budget for hospital rehabilitation and, its provincial counterparts allowed 12% of its allocation for the country's nutrition programme to go unspent.

9. Data Collection

Reservations were voiced throughout the meeting about the paucity of available data on health statistics which is impeding the drawing up of an overall picture of conclusions reached. For instance, while data is plentiful on the mortality rates of younger age groups, the corresponding information is not so comprehensive of older age groups. This is just one instance whereby the bank of data material needs to be developed. WG2 undertook as a result of the meeting to synthesize the needs expressed by other Working Groups for more and better data to carry out their mandate.

Conclusion:

In the final analysis discussions at the CMH meeting in Addis highlighted unresolved issues which needed to be resolved (see Annex), highlighted key areas requiring a firm stance and referred to concrete evidence of the macroeconomic policy changes needed to ensure that health systems promote health outcomes amongst the most vulnerable segments of society. The underlying thought expressed throughout the presentations of the UK delegation at the opening of the meeting and reiterated in the course of the debate on the overall agenda of the CMH is the need to outline what else is needed to ensure **sustainable health improvements** – more money….. and health system reform.

Annex

Challenges that were identified by each of the Working Groups

Working Group 1

- The need to study the broad determinants of health (income, water, sanitation, education, health sector). It was felt that additional expertise was needed to make such a study under the umbrella of Working Group 1's mandate.
- The need to be clear about how much is being asked for.

Working Group 2

- Identifying new solutions to the problem of building research capacity in low-income countries. Some middle-income countries have moved ahead strongly to develop a significant health research infrastructure. By contrast, most low-income countries have little indigenous capacity to conduct research on their own priority health problems. WG2 has found few fresh ideas about reversing this dismal picture.
- Assessing the need for modifications of the US/European patent systems. Working Group 2 members are divided in their view about whether the current IPR system strikes the correct balance between the public and the private interest.
- Clarifying the importance of a continued role for the public sector in the R&D process. Although the focus of Working Group 2 is on incentivizing the private sector to participate more actively in R&D for drugs and vaccines for the poor, these private incentives must be placed in the context of continued public sector involvement.
- Synthesizing the needs expressed by other Working Groups for more and better data to carry out their mandate. Working Group 2 is interested in building a case for global information needs. The challenge is to identify priorities and commonality of purpose (whether for research, needs assessment, or monitoring/evaluation).

Working Group 3

- The need to generate additional resources from domestic sources through both improved expenditure allocations and tax effort.
- The need to generate additionality of spending on health interventions in the presence of increased inflow of donor assistance.
- The need to strengthen the public expenditure management systems to ensure that additional resources from domestic and foreign sources are utilized for intended purposes.
- The need to make a special effort to engage policy makers/stakeholders/ministers of finance in the process.
- The need to elaborate on incentives for health personnel (not solely with a bias towards higher salaries).
- The question of ownership at country level needs to be given operational meaning.

Working Group 4

- One of the biggest challenges will be to evolve a consensus on the issue of IPRs and the TRIPs agreement.
- Another important issue on which concrete policy suggestions are required concerns pricing. How can price controls and tiered pricing be used to benefit the poor countries?
- Financing is another issue that needs to be addressed. How will the liberalization of health insurance services affect domestic financing for the health sector
- The impact of privatization of health care and its effect on the quality and resources available for the health sector needs to be addressed.
- Should health services be included under GATS or should they be carved out as they are provided mainly in the exercise of government authority and often on non-commercial and noncompetitive terms?
- Some thought is required on how more countries can be motivated to discuss trade in health services under the GATS. Is there scope for pushing this issue under regional economic groups which cover services trade?
- The need to reach a consensus on the issue of labor mobility in health services and on the brain drain
- What is the working group's view on issues such as harmonization of standards in health care delivery and health education across countries?
- To reach a stance on globalization and health.

Working Group 5

- As choices around interventions relate to determinants there is a need to examine more closely the peripheral determinants and not solely the health determinants
- Focus on the overwhelming impact on mortality of HIV/AIDS and come up with evidence-based policy recommendations.
- The issue of delivery vehicles needs to be addressed. The distinction between vertical and horizontal programs is not always specific enough - there is a need to be more focused at the local, national and international levels.
- Does more money solve most constraints?
- What to do in highly constrained environments?

Working Group 6

- The financial architecture of future ODA flows for health needs to be defined in terms of efficiency of delivery.
- The question of whether the donor community can deliver more, better, faster – What priority should donors place on these dimensions? Can we deliver on all three?
- The need to examine how donors can cooperate with each other in order to define and then use a common framework for assessing effective interventions in the health sector and also to examine and help strengthen capacity to monitor and evaluate results at the country and sectoral level.