5 November 2001

World Health Organization

Evidence and Information for Policy

The Commission on Macroeconomics and Health (CMH)

OVERVIEW

Principles underlying the CMH

Each bullet reflects the rationale behind the establishment of the six CMH working groups

Working Group 1 - "Health, economic growth and poverty reduction". - Reducing the burden on the poor by improving health in developing countries: **"From health to income: the positive correlation between health and income per capita is one of the best known in international development. This correlation is commonly thought to reflect a casual link from income to health…. Recently however researchers have been investigating that the health-income correlation is partly explained by a casual link running the other way - from health to income". (D.E. Bloom, D. Canning, The Health and Wealth of Nations, World Health Opportunity: developing health, reducing poverty; Meeting held in London, May 1999).**

Working Group 2 - "International public goods for health" **"The Transition out of poverty into prosperity is only possible when people enjoy good health. Healthy people make a good contribution to their nation's prosperity. Good health is vital for individual well-being, for societies to develop, for nations to grow, for regional security, and for the proper use of global resources". (Dr Gro Harlem Brundtland, Twenty-Fourth Session of the General Assembly: World Summit for Social Development and Beyond: achieving social development for all in a globalizing world". Statement to the Ad Hoc Committee of the Whole, Geneva, 26 June, 2000.**

Working Group 3 - "Mobilization of domestic resources for health". **"The ultimate responsibility for performance of a country's health system lies with governments. The careful and responsible management of well-being of the population-stewardship-is the very essence of good government. The health of people is always a national priority: government responsibility for it is continuous and permanent. … The challenge facing governments in low income countries is to reduce the regressive burden of out-of the pocket payment for health by expanding prepayment schemes". (WHO-The World Health Report 2000).**

Working Group 4 - "Health and the international economy". A third of the world population, mainly in the tropics and in landlocked regions, are excluded from technology innovation: **"In the global economy of the 21st century, economic development will increasingly be linked to transnational access to knowledge and information networks and the exchange of information. …Concerns will continue to be raised that economical globalisation should not be seen as an end in itself, but as an economic tool which should be adapted so that marginalized populations and broader social policies are not neglected…".(Bettcher et al, Global Trade and Health: key linkages and future challenges, Bulletin of WHO, 78 (4) 2000).**

Working Group 5 - "Improving health outcomes of the poor". Closing the equity gap by improving health outcomes of the poor : **"How and can the health of the population that has a backlog of disease to be improved? Fortunately the interventions that reduce the backlog are also some of the most cost-effective. The issue is how to allocate government resources to close the equity gap…The population that needs coverage usually lives in remote and poor areas. Thus, traditional interventions that have been used for urban population are not likely to be either effective or efficient in providing health care to disperse rural population. In these countries most of the alternatives for improving the value for money are at the micro level". (Inter-American Development Bank, JL Bobadilla, Searching for Essential Health Services in Low and Middle-Income Countries, 1998).**

Working Group 6 - "Development assistance and health". Rethinking aid: **"Oversee Development Aid (ODA) is essential in the fight against poverty. We commit ourselves to strengthen the effectiveness of our ODA in support of countries'own efforts to tackle poverty, including through national strategies for poverty reduction…… To achieve increased effectiveness of ODA, we resolve to untie our aid to the Least Developed Countries on the basis of progress made in the Organisation for Economic Co-operation and Development (OECD) to date and a fair burden-sharing mechanism that we will agree with our OECD partners..…"(G8 Comuniqué Okinawa 2000).**

I. Background

The world economy is at a crossroads: globalization moves apace and generates real benefits; but actions are required to ensure that these benefits do not exclude the world's one and a half billion poor. The Commission on Macroeconomics and Health (CMH) was established in January 2000 by Dr Gro Harlem Brundtland, Director-General of the World Health Organization (WHO) in **response to the need to place health at the centre of the development agenda**. The premise is that by ensuring that people, particularly the poor, enjoy better health is a major factor in efforts to improve the economic well-being of populations in general, and in reducing poverty in particular. The Commission is a crucial part of WHO's strategy to meet the challenge of assembling and analysing the evidence linking health status and poverty reduction. The Commission will communicate its findings to policy makers in national governments and in development agencies.

Context

To date, there have been very few linkages made between the spheres of public health and macroeconomics. However:

1) It is well established that poverty predisposes individuals and countries to ill-health. Thus, sound macroeconomic polices that reduce poverty will improve health. It is also clear that ill-health perpetuates poverty. Thus, **appropriate investments in improving health can provide an important set of instruments for poverty reduction and economic growth.** What is missing are the specific research and operational tools needed to place health within the overall developmental agenda.
2) New research commissioned by WHO suggests that countries with higher levels of health grow faster. Indeed, improvements in health may account for a significant fraction of the rapid economic growth of much of the world in the 20th century.
3) The global macroeconomic incentives for research and development of new health technologies have not been well studied. In contrast to health, other sectors such as environment have made substantial linkages to the macroeconomic and developmental agendas, partly by improving the scientific and economic base upon which policy can be based.

The increasing use of International Development Targets, including targets in public health, as the encompassing framework to evaluate the progress in the fight against poverty, is a testament to the increasing recognition of the linkages from improved health to the escape from poverty. ***Improving health is recognized as a poverty reduction goal in itself, and is increasingly understood to be an input into improved economic performance.***

The World Health Report (WHR) 1999 entitled *Making a Difference* emphasised health as a key item in the developmental agenda, including a focus on health investments to improve health outcomes of the poorest billion and a half in the world. WHO has drawn on these findings to argue that health should be a major concern not just of Health Ministers but of Finance, Economy and Development Ministers. This is particularly so because the development agenda is moving from an exclusive focus on trade and macroeconomic stabilization to a real **concern for poverty**. In the World Health Report 2000 entitled *Health Systems: Improving Performance,* the emphasis is on the pivotal role of the health sector in economic development. The Report breaks new ground in that it enunciates the essential goals of health systems. Starting from the premise that the defining purpose of a health system is to improve and protect health, health systems should be concerned with fairness in the way people pay for health care, with how systems respond to people's expectations and with regard to how they are treated. The goals of a health system must also include reducing inequalities, in ways that improve the plight of the worse-off. If policy-makers adhere to these guidelines, to quote Dr

Brundtland "substantial gains will be possible for all countries, and the poor will be the principal beneficiaries".

Yet health remains far from the centre of the development agenda. Many health professionals continue to ignore that the health sector itself is only a minor player in efforts to improve the health of populations. The overwhelming majority of finance officials and development economists tend to assume that health itself is relatively unimportant as a development goal or as an instrument for reducing poverty. Therefore, a **major challenge for WHO** in the next few years is to stimulate the strengthening of the evidence base and to communicate much more effectively what is already known.

In May 1999, WHO and the United Kingdom's Department for International Development (DFID) organised a meeting called "World Health Opportunity: Developing Health, Reducing Poverty." This meeting clearly emphasised WHO's role as the lead technical agency on health to provide the analytic and operational basis for health to be at the "heart" of development and communicating this to the global economic community.

WHO's Response

WHO is mounting a major effort to improve its linkages to broad developmental issues, with a focus on the potential of health in poverty reduction. WHO has responded in three specific ways by:

- better defining its policy on poverty, including links to inequality and equity, broader development goals, and its policy for the Copenhagen plus 5 Summit
- a focused review of technical packages for health interventions that most directly relate to the poorest billion
- creating a Commission on Macroeconomics and Health (CMH).

Rationale for WHO's involvement and role

It is clear that WHO's comparative advantage is in technical advice on health and not on macroeconomics. The rationale behind WHO's involvement in macroeconomics is twofold. First, the CMH is a continuation of WHO's emphasis on evidence. By critically examining selected key aspects of health and development, the CMH is increasing the set of tools and policy conclusions available to ministries of health and finance. Second, the CMH is helping relate key aspects of WHO policy (such as financing health services for all, but not all health services) into practical issues that must be addressed by ministries of finance (e.g., types of tax systems to use in different settings).

II. CMH Structure

CMH Terms of Reference and Composition

The CMH's chief task is to act as a source of advice and analyses for WHO and the broader development community on how health relates to macroeconomic and development issues. It will help also to disseminate key aspects of WHO policy to Finance and other Ministers world-wide. (See Annex 1 for CMH terms of reference).

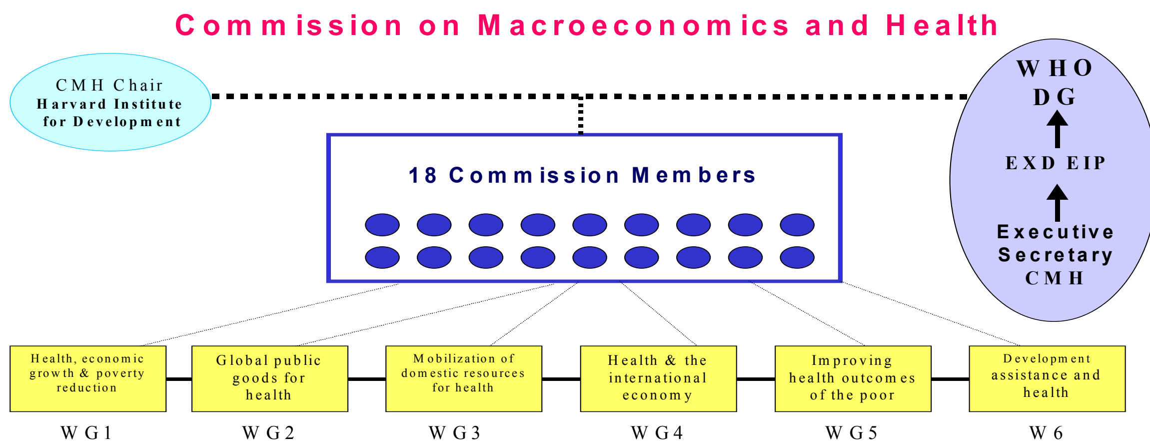
Chaired by Professor Jeffrey Sachs, Professor, Economics at Harvard University and Director, Center for International Development (CID, the CMH is a time-limited body, comprising:

- **18 Commission members**, who include development economists, macroeconomists, health economists, and internationally recognised health and economic policy makers. (A list of Commission members can be found in Annex 2).

- **Six working groups** - with six distinct mandates - **entrusted with the main work of the CMH**.

- **The Chairman's team** (assistant, administrative staff, and researchers) are responsible for presenting the on-going activities and interim products of the Commission and the working groups in quarterly progress reports; for facilitating peer review of papers and reports produced by the working groups; and for working closely with WHO in managing the CMH's work.

- **An Executive Secretariat**, based at WHO headquarters, to facilitate the work of the Commission. The Executive Secretary is the first point of contact for the CMH Chair and WG CO-Chairs on issues relating to CMH management and for ensuring that the rationale for and outcomes of the Commission's work are more widely understood and disseminated.



- The CMH will meet approximately 6 times during 2000 and 2001. (Two CMH meetings have been completed; the first meeting was held from 16-18 January 2000 in Geneva, Switzerland and the second from 14-17 April 2000 in New Delhi, India). (Annex 3 provides a summary of key events).

III. Expected outputs

- *By summer 2001, the groups are to complete their work by producing a final Working Groups' Report completed well in time for the final drafting of the overall Report that will begin in September 2001.*

- *The CMH will produce a synthesis Report on the Commissioners' recommendations by December 2001. This report will be produced through careful evaluation and analysis of the six Working Groups' findings.*

- The final Report will be disseminated to the international development community and to Ministers of Health at the 2002 World Health Assembly.

CMH Working Groups - Composition and *modus operandi* of each Working Group

Each Working Group is chaired by two or three co-chairs and is funded through a budget allocated to an institution to which one of the co-chairs is affiliated. Working groups **consist of CMH members**, staff of various international agencies (WHO, World Bank, IMF, UNDP, etc.), and experts from various governments, academic institutions, NGOs and the private sector. Working groups will take stock of the existing knowledge base in order to identify implications for policy rather than the generation of new knowledge. The groups are expected to consult widely with developing country policy makers and professionals as part of their work.

Working Groups and their expected product
Working Group 1 - Health, economic growth and poverty reduction - will address the interrelations between health, economic growth and poverty reduction. Subjects to be addressed include health effects on demographic structure, fertility and other aggregate dynamics of the health-growth linkage; adult health and labour productivity; human capital formation and health in the life cycle; inequalities in health and income; and a collation of available data sets, indicators and literature on the topic. This WG will produce at least one working paper on each of the above topics as well as a database on available related literature. A presentation on the health-development-growth linkage will also be produced for to dissemination among policy-makers. Co-chairs are Sir George Alleyne (PAHO) and Professor Daniel Cohen (Ecole Normale Supérieure, Paris, France).
Working Group 2 - International public goods for health - will develop a study that will focus on global public goods for health in the areas of research, information and networks, and communicable diseases. The work will build on studies currently ongoing at various agencies and academic institutions, and will focus on how important international public goods for health can be financed. This is a joint effort with the Institute for Global Health, various WHO units, and IAVI (International AIDS Vaccine Initiative). Co-Chairs are Professor Richard Feachem (Institute for Global Health, University of California-San Francisco, USA) and Professor Jeffrey Sachs (Harvard University, USA).
Working Group 3 - Mobilization of domestic resources for health - will assess economic consequences of alternative approaches to resource mobilisation for health systems and interventions form domestic resources and will be carried out in collaboration with the IMF and other institutions. The focus will be on how health systems can be best financed at country level, including by reallocation of public sector budgets and by expanding the role of the private sector. Ongoing work in WHO will also be an important input into this working group. Co-Chairs are Dr Alan Tait (former senior IMF official) and Professor Kwesi Botchwey (Harvard University, USA and former Minister of Finance, Ghana).
Working Group 4 - Health and the international economy - will examine trade in health services, health commodities and health insurance; patents for medicines and Trade-Related Intellectual Property Rights (TRIPs); international movements of risk factors; international migration of health workers; health conditions and health finance policies as rationales for protection; and other ways that trade may be impacting on the health sector. The Co-Chair is Dr Isher Judge Ahluwalia (Indian Center for Research in International Economic Relations, New Delhi, India).
Working Group 5 - Improving health outcomes of the poor - will elaborate technical options and costs for mounting a major global effort to dramatically improve the health of the poor by 2015. It will examine interventions within and outside the health sector, and is expected to draw extensively on ongoing work within WHO and at the World Bank. Teams based at the London School of Hygiene and Tropical Medicine, WHO and outside expert consultants have been assigned different topics according to their area of expertise. Subjects to be addressed in papers include intervention cost, coverage levels and scaling up coverage for interventions such as

HIV-AIDS, tuberculosis, malaria, prevention of under 5 mortality and maternal mortality, and tobacco-related interventions. WG 5 will produce papers documenting the evidence-based knowledge pertaining to the above topics and reporting gaps still in existence.

Co-chairs for this working group are Professor Anne Mills (London School of Hygiene and Tropical Medicine, UK) and Dr Prabhat Jha (WHO).

Working Group 6 **-** Development assistance and health is co-sponsored by the World Bank. It will review health implications of development assistance policies including modalities relating to economic crisis and to debt relief. It will focus on the policies and approaches of international developmental agencies. One emphasis will be on the appropriate balance between country specific work and support for activities that address international externalities or provision of international public goods. The assessment will include interventions outside the health sector, such as water supply, sanitation, population, nutrition and environment.

The Co-chairs are Mr Christopher Lovelace (World Bank), Mr Zephirin Diabre (UNDP) and Ms Carin Norberg, Ass. Director-General, SIDA

Product 7 - refers to the Chairman's office based at Harvard Center for International Development (CID). The office is made up of the CMH Chairman, other technical experts, and researchers. This group will produce a report and study on the interrelationships between health production, economic growth, and international initiatives.

Product 8 - Support to Chairman's office - consists of support to the Chairman's office. This team is responsible for presenting on-going activities and interim products of the Commission and the working groups into quarterly progress reports to facilitate peer review of papers produced by the working groups. Development of a website, a resource database and meeting organization will also be the responsibility of this team. This team will also work closely with WHO in producing the final report of the CMH. Included in this team's budget are salaries for a Senior Economist, an administrative assistant, CMH operating costs, travel and other additional costs for support of the CMH work.

Product 9 (Support to CMH meetings) will also be necessary for reporting and consensus purposes. The first meeting, held in Geneva, and the second meeting, New Delhi, have already taken place. It is planned that a meeting take place on each continent. They will serve as a forum for the WGs to come together and present findings as well as to monitor the progress of the overall CMH goals and final products. The list of meetings are as follows:

1st	Jan. 16-18	2000	CMH meeting Geneva
2nd	April 14-17	2000	CMH meeting New Delhi
3rd	Nov. 8-10	2000	CMH meeting Paris
4th	March 6-8	2001	CMH meeting Addis Ababa
5th	May/June	2001	CMH meeting in Mexico
6th	21-23 Aug.	2001	CMH meeting Geneva
7th	Dec.	2001	Venue to be determined

Product 10- Drafting and Printing of CMH final report

This product is a critical part of the work of the CMH since the final report will serve as the mechanism to disseminate the findings of all the studies that have been undertaken.

V. Progress to date

The Commission's work is well underway. The working groups have met. The terms of reference of each working group have been finalised, a detailed workplan established, and the expected products defined. Some of the working groups have already produced initial findings on their topics.

The Commission is already highly visible. Initial findings of the Commission on the linkages between health and development have already been cited by policy makers. In a recent speech, the UK Health Minister called for more investment in health as a way to improve national economic performance. As stated at the recent G8 summit in Kyushu-Okinawa on Poverty Reduction and Economic Development - "Global public goods such as environment and health deserve priority attention and require strong involvement of the IFIs, in particular the World Bank and the regional development banks, and also by bilateral donors". Such engagements can be counted as an achievement of the Commission. Although far from enough, capitals in various OECD countries are moving to address critical issues such as creating a market for new products such as a malaria vaccine.

VI. *Conclusion*

The world economy is at an important crossroads. The key to addressing the needs of the poorest of the poor is to place health investments at the centre of the international development agenda. The rationale behind the creation of the CMH is that health is **key** to improving the economic well being of people in general and reducing poverty in particular. During the two year period, the CMH will act as a source of advice and analysis for WHO and the broader development community on the relationship between health, economics and poverty reduction.

To quote Professor William Foege from his recent address to the World Health Assembly in May, "We are here because we can do it better together than we can do separately".

Annex 1

COMMISSION ON MACROECONOMICS AND HEALTH

Terms-of-Reference

WHO has established a **Commission on Macroeconomics and Health (CMH)** to assess critically and, where appropriate, to extend the evidence base concerning the following topics:

- the nature and magnitude of the economic outcomes (income and productivity growth, poverty reduction, and social protection) of investing in health;
- the economics of incentives for research and development for drugs, vaccines and other technologies that address diseases primarily affecting the poor;
- effective and equitable mobilization of resources (including reallocation of current public budgets) to finance control of major specific health problems of the poor and to develop and sustain health systems more generally;
- health and the international economy, particularly trade-related issues;
- costs and efficiency in use of resources to improve health outcomes of the poor, including consideration of interventions and policies within and outside the health sector; and
- development assistance and health (including consideration of efficiency in use of assistance oriented to improving health, debt relief, and external assistance for international public goods).

The CMH may add topics; and it may choose to exemplify its findings with disease, country or regionally specific analyses. It will draw on and contribute to ongoing initiatives elsewhere.

The CMH will provide analysis with a view to assisting WHO and the international community in their consideration of issues relating to health and development in low- and middle-income countries. It is accordingly foreseen that the results of its work will be published by WHO and widely disseminated.

The composition of the CMH is intended to include macroeconomists from academia, governments, and agencies. It may, in addition, include a health economist, a public health specialist, a biomedical scientist and a current or former health minister. Members will serve in their personal capacities but those from governments or agencies may designate alternates for some meetings. The Director-General of WHO will appoint the members and Chair of the CMH.

The CMH will complete its work by December 2001, unless the Director-General of WHO authorizes a later date.

Annex 2

COMMISSION OF MACROECONOMICS AND HEALTH (CMH)

List of Members

Professor Jeffrey Sachs (Chair)
Professor at Harvard University and Director, Center for International Development at Harvard University, Boston, USA
Nationality: US

Dr Isher Judge Ahluwalia
Director, Indian Center for Research in International Economic Relations, New Delhi, India
Nationality: Indian

Mr K.Y. Amoako
Executive Secretary of the Economic Commission for Africa, UN Economic Commission for Africa, Addis Ababa, Ethiopia
Nationality: Ghanian

Dr Eduardo Aninat
Former Minister of Finance, Chile and Deputy Managing Director, International Monetary Fund
Nationality: Chilean

Daniel Cohen
Professor of Economics, Ecole normale supérieure, Paris, France
Nationality: French

Mr Zephirin Diabre
Associate Administrator, United Nations Development Programme, New York, USA
Nationality: Burkinabe

Mr Eduardo Doryan
Vice President, The World Bank, Washington, DC USA
Nationality: Costa Rican

Professor Richard Feachem
Director, Institute of Global Health, San Francisco, USA
Nationality: British

Professor Robert W. Fogel
Professor of Economics, Center for Population Economics, The University of Chicago, Chicago, USA
Nationality: US

Professor Dean Jamison
Professor of Economics, Center for Pacific Rim Studies, University of California, Los Angeles, USA
Nationality: US

Ms Nora Lustig
Deputy Director, The World Development Report, The World Bank, and Director, Inter American Development Bank, Washington, DC, USA
Nationality: Argentine

Professor Anne Mills

Head, Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine, London, UK
Nationality: British

Mr Thorvald Moe
Deputy Secretary General, Organization for Economic Co-operation and Development, Paris, France
Nationality: Norwegian

Dr Supachai Panitchpakdi
Deputy Prime Minister & Minister of Commerce, Thailand, and incoming Director General, World Trade Organization
Nationality: Thai

Dr Takatoshi Kato
Adviser to the President, Bank of Tokyo-Mitsubishi Ltd. Tokyo, Japan
Nationality: Japanese

Dr Manmohan Singh
Member of Rajya Sabha, and former Minister of Finance, Government of India,
New Delhi, India
Nationality: Indian

Professor Laura Tyson
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Annex 3
COMMISSION ON MACROECONOMICS AND HEALTH

Summary of Key Events

The working groups' background studies and the Commission's report will ready by the end of 2001. Their recommendations will be based upon robust analyses and evidence, not just advocacy. For example, the Commission does not only argue that there should be more investment in health in low-income countries, but also addresses the issue where resources can be mobilized for this purpose.

Event	*Description*	*Date*	*Venue*
1st CMH meeting	Launch of CMH, finalisation of CMH TOR, naming of CMH members and WG co-chairs	16-18th January, 2000	WHO, Geneva, Switzerland
2nd CMH meeting	Discussion of WG topics and TOR	14-17th April, 2000	Indian Center for Research in International Economic Relations (ICRIER), New Delhi, India
Working groups' meetings	Working groups meet individually to discuss the work plans	April – June, 2000	Various venues
Special CMH meeting	For CMH members who were unable to attend 1st and 2nd CMH meetings	27th June, 2000	Sloan-Kettering Center, New York USA
3rd CMH meeting	Review progress of the working groups	8th-10th November, 2000	OECD, Paris, France
Bellagio meeting	Funded by the Rockefeller Foundation, this meeting will focus on health and economic growth and dialogue with African policy makers	12-16th February, 2001	Bellagio, Italy.
4th CMH meeting	Review progress of the working groups	6th –8th March, 2001	UN Economic Commission for Africa, Addis Ababa, Ethiopia
5th CMH meeting	Discussion of the initial drafts of all working group reports.	11-14 June 2001	Mexico
6th CMH	Discussion of final submissions by the six working groups	21-23 August	Geneva
Final CMH meeting	Finalization of the CMH report	December 2001	Venue to be announced
Dissemination		May 2002	World Health Assembly WHO Geneva, Switzerland