INVESTING IN HEALTH

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

WORLD HEALTH ORGANIZATION
CMH SUPPORT UNIT

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Foreword

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

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

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

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

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

The Commission on Macroeconomics and Health

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

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

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

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

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

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

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

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

The Ten Recommendations

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

The main recommendations of the CMH Report are:

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

CMH Report p 18-19 and p 108-111

Poverty and ill-health are closely linked

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

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

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

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

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

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

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

CMH action in countries

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

Health-related Millennium Development Goals

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

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

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

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

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

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

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

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

Goal 8. Build a global partnership for development: to help poor countries eradicate poverty, hunger, and premature death will require a new global partnership for development based on stronger policies and good governance.

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

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

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

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

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

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

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

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

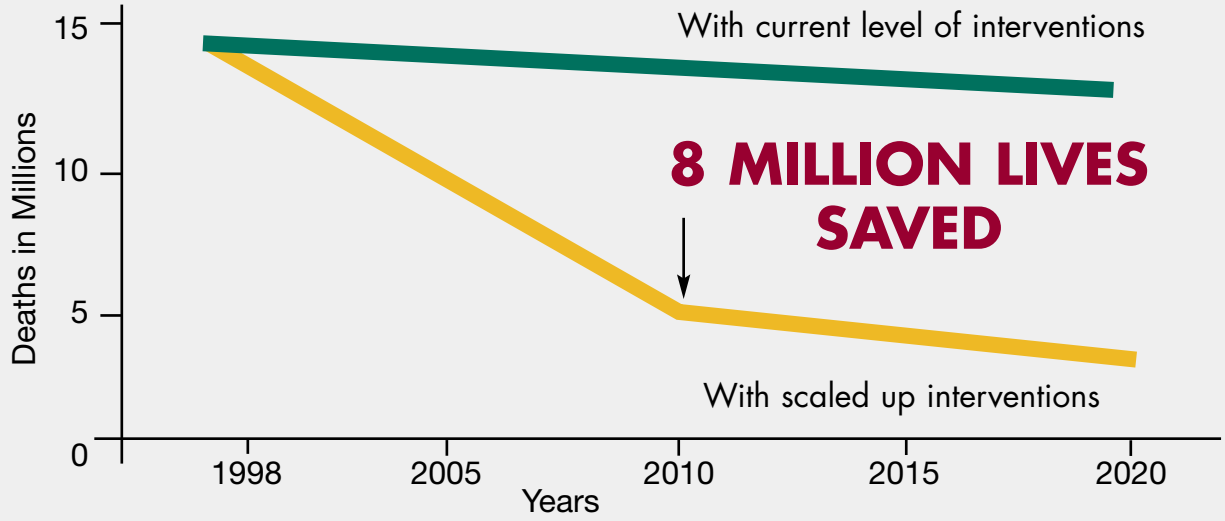
CMH Report p 91-101, Working Group 3 Report p 57-100, Working Group 6 Report p 35-43

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

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

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

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



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

Examples of essential interventions to combat major infectious diseases and malnutrition

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

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

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

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

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

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

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

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

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

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

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

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

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

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

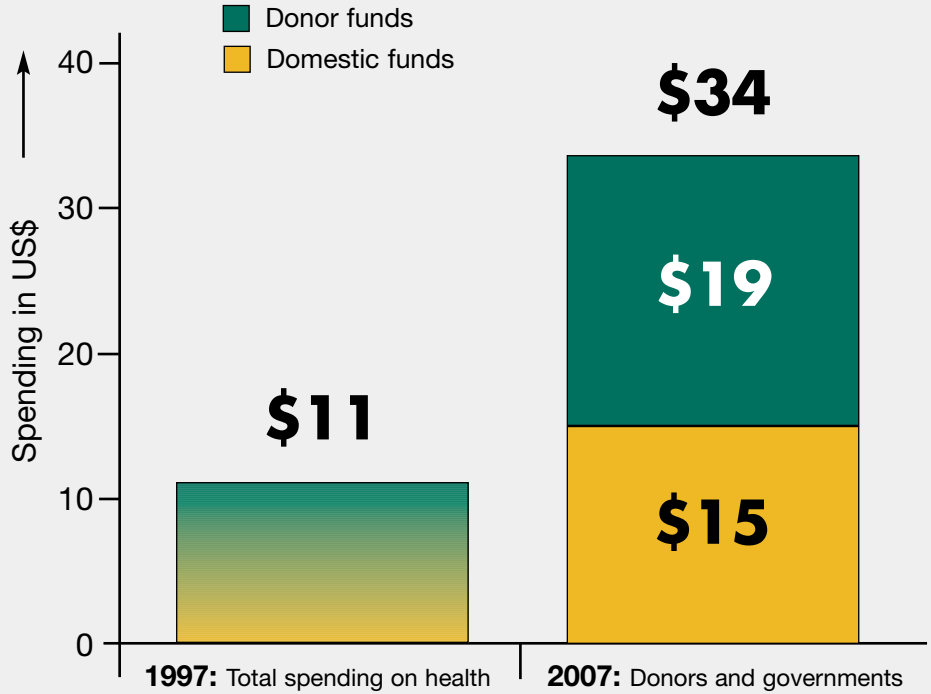
Domestic Spending and Donor Assistance on Health (1997-1999)

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

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

The Cost of Essential Interventions

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



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

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

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

The extra funding required is unaffordable for poor countries

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

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

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

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

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

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

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

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

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

Mobilising greater resources for health in low-income countries

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

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

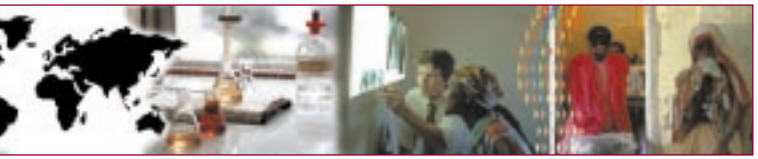
CMH Report p 61-62

Mobilising greater resources for health in middle-income countries

As part of an economic development strategy the Commission recommends:

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

CMH Report p 63



Increased investment in health is urgently needed

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

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

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

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

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

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

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

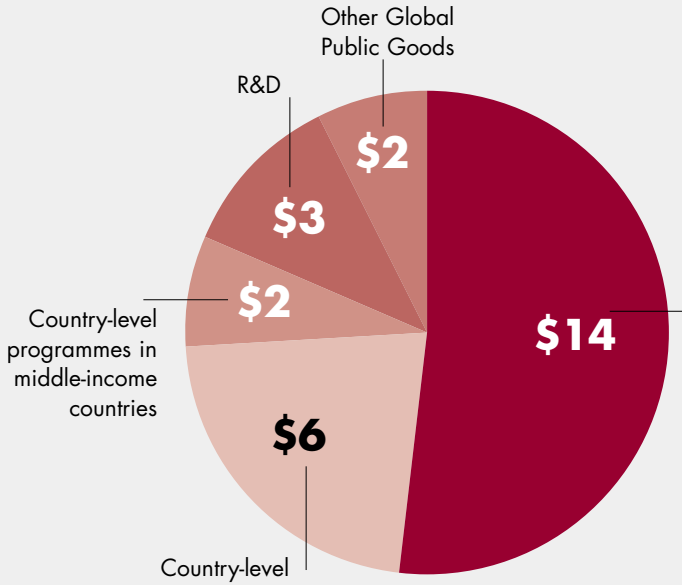
Recommended donor commitments

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

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

Breakdown of recommended donor commitment (incremental) US$ billions

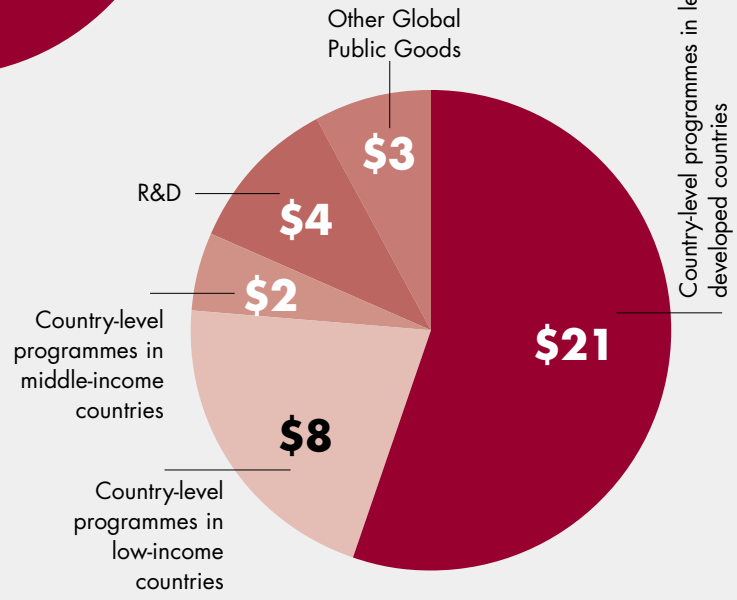
For the least-developed, low- and middle-income countries



US$ in billions (constant 2002 US$)

2007 Estimates:

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



US$ in billions (constant 2002 US$)

2015 Estimates:

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

CMH Report p 20, p 168

The supply of global public goods in poor countries

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

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

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

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

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

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

The Commission calls for an increase in research and development:

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

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

The 10/90 Gap

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

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

Access to essential medicines

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

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

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

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

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

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

CMH Report p 86-91

Responsibilities of low-income countries

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

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

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

Responsibilities of the international community

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

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

Responsibilities of the pharmaceutical industry

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

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

New ways of investing in health for development

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

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

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

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

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

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

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

Facilitating investment in health

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

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

  CMH Report p 81-86

Initiating macroeconomics and health work at country level

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

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

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

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

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

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

Important Macroeconomics and Health Activities

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

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

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

How countries are moving forward

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

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

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

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

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

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

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

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

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

National responses to the CMH Report

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

Senior representatives from the following countries participated in the Consultation:

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

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

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

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

The European region
- Poland

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INVESTING IN HEALTH

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

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