

Macroeconomics and Health

*Report of a Regional Consultation
SEARO, New Delhi, India, 18-19 August 2003*



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1. INTRODUCTION AND BACKGROUND

The Commission on Macroeconomics and Health, established in January 2000, presented its report in December 2001. The report confirmed, on the basis of evidence, the critical importance of public health for poverty reduction and economic growth. It stressed the benefits of substantially increased, strategic and well-managed investments in health outcomes, especially in low-income countries. The report demonstrated that increased investments in the health of vulnerable populations is feasible and affordable through a joint effort by low- and high-income nations. It indicated that a relatively small financial investment in health could yield substantial (six-fold) economic returns.

The Regional Consultation on Macroeconomics and Health was held in SEARO, New Delhi, from 18-19 August 2003 with the following objectives and outcomes:

Objectives	Outcomes
(1) To provide an overview of Macroeconomics and Health and its implications for the global, regional, and national strategies;	(1) National authorities and others concerned are updated on macroeconomics and health implications;
(2) To review progress on macroeconomics and health in the countries of the SEA Region, including challenges and opportunities;	(2) Enhanced appreciation of how to meet the challenges and maximize opportunities through sharing views and experiences;
(3) To review the draft Regional Macroeconomics and Health Framework;	(3) Consensus on Regional Macroeconomics and Health Framework;
(4) To identify actions at regional and national levels, including WHO support, to move forward, and	(4) Concrete actions to move forward related WHO support identifies, and
(5) To discuss countries' expectations from the Global Consultation (October 2003) and their contributions towards it.	(5) Enhancement of the importance and significance of the Global Consultation.

To achieve the above objectives, the following substantive items were on the **Agenda**:

- Overview of macroeconomics and health – implications for global, regional and national health agendas;
- Columbia University's support to MacroHealth;
- World Bank's views/perceptions on macroeconomics and health;
- Status reports of the countries of the SEA Region on macroeconomics and health;
- Review of draft Regional Macroeconomics and Health Framework;
- Briefing on Global Consultation on Macroeconomics and Health, Geneva, 28-30 October 2003, and
- Discussion on concrete actions for moving forward and WHO support therefor.

The meeting brought together representatives from the ministries of health, finance and planning from Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, and Thailand. Timor-Leste was represented by WR Timor-Leste. Other participants included WHO representatives from HQ, Regional and Country Offices and representatives from the World Bank, Columbia University, UNICEF and USAID. (See Annexes A and B for list of participants and Agenda.)

WHO-SEARO has been actively facilitating countries of the SEA Region to organize interministerial and intersectoral seminars and workshops, involving all stake holders, for disseminating the key findings and recommendations of the report of the Commission on Macroeconomics and Health (CMH Report). The Regional Office has established a Working Group, under the chairpersonship of the Deputy Regional Director, for making strategic policy decisions for implementing the framework of the CMH Report in the countries and providing required support to them.

The Regional Office convened a Regional Conference of Parliamentarians on the report of the CMH in December 2002 in Bangkok, Thailand. The CMH report was also on the agenda of the meeting of the Regional Director with WHO Country Representatives in April 2003. Earlier, the meetings of health secretaries and health ministers, held in April and September 2002 respectively, had the CMH report on their agendas.

In conjunction with the above meetings, the Regional Office finalized the *Country Guidelines for CMH Follow-up* and a related document, *Outline for a Strategic Framework and Investment Plan* and shared the same with all countries.

2. INAUGURAL SESSION

Dr Uton Muchtar Rafei, Regional Director, WHO-SEARO, inaugurated the Consultation. He highlighted the significant health gains achieved globally and in the Region, but underlined that these accomplishments had bypassed millions of the poor and underserved of the Region. He also stressed the challenges of modern epidemics such as AIDS, re-emergence of diseases such as TB and the increasing incidence of noncommunicable diseases, especially in the setting of poverty, illiteracy and uncontrolled population growth.

Dr Uton described the report of the Commission on Macroeconomics and Health as a “new global blueprint for poverty reduction and for stimulating growth in developing countries by scaling up investment in health”. He stressed the importance of increasing resources for health and scaling up essential health interventions in order to reach Millennium Development Goals. He underlined that this required partnerships among developing nations and developed countries and funding institutions.

Dr Uton went on to highlight the importance of national political commitment and a multisectoral effort to improve health and socioeconomic outcomes. In conclusion, the Regional Director summarized the objectives of the Consultation by stating, “*This Consultation will provide a good opportunity to take stock of our progress, recognize the constraints, realize the opportunities and identify actions for future progress.*” (See full-text of the inaugural address at Annex C.)

Dr Patricia Alailima, Director-General, Department of National Planning, Ministry of Finance, Government of Sri Lanka, was nominated as the Chairperson and Dr Gunawan Setiadi, Chief, Centre for Health Analysis and Development, Ministry of Health, Indonesia, as the Co-Chairperson of the Consultation. Dr B B Karki, Chief, Policy, Planning & International Cooperation Division, Ministry of Health, Nepal, and Mr Thinley Dorji, Planning Officer, Policy Planning Division, Ministry of Health, Bhutan were nominated Rapporteurs.

3. GIST OF THE PRESENTATIONS

3.1 Overview of Macroeconomics and Health – Implications for Global, Regional and National Health Agendas

Dr Sergio Spinaci, Executive Secretary, CMH Support Unit, WHO-HQ, presented an overview of Macroeconomics and Health in the global, regional and national arenas, as well as the role of WHO in supporting the process in the countries. He highlighted the growing trend towards integration of health in many global developments and funding initiatives, including Global Alliance on Vaccines and Immunization; Global Fund to fight AIDS, Tuberculosis and Malaria and PRSPs. He noted that health-related goals were also prominent among the Millennium Development Goals (MDGs).

He underlined that based on the recommendations of the Commission on Macroeconomics and Health, the Macroeconomics and Health Strategy (MHS) encompassed the following three main themes:

- (1) to improve health outcomes among the poor;
- (2) to strengthen commitment to increased financial investments in health, and
- (3) to minimize non-financial constraints to the efficient and equitable utilization of investments in health.

Dr Spinaci highlighted that the activities to move forward at the country level, with support from WHO, fell in the following six main areas: (1) alliance building and maintenance; (2) analyses of issues and options; (3) marketing and advocacy; (4) policies to achieve specific health outcomes; (5) development of health investment plans, and (6) monitoring for management.

3.2 Columbia University's support to MacroHealth

The role of Columbia University in supporting macroeconomics and health activities was presented by Ms Ann Rosenberg, Centre for Global Health and Economic Development, Columbia University. She noted that Columbia University's collaboration with WHO in macroeconomics and health activities could be traced back to the Commission on Macroeconomics and Health, which was chaired by Professor Jeffrey Sachs. Dr Sachs and his team at Columbia were instrumental in disseminating the recommendations of the CMH Report around the world. A proposal had been made to the Gates Foundation outlining WHO-led country support in the CMH follow-up work in collaboration with Columbia University.

It was noted that the Centre for Global Health and Economic Development (CGHED) at Columbia, in close collaboration with WHO country offices, provided

technical assistance in macroeconomics and public health for developing a strategic plan for addressing macroeconomics and health issues as per the specific conditions and needs of each country. The Columbia team also helped build national commitment and cross-ministerial relationships and facilitated development of a framework for country macroeconomics and health activities. CGHED had worked with several countries, including Ghana, Ethiopia, Rwanda, China, Kenya, and Sri Lanka, in supporting macroeconomics and health technical work.

3.3 World Bank's views/perceptions on Macroeconomics and Health

Dr V Selvaraju, Economist at the New Delhi office of the World Bank, shared World Bank's views and perceptions on macroeconomics and health. Dr Selvaraju discussed the convergence of Millennium Development Goals and other global initiatives with the objectives of macroeconomics and health. He emphasized that the focus of the World Bank was not only on increasing investments in the health sector but in all sectors which contributed to health development. With respect to India, he described a health investment strategy, which varied from state to state.

In conclusion, the importance of public-private partnerships in health delivery was underlined. While the private health sector was recognized as an important source of health services, there was an even larger unrecognized and unregulated private provider of high services, especially to the poor, which contributed to the inefficiency of the system in that the poor contributed a higher percentage of their income for health without commensurate health outcomes. Hence, the need for regulation and State's role in forging a purposive public-private partnership.

3.4 Status Reports of SEAR Countries on Macroeconomics and Health

Bangladesh

Over the last two decades, Bangladesh had made significant strides in improving the health of its citizens, including an increase in life expectancy from 48 years to 61 years and a decrease in total fertility rate from 6.3 to 3.3. There is, however, significant inequality in the health indicators and provision of health services between the rich and the poor. Bangladesh is currently participating in various poverty reduction and health promotion strategies, including i-PRSP and the Global Fund, in partnership with development partners and donors.

In this setting, Bangladesh plans to build on the available data and analyses and supplement the same with further work on pro-poor health planning and policy formulation. The government is committed to a pro-poor health strategy that targets

priority health objectives and the Essential Services Package (ESP) within its new Health, Nutrition and Population Sector Programme (HNPS) for 2003-2006.

The Ministry of Health and Family Welfare has taken several steps in response to the recommendations of the CMH report. These include:

- (1) Preparation of background paper on poverty reduction strategy;
- (2) High-level inter-ministerial global study tour of pro-poor intersectoral planning;
- (3) Dissemination workshop on CMH report;
- (4) Bangladesh Response to the Report of CMH in Geneva;
- (5) Formation of Bangladesh NCMH is under consideration, and
- (6) Commitment of the Finance Division is to increasing public health expenditures over the next three years.

Bangladesh believes that recommendations of the CMH Report can only be implemented when both the developed and developing countries can proceed hand-in-hand and international agencies like World Bank, IMF, WHO, WTO etc. help to build a smooth road map to achieve her goals.

Bhutan

Bhutan has adopted a development strategy based on the concept of gross national happiness. For the past four decades, health has been placed at the centre of the development agenda. Consequently, major investments were made in education and health. Bhutan has had significant public health successes, including the elimination of iodine and vitamin A deficiencies and the achievement of 80% water supply and sanitation coverage in both rural and urban areas.

Many of the recommendations of the CMH report were already part of the government's health and development agenda. Bhutan enjoys high –level political commitment to health and education and, in fact, more than 90% of the population now has access to basic health services.

There is no need for a National Commission on Macroeconomics and Health in Bhutan since the Planning Commission develops the five-year plans which provide detailed, costed, time-bound plans for prioritized action for improved health outcomes. Therefore, macroeconomics and health work in Bhutan will be handled by the Planning Commission. The percentage of the total plan allocated to the social sector is 25% and health care expenditures represent 4% of GDP.

There is already much intersectoral coordination and collaboration at the national, district and programme levels and multisectoral task forces are in place to deal with intersectoral issues.

India

In the background of India's noteworthy achievements in public health in the face of complex challenges, based on the recommendations of the CMH report, the Government of India has decided to establish a temporary National Commission for Macroeconomics and Health to assess the place of health in national economic development. The objectives of the NCMH are to assess the impact of increased investments in health on poverty reduction and economic development and to formulate a long-term strategy for scaling-up essential health interventions, with a focus on the poor.

The terms of reference for the NCMH and its composition are under active consideration. The next step in making the NCMH functional is the selection of a Task Force headed by a full-time chair, 1-2 economists, 1-2 public health experts and the Secretary of the Commission. The task force will be the technical and operational arm of the NCMH. It will conduct meetings and hire consultants and experts as necessary to carry forward the objectives of the NCMH.

Indonesia

The government of Indonesia will integrate its health and development initiatives under an overall macroeconomics and health policy framework. The objectives of this framework are:

- (1) To accelerate existing initiatives for pro-poor policy and funding commitments and forum of the Consultative Group of Indonesia (CGI) and the strategies such as PRSP;
- (2) To provide focused technical assistance to address systemic issues and integrate poverty issues into policy processes, and
- (3) To increase political commitment for health as a means of poverty reduction and economic development.

Within the above framework and in the setting of fiscal decentralization and present economic growth, Indonesia aims to improve the overall health status through policy development and corresponding financial commitments. Indonesia has made considerable strides in improving access to basic health services. Still, the

effect of ill health on productivity is enormous and its burden disproportionately affects the poor.

To achieve the health outcomes outlined in Healthy Indonesia 2010 and the Millennium Development Goals, the Consultative Group on Indonesia Health Working Group, the Government of Indonesia and the donor community have agreed on a shared plan of work with the following six objectives:

- (1) To reduce the financial vulnerability of the poor to major medical expenses;
- (2) To optimize the participation of private and NGO health providers in increasing health coverage;
- (3) To create a pro-poor institutional environment under decentralization;
- (4) To ensure allocation of sufficient financial resources to priority health programme;
- (5) To ensure access for the poor (tackling non-financial constraints) to health services, and
- (6) To ensure accountability by local government.

As Indonesia moves ahead within a macroeconomics framework, the focus will be on advocating an understanding about interlinkages between poverty and health and gaining commitment for increased investments in health, developing broad partnerships among government sectors, communities, universities, private sector, NGOs, and others, focusing resources on public goods; and supporting institutional and capacity development within decentralization. In the long-term, Indonesia recognizes the need for sustained political commitment to the process and increasing financial support, while also strengthening capacity to absorb funds and expand coverage and collecting data needed to monitor the process and evaluate health outcomes.

Maldives

Maldives has made significant progress in improving the health of its population as reflected by the declining infant under-five and maternal mortality rates. These public health successes have been achieved in an environment of economic growth and increasing social sector expenditures by the government. Health has remained a priority for the government even in the context of an economy relying solely on two volatile industries - fishing and tourism.

Maldives recognizes that even though significant health improvements have been made over the last three decades, there still remain disparities among income

groups and geographic areas. Also, Maldives has been facing new health threats, including noncommunicable diseases, HIV/AIDS and narcotic use, over the last few years.

The government of Maldives supports the findings of the CMH report. No specific activity, excepting a seminar on the CMH report, has been undertaken to initiate a macroeconomics and health process and no national CMH mechanism has been developed. The government is, however, dedicated to maintaining and increasing funding of the social sector through internal and external funds.

Myanmar

Health expenditure has been around 2% of the GDP in Myanmar over the last several years. Private household health expenditure has been increasing. The government has set up National Health Accounts to more accurately determine the actual public and private expenditures on health.

In its efforts to achieve MDGs, Myanmar has adopted various health development strategies, including Myanmar Health Vision 2030 and National Health Plans. Within the framework of these plans, Myanmar aims to increase health expenditure to 3.5% of GDP and to decrease IMR to 7.5. Myanmar also participates in various international health initiatives including GAVI, and the Global Fund.

In an effort to align the country's health policies and plans with the recommendations of the Commission on Macroeconomics and Health, Myanmar has taken several steps. In 2002, MOH formed a Working Group on CMH, headed by the Director-General of Health Planning, comprising 14 members from health and health-related departments. A seminar on the CMH Report was held in Myanmar in October 2002 and representatives were sent to the Regional Conference on Parliamentarians on the Report of the CMH in December 2002. The National Health Committee, headed by the Secretary of the State Peace and Development Council that has been in existence since 1989, will guide the macroeconomics and health process. A draft work plan has been developed for 2003-2004 outlining the work of the working group on CMH.

Nepal

Nepal has experienced improvements in national health outcomes, including expansion of essential health care to about 70% of the population. The access to health care facilities in the rural communities has significantly improved. However, geographical variations in health indicators persist, with a much larger percentage

of rural population having poorer health outcomes than the urban population. There are significant resource gaps for achieving MDGs.

In response to the recommendations of the CMH Report, a Sub-Commission on Macroeconomics and Health (SCMH), under the National Commission on Sustainable Development, has been formed. The Sub-Commission is chaired by the ministers of health and finance and comprises of representatives from the National Planning Commission, responsible for Health, Health Secretary (Member-Secretary of the Sub-Commission), Chief, Planning, Ministry of Health, and private sector. The Sub-commission has formed a sub-committee consisting of the Chief, Planning Division, Ministry of Health, and one representative each from the Ministry of Finance and the National Planning Commission. This subcommittee has identified key activities and areas of research, including advocacy workshops, dissemination of the CMH recommendations, epidemiological profile of disease among specific populations, study of private health expenditures, and development of a coordinated effort for health sector reform and poverty alleviation, needed to take the macroeconomics and health process forward.

Nepal has already been working on the Health Sector Reform for almost two years closely involving all the major development partners and the private sector. The government realizes the need for political stability as well as mobilization of internal and external funds and hopes to work through partnerships with external donors and other stakeholders to achieve its health and development goals.

Sri Lanka

Sri Lanka has achieved well known and significant successes in public health, including declining birth and death rates, increasing life expectancy to the levels of developed countries and low infant mortality rates and maternal mortality ratios. However, there are still significant disease challenges for Sri Lanka. Malaria, TB and mental illness are on the rise and malnutrition is not under control. Sri Lanka is also addressing current human resources issues such as a shortage of nurses and paramedics, as well as the commitment by the government to absorb all graduating doctors through 2009.

In light of the existing health issues, Sri Lanka is assessing whether it is investing enough in health. Compared to other countries in the Region and globally, Sri Lanka's national health expenditure, as a percentage of GDP (3.2%), is lower. Sri Lanka is currently evaluating various strategies to mobilize funding for health, including the feasibility of private insurance, community financing, earmarked taxes, and cost-containment strategies.

Sri Lanka has set up a NCMH under the Co-Chairmanship of its Health Minister and Deputy Minister of Finance. The NCMH, launched in December 2002, is operational. Recently, a Planning Committee was formed to carry on the regular working of the NCMH.

Thailand

In response to the CMH Report, the Ministry of Public Health, Thailand has set up a Working Group on Macroeconomics and Health, co-chaired by the Senior Advisor (Health Economics) and a top Officer of the Ministry of Public Health besides 15 experts from the health, economic, and financial sectors. The Working Group has developed a proposal to set up a National Commission on Macroeconomics and Health (NCMH). It has been proposed that the NCMH be jointly chaired by the Health and Finance Ministers.

The Macroeconomics and Health process for Thailand, as defined by the Working Group, consists of the following six steps:

- (1) Analysis of current situations and trends focusing on the poor and marginalized;
- (2) Diagnosis and prioritization of the main health problems;
- (3) Examination and evaluation of selected health interventions for cost-effectiveness and feasibility;
- (4) Development of a Strategic Framework and Investment Plan;
- (5) Advocacy for mobilizing political support for integration of health into poverty reduction strategies, and
- (6) Research on cost-effectiveness of identified interventions.

3.5 Review of Draft Regional Macroeconomics and Health Framework

Dr Abusaleh Shariff, Chief Economist and Head of the Human Development Division, National Council of Applied Economic Research, highlighted, at the outset, the following objectives of the Regional Macroeconomics and Health Framework:

- (1) To highlight that monetary and physical investment in primary care is essential to achieve health for all in the South-East Asia (SEA) Region;
- (2) To assess the health deficits covered by the high incidence of preventable diseases in the SEA Region;

- (3) To present a profile of health spending and its linkages with the state of health in the SEA Region;
- (4) To identify mechanism to enhance the health coverage of the poor in the SEA Region, and
- (5) To assess the effect of globalization and introduction of GATS and TRIPS on the availability of drugs and medicine.

Dr Shariff presented a summary of the links between macroeconomics and health in the South-East Asian Region. He went on to describe the well-supported vicious cycle of ill-health, decreased productivity, and poverty in developing countries.

It was noted that the direct and indirect costs associated with ill-health were manifold, starting from loss of personal income and national income, as well as under-investment in children's education and reduction in the sources of resource mobilization. Continuing disease episodes of the workers adversely affected the productivity of firms which, in turn, increased the cost of production. On the other hand, a healthy labour force improved the firm's capacity to compete in the international market.

It has been observed that health plays a multifaceted role in the economic development of a country. High and advanced qualities of health and education trigger economic development of any country, as healthy individuals are more productive and live longer to generate high levels of incomes and savings. Childhood sickness results in disability in adulthood and thus the quality of future stock of capital is adversely affected.

It was brought out that an analysis of MDGs in the SEA Region showed that while the performance of Bangladesh, Bhutan and Indonesia in reducing under-five mortality rates, was good, that of DPR Korea and Thailand was moderate. Myanmar's progress was not satisfactory. Sri Lanka showed good improvement in respect of every health indicator. Particularly noteworthy was the reversal of the order of 80% in the spread of HIV/AIDS in Thailand and Sri Lanka's high life expectancy.

Available data showed that prevailing per capita expenditure on health in the countries of the SEA Region was quite low. Public health expenditure should be directed towards diseases of the poor, i.e., on controlling communicable diseases, to be cost-effective. Providing clinical services was regarded as public good against curative care which was considered private good. The CMH report stated that an investment of US\$ 4 for public health and US\$ 8 for clinical services was capable of achieving a reduction of over 32 percent of all DALYs amounting to 226 million

years of DALYs saved in low income countries. Dr Shariff noted that US\$15 per capita spent on health would reduce the disease burden by 25% in developing countries. The achievement of greater investments in health required not only increases in public expenditure by poor countries, but also a public-private compact to consolidate resources and a rich and poor country compact for greater and more efficient external funding.

Public expenditure in health care was essential and so was public-private compact. Health as a public good was subject to market failure and the financial risk was covered by the government in times of crisis, especially to the poor. Promoting public-private compact was essential in insurance, production of drugs and medicine, and in training, as the public institutions in the countries of the SEA Region were weak, lacked resources and suffered from poor management and accountability. To improve the quality of services poor patients received, governments could contract to or purchase services from private sources for identified poor; or, provide funds for diseases that disproportionately affected the poor. Government could also enhance the quality regulations and professional ethics on informal providers, or encourage community financing.

High-income countries should help the low-income countries to pursue their health objectives. Millennium Development compact states that high priority needs of poor countries cannot wait until they develop economically, rather they need large injections of donor financing now and in the coming years. The Monterrey Consensus on the Millennium Declaration calls upon the developed countries to make concrete efforts towards the target of 0.7 per cent of their GNP as ODA to developing countries: this would amount to US\$165 billion a year, which is adequate to achieve the MDGs.

The era of globalization had added to the disease burden of the people in this Region: simultaneously, it had broadened the horizons of reducing it. Emphasis had been laid on R&D as a means to improve the quality of healthcare. The questions on WTO, TRIPS and GATS in improving availability of drugs in low income countries were not clear.

To increase the health access of the poor, the number of health centres and health posts in rural areas should be increased and outreach facilities improved. Providing adequate incentives and allowances to the health personnel might be another way to improve health services in the remote areas. The health access of the poor could also be improved by increasing the resources available for health facilities frequented by the poor. This could be done by decentralization, carefully planned user-fee and cost recovery mechanism, or by social health insurance schemes.

Since most of the governments in the SEA Region were likely to continue their role as a health provider, the strategy should continue identifying ways to improve the quality and efficiency of the government health services so that the poor could optimize their use of these services.

3.6 Group Work

The participants, in three groups, discussed in depth the following three underlying themes of the CMH Report:

- Group 1 – Better health of the poor
- Group 2 - Additional financial resources for health
- Group 3 - Tackling non-financial constraints

The group-wise recommendations are listed below:

Better health of the poor

Health policy and programmes for the poor

- (1) Countries should review their health policies to re-evaluate whether the poor are adequately covered: this may be relevant even if some countries have universal coverage under their health policy.
- (2) Health policies should be in line with MDGs.
- (3) Health policies should take Poverty Reduction Strategy Papers into account for greater synergy for health development.

Non-health public policy and programmes for the poor

- (1) Important non-health sectors to be included are: education, water/sanitation, environment, housing agriculture and energy.
 - Examples of multisectoral programmes in SEAR countries – Thailand and Sri Lanka- housing programme for the poor; Bangladesh – free education upto secondary level
- (2) Well-designed multisectoral programmes can address the non-health public policy issues.

Health status and needs of the poor

Data should be optimally disaggregated by geographical boundaries, sex and income. Data disaggregated by income level may be beyond the capacity of most countries.

Allocative efficiency of health resources

The following issues should be addressed: Equity; Human resources; Allocation of larger resources to primary care, and Targeting curative care of the poor.

Prioritization of health interventions

- (1) The disease burden and risk profile should be assessed first to prioritize interventions for diseases with the greatest burden, especially on the poor.
- (2) If such information is not available, WHO-suggested cost-effective interventions could be used.
- (3) Medical and non-medical interventions should be equally considered.

Reliable health indicators

The following health indicators should be used: MDGs, nutritional status, level of acceptance and rate of utilization of health services, increased contraceptive protection rate and epidemiology.

Additional financial resources for health

- (1) Evidence-based advocacy efforts should be undertaken through Parliamentary committees, civil society, NGOs, think tanks and education and media.
- (2) Strategies for mobilizing internal resources should include: (1) Improvement of internal efficiency and reduction of leakages; (2) need-based budgeting; (3) improvement of health insurance coverage; (4) reduction in debt burden, and (5) maintaining a community score card.
- (3) External resources can be maximized by treating external funds obtained as additional to the health budget and improving the cost effectiveness and impact of donor funds.

- (4) Different pro-poor mechanisms for health care would include general taxation; microcredit programmes; health cards, and universal health insurance.
- (5) Indicators of impact of increased health investment in the short-term would include immunization; number of health personnel per capita in undeserved areas, and waiting time at clinics, while achievement of MDGs would be a long-term indicator.

Tackling non-financial constraints

The following non-financial issues posed serious constraints: Lack of coordination; women not being at forefront; bureaucracy; religion; lack of commitment; misconception that investment in other sectors is more productive; geographical constraints; inaccessibility; unsustainability of human resources; long-term investment; political system and policy such as “health care provision for the poor”, and separate functions between public and private health services.

Possible solutions would include Community participation; integrating health in national development plan; setting and prioritizing targets; creating awareness among sectors other than health; issuing certificate to people below poverty line for free services; improving coordination; translating political commitment into action, and ensuring cost-effective implementation.

NCMH will help health get a high profile and visibility. Similar existing mechanisms could be used, provided that clear mandates and targets are set.

3.7 Global Consultation on Macroeconomics and Health, Geneva, 28-30 October 2003

Dr Sergio Spinaci presented the purpose and objectives of the Second Global Consultation on Macroeconomics and Health to be held in Geneva on 28-30 October 2003. The purpose of the consultation is to strengthen common action, with a focus on country activities, for the integration of health investments into national poverty reduction and development mechanisms for the achievement of the Millennium Development Goals.

The meeting will be attended by ministers/high-level participants from ministries of health, finance and planning from 30 countries and representatives from WHO, World Bank, 15-20 bilateral donors, the private sector and others.

The expected outcomes of the meeting would be:

- (1) Sharing of experiences by countries, based on progress and plans of action;
- (2) Framework for further implementation of macroeconomics and health strategy clarified;
- (3) Promotion of inter-linkages and joint bilateral planning initiatives, and
- (4) Facilitation of networking among committed decision-makers and analysts.

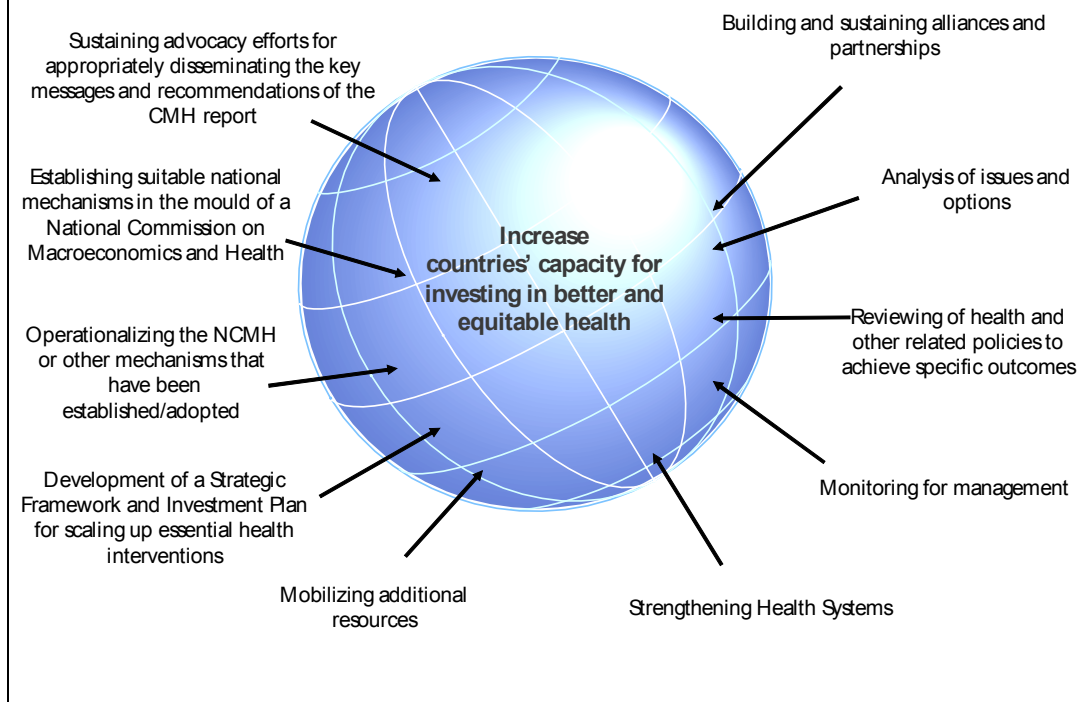
3.8 The Way Forward

At the instance of the chairperson, the discussion was initiated by Mr B S Lamba and Dr Sergio Spinaci. Mr Lamba focused on the need for sustaining advocacy efforts for appropriately disseminating the key messages and recommendations of the CMH report; establishing suitable national mechanisms in the mould of a National Commission on Macroeconomics and Health; operationalizing the NCMH or other mechanisms that have been established/adopted, and development of a Strategic Framework and Investment Plan for scaling up essential health interventions.

Dr Sergio Spinaci stressed the need for building and sustaining alliances and partnerships, analysis of issues and options, reviewing of health and other related policies to achieve specific outcomes, and monitoring for management.

The ensuing discussions are generally captured in Figure 1.

Figure 1. Moving Forward: Ten Actions



The detailed discussions referred to the presentations made at the meeting on the various agenda items, particularly to the status reports on macroeconomics and health in countries and recommendations by the working groups. The outcome of the discussions is also reflected in the following section on conclusions and recommendations.

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 Country-specific

- (1) The availability and potential of internal resources for health as also the requirement of external resources needs to be identified by each country.
- (2) The nature and magnitude of non-financial constraints also vary from country to country: therefore, mechanisms for tackling the same would also be country-specific.
- (3) Countries need to assess what concrete technical support is needed.

- (4) Political stability, integrity and commitment to human health and wellbeing are necessary.
- (5) The macroeconomics and health process will help countries to enhance the efficiency and efficacy of what they are already doing. MacroHealth is a process and not an additional initiative or project. A MacroHealth investment plan is qualitatively different from the health plans (five-year/annual) that have been going on in the countries. This, as elaborated later, represents the vision of the CMH whereunder investing in health will accelerate economic growth and alleviate poverty.

Recommendation

Countries must not be unnecessarily burdened with too many initiatives that require avoidable documentation and paperwork and impose an unnecessary burden on limited time and resources.

4.2 Development Partners and Donor Countries

Recommendation

Developed countries and development partners (e.g., World Bank and ADB) should be sensitized to the main findings and recommendations of the CMH report, to make them realize their respective roles in the process. Their support should be basically in harmony with national policies and priorities.

4.3 Advocacy

The crucial importance of well conceived, planned and well-targeted advocacy was well recognized.

The composition of CMH was dominated by economists and development experts rather than the health fraternity: their findings and messages should, therefore, carry conviction with the economists and financial experts manning the ministries of planning and finance and development partners such as IMF and the World Bank. Secondly, the Commission has quantified the requirement of financial resources for scaling up essential health interventions: to meet the requirement, it has called for a new compact between the rich and the poor countries. Thirdly, the Commission has emphasized the need for overcoming non-financial constraints. Importantly, it has asked for a national mechanism in the mould of a national Commission on Macroeconomics and Health to develop a long term MacroHealth Investment Plan for scaling up essential health interventions, which would not only

transform the health scenario, but also contribute to economic growth and impact on poverty.

Recommendations

- (1) Advocacy of the CMH report to policy-makers and other sectors needs to be reinforced and sustained in order to develop a national consensus on the centrality of health in overall development and achievement of greater synergy for health through complementary investments across sectors (e.g. water and sanitation, food and nutrition, education, women empowerment and environmental protection).
- (2) Advocacy should also counter the negative impressions regarding CMH report being old wine in a new bottle!

4.4 MacroHealth Investment Plan

The MacroHealth Investment Plan aims at scaling up essential health interventions by focusing on the identified 7-8 diseases and health conditions that primarily account for the national health deficit. It is fully financed through internal and external resources and also has in place mechanisms for tackling non-financial constraints in the way of health development. In sum, it would be built on the twin pillars of adequate resources and mechanisms to ensure that the same are efficiently and equitably utilized.

Insufficient resources and budgetary constraints are not the only problems: building fair, equitable and efficient health sectors is equally important. Furthermore, mechanisms for monitoring and evaluation should be strengthened to ensure that health resources are utilized as intended, so that both external and internal resource mobilization is sustained.

Long-term technical support in developing the MacroHealth investment plan is needed by countries. Technical support needs to focus on building national capacity by training local personnel and strengthening national institutions.

The MacroHealth Investment Plan is underpinned by three themes: how to achieve better health for the poor; financial resources required; and loosening of non-financial constraints.

Recommendations

- (1) Existing structures, procedures and mechanisms should be strengthened to develop a MacroHealth Investment Plan. Ongoing processes such as national health accounts, health surveys, national health management and information systems, etc. should be appropriately utilized for developing MacroHealth Investment Plans for scaling up essential health interventions.
- (2) The MacroHealth Investment Plan could be operationalized by a strengthened existing national mechanism or by establishing a temporary national commission on Macroeconomics and Health. (The guidelines for following up on the recommendations of the CMH at country level and an Outline of the Investment Plan are attached as Annexes D and E.)

4.5 Partnership

Admittedly, there are competing demands on the limited resources that the planning and finance ministries can disburse to various sectors including health. Yet, it is well established that the proportion of public funds being spent on health is grossly inadequate. If health is to contribute to economic growth and poverty reduction, larger resources will have to be invested in it.

Recommendations

- (1) The ministries of planning and finance are strategic partners to ensure that adequate plan outlays and budgetary allocations are provided for investment in health. These ministries should, therefore, be made fully aware of the productive nature of investment in health. Further, as poverty alleviation and economic growth are national goals, the contribution of investing in health to their achievement should be realized by one and all. Evidence in this respect should be appropriately disseminated.
- (2) Public-private partnerships need to be established in order to ensure that the reality of the increasing role of private sector in health is harnessed for the benefit of the people, including the poor.
- (3) Partnerships of poor and rich countries should be based upon the principle of mutual understanding, solidarity and respect, as the increasingly globalized world can no longer remain divided between an impoverished and diseased part on the one side and the rich and healthy on the other.
- (4) The macroeconomics and health process should be suitably integrated in the ongoing processes such as HIPCs, PRSP, SWAP, MDGs, evaluation of the cost-effectiveness of ongoing programmes and long/medium term health expenditure plans: these ongoing processes should be appropriately strengthened as required.

4.6 Role of WHO

Recommendations

WHO should provide leadership in taking macroeconomics and health forward at global, regional and national levels. Towards this end, it should:

- (1) Lead and support advocacy efforts at all levels;
- (2) Provide technical assistance wherever required to build national capacities for scaling up essential health interventions, and for monitoring and evaluation;
- (3) Mobilizing additional resources;
- (4) Prioritizing target diseases and health conditions and cost-effective interventions for addressing the same;
- (5) Enhancement of multisectoral support so that all sectors benefit from health and health depend on other sectors;
- (6) Coordination of external assistance (donors) to improve the efficiency of aid;
- (7) Support debt cancellation etc. at appropriate forums so that the released funds are also available for health;
- (8) Lobby with the development partners and bilateral donors that their conditional support does not put any impediments towards achieving MDGs and put additional burden on the poor and developing countries;
- (9) Research and development with a focus on the needs of the poor, and
- (10)** Documentation, dissemination, experience sharing and networking.

Annex 1

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Annex 2

AGENDA

- (1) Opening Session
- (2) Introductory Session
- (3) Overview of Macroeconomics and Health – implications for global, regional and national health agendas
- (4) Columbia University's support to MacroHealth
- (5) World Bank's views/perceptions on Macroeconomics and Health
- (6) SEAR countries' status report on Macroeconomics and Health
- (7) Review of draft Regional Macroeconomics and Health Framework
- (8) Briefing on Global Consultation on Macroeconomics and Health, Geneva, 28-30 October 2003
- (9) Discussion on concrete actions for moving forward and WHO support therefor
- (10) Summary of the Conclusions and Recommendations
- (11) Closing Session

Annex 3

TEXT OF OPENING REMARKS BY DR UTON MUCHTAR RAFEL, REGIONAL DIRECTOR, WHO, SEARO

Distinguished participants, colleagues, ladies and gentlemen,

It gives me great pleasure to welcome you all to this Regional Consultation on Macroeconomics and Health.

As you are aware, humanity has benefited significantly from the unprecedented health gains over the last 50 years. Globally, life expectancy has increased from less than 47 years during 1950-1955 to over 65 years in 2000. Our Region too has gained much from this revolution.

Unfortunately, these gains have bypassed millions of the poor and disadvantaged in our countries. At the same time, our Region is beset by the re-emergence of tuberculosis and malaria, and rising incidence of noncommunicable diseases. HIV/AIDS is threatening to offset our hard-won health and socioeconomic gains.

We have to address these health challenges in the face of widespread poverty and illiteracy, environmental degradation, and population explosion.

However, the CMH report will help us to make a breakthrough in health development, especially to benefit the poor.

The report of the Commission provides a new global blueprint for poverty reduction and for stimulating growth in developing countries by scaling up investment in health. This Report shows that disease is a drain on development, and that, investments in health are a concrete input into economic development. It constitutes a turning point in development. Health used to be the poor cousin in the family of development. It was mostly neglected in the past. The focus was on building infrastructure and creating favourable investment climates. Health can now claim its rightful central role - thanks to the strong evidence provided by the Commission.

The report of the Commission also provides the strategic framework for achieving the Millennium Development Goals pertaining to health.

The need to drastically increase resources to improve health is crucial to take this agenda forward. We have been witnessing an increasing commitment on the part of a number of key industrialized nations and funding institutions to step up development assistance dedicated to health. This can be seen in the growing health-investments by the European Union, pledges made by the United States and other rich countries, statements given by the President of the World Bank and pronouncements issued during meetings of G8.

In addition to increased investments in health, there is an urgent need to develop and strengthen health systems.

Dear Colleagues,

The agenda of this Consultation covers interesting aspects of the linkages between health and development. You will be informed of the need to tackle a handful of diseases and conditions responsible for the present health deficit. I would like to reiterate that increased resources and their efficient and effective management is indispensable. Similarly, political commitment is vital.

The need of the hour is to strengthen the partnership between the developing countries and the rich nations and development partners. Such a partnership is steadily, but surely, emerging. We need to accelerate the process. We cannot afford to miss the window of opportunity now presented by the Commission on Macroeconomics and Health.

Health development is a multisectoral effort. The ministries of health alone cannot achieve the set targets. It requires synergy and commitment on the part of all sectors and the entire civil society. It is for this reason that we have invited senior representatives of the Ministries of Finance and Planning to this Consultation. Close collaboration among the Ministries of Health, Finance and Planning is necessary. This will enhance the outlays for health. It will also synergize intersectoral planning and action for health development.

There will be substantial gaps in spite of increased investments made by least developed countries and the developing ones. These gaps need to be filled through development assistance. The Report of the Commission estimates that, by 2015, US\$ 66 billion will be needed. More than 50% of it will have to be covered by international development assistance. That is why support from World Bank, ADB, UNDP and others is essential. I would like to acknowledge their significant contributions. I also welcome their partnership in health development as an integral part of sustainable development.

I am aware that the Member Countries of the South-East Asia Region have taken a lead in disseminating the key findings and messages of the report of the

Commission. National Commissions on Macroeconomics and Health have been established in many countries. Other suitable mechanisms have been put in place to implement the Commission's recommendations on scaling up essential health interventions.

These developments are most welcome. I also recall that we had included the CMH report in the Seventh Meeting of the Health Secretaries and the 20th Meeting of the Health Ministers held last year. The Regional Conference of Parliamentarians also was entirely devoted to the report of the Commission.

I am sure that this Consultation will provide a good opportunity to take stock of our progress, recognize the constraints, realize the opportunities, and identify actions for further progress.

I trust that the deliberations at this Consultation will be fruitful and help us in strengthening our efforts to improve the health of our people.

Wishing you a pleasant and comfortable stay in Delhi, I thank you for your attention.

Annex 4

COUNTRY GUIDELINES FOR COMMISSION ON MACROECONOMICS AND HEALTH (CMH) FOLLOW-UP

Introduction

These guidelines seek to assist countries in the preparation of proposals for WHO assistance for CMH follow-up activities. These are indicative rather than prescriptive, and countries should feel free to adapt them to suit their specific needs and conditions.

The CMH follow-up could be conveniently divided into three parts:

- Part 1: Preparatory phase-6 months,
- Part 2: Planning phase (to commence after the establishment of the NCMH or equivalent)- 18 months,
- Part 3: Implementation phase (to be taken up after the approval of the investment plan) 5-10 years

The entire gamut of follow-up activities should be considered as one continuous exercise, and its division into three parts is only for the purpose of administrative convenience. The activities in different phases could, therefore, often overlap and be carried forward from one phase to another.

The present guidelines seek to cover only the first two parts and the development of guidelines for the third part would depend on the outcome of the strategic framework to be developed by the NCMH or its equivalent in the second phase.

Part 1

Objectives

- (1) Dissemination and advocacy of the key messages of the CMH.
- (2) Discussion and debate on CMH findings and recommendations in the context of the national situation.

- (3) Preparatory steps for the establishment of a national CMH or its equivalent.
- (4) Identification of critical gaps in information, data and analyses, particularly disaggregated data on the health status of the poor and backward areas.
- (5) Taking the principal development partners on board for a coordinated approach and support for carrying forward the CMH process.
- (6) Integration of health into poverty reduction strategies, such as PRSP, and SWAP etc., with a view to reposition health as a key component therein.

Activities

- (1) Organize seminars, workshops, media events and such other activities as may subserve the objectives.
- (2) Associate eminent personalities, such as CMH chair and Commissioners, and senior functionaries of WHO, World Bank etc., with 1 above, and to use their good offices for highlighting the importance of early establishment of NCMH, or its equivalent, to the political leadership.
- (3) Developing the terms of reference, composition, secretarial support and related details for the proposed national mechanism (NCMH or equivalent).
- (4) Establishment of an expert group to review the available information, data and analyses for identifying :
 - Areas for further studies, rapid surveys, operational research including compilation of disaggregated data on health status of the poor and vulnerable sections.
 - Areas requiring external technical support.
- (5) Identification of a lead agency from among the development partners for coordinating the approach to the strategic framework and investment plan.
- (6) Establishment of an inter-ministerial group along with development partners to review existing/evolving poverty reduction strategies and SWAPs in order to integrate health with the same and reposition its role in the light of CMH recommendations.

Expected Outcomes

- (1) Greater awareness of CMH findings and recommendations leading to higher visibility and understanding of health issues and their critical contribution to economic growth and poverty alleviation.

- (2) Constitution of a NCMH or equivalent, with appropriate support structure to make it effective and fully operational.
- (3) Critical gaps in data, information and analyses, including disaggregated data on health status of the poor, requiring further work and external technical support identified.
- (4) Lead agency among development partners identified and the process of consultation initiated.
- (5) Inter-ministerial group established, which reviews PRSP etc. and integrates health in these strategies along with appropriately repositioning its role.

Part 2

Objectives

- (1) To establish the national mechanism and to make it fully operational.
- (2) To take necessary steps to fill in the identified critical gaps in data, information and analyses, particularly those relating to the health status of the poor.
- (3) To develop a strategic framework, including an investment plan divided into appropriate phases having clear targets and milestones for scaling up essential health interventions, and improving `close to client` services in the light of the CMH report.
- (4) To develop synergies with other key health related sectors.
- (5) Objectives 1,2,5 and 6 listed in Part 1, would continue to be relevant.

Activities

- (1) To provide physical infrastructure, requisite staff and financial support for the national mechanism.
- (2) Commission studies etc to fill in identified critical gaps in information, data and analyses, particularly with a view to develop disaggregated data on the health status of the poor, keeping in view the external technical assistance to be provided through WHO.
- (3) The national mechanism to develop a strategic framework including an investment plan with the following components:

- Review of the national health priorities based on the latest epidemiological data and recommendations of the CMH.
- Identification of key areas requiring scaled up interventions in the light of the above, and working out realistic targets with clear timeframes.
- Identifying the main constraints to scaling up as per targets set above and developing a plan of action for overcoming them with cost estimates.
- Assessing the requirements of manpower for scaling up and providing for their training and deployment.
- Reviewing the performance of the health system and identifying main causes for sub-optimal performance.
- Recommending specific reforms to address the above causes.
- Reviewing the personnel management policies, including the incentive structure and management practices, to eliminate critical manpower shortages and to motivate the staff for better performance.
- Estimating realistically the requirement of financial resources for the above activities in both short and medium terms, and its break up into domestic and external components.
- Identifying possible sources for additional domestic resource mobilization, as well as donor agencies for the external component.
- Estimating the requirement of external assistance with broad identification of possible sources.
- Identifying non-financial constraints to scaling up essential health interventions along with specific recommendations for overcoming them.
- Estimation of the required health manpower to match scaled up interventions and reviewing the management and incentive structure for attracting, retaining and motivating health personnel for optimal performance.
- Intensive review of the existing health system to identify causes of sub-optimal performance, with particular reference to 'close to client' services and interventions relevant to the poor.
- Develop specific action plans to overcome the above deficiencies in a definite time frame.

- Specify mechanisms for close monitoring and review, and define milestones and targets for the same.
- Develop institutional mechanisms for inter-sectoral co-ordination between health and related sectors.

(4) Activities 1,2 5 and 6 of Part 1 to be continued as required.

Expected outcomes

- (1) National mechanism made fully functional.
- (2) Commissioned studies including work of external technical teams, if any completed and their inputs taken into account in the formulation of the strategic framework and investment plan.
- (3) Strategic framework, including investment plan, developed.
- (4) Enhanced political commitment and support for greater investment in health on the lines suggested by the CMH.
- (5) Intensive consultation among development partners leading to a coordinated approach and support for the strategic framework and investment plan.
- (6) The process of repositioning the role of health in poverty reduction strategies completed.

General

- (1) These guidelines do not indicate any financial outlays as they could vary widely between countries. The budget estimates in the proposals, therefore, need to be carefully developed on the basis of realistic costs.
- (2) The targets and milestones would need to be linked to budget outlays for regular monitoring of performance.
- (3) The sequencing of activities would need to be carefully planned to achieve the expected outcomes within the set timeframe.
- (4) The technical expertise available with the WHO country and regional offices can be drawn upon for assisting the preparation of the proposals for CMH follow-up and WHO support. Where necessary, the country offices could be suitably strengthened for this purpose.

Annex 5

STRATEGIC FRAMEWORK AND INVESTMENT PLAN AT COUNTRY LEVEL - AN OUTLINE

Introduction

The CMH report recommended setting up of national CMH or equivalent, in all LMICs, to prepare a strategic framework and investment plan (SFIP) to scale up essential health interventions to achieve the objectives laid out in the report. A separate document 'Country Guidelines' gives the details of the action to be taken to set up national mechanisms for this purpose. The objective of this document is to lay down the broad outlines of the process of the preparation of the SFIP, indicate its main ingredients, and identify the areas that could require external technical inputs. At the outset, it must be clarified, that considering the wide diversity of situations obtaining in different countries, no 'one size fits all' outline is either possible or even desirable. This document therefore seeks only to give the broad direction of the work expected from the national mechanisms (NMs) in the development of SFIP, and these bodies should feel free to modify their plan of action to suit individual needs and situations.

The Process

Situational Analysis

This would involve the following steps:

- A close study of the epidemiological data to develop reliable estimates of the burden of disease, and causes of morbidity and mortality. This work would need to particularly focus on the main causes of morbidity and mortality among the poor, gender differentials in health status, and the special problems faced by backward and remote regions. The availability of desegregated data for the above would be critical to this analysis.
- A similar examination of health and demographic indicators desegregated on the basis of income levels, gender and regions would be needed to assess the health status of different groups of population
- A study of demographic data to assess the age profile of the population along with projections for the medium and long term to estimate the

pace and scale of demographic transition would be essential. The distribution of the population among different income groups and particularly, the estimation of the population below the poverty line would be critical to the exercise. Besides, the identification of areas having a concentration of the absolute poor would be essential to develop specific health interventions for them.

- The epidemiological and demographic data as well as the health status indicators would need to be studied in a time series to identify the trends and make dependable projections.
- An intensive study of the health system to examine both its strengths and weaknesses, particularly in relation to the access and delivery of both public health and curative services to the poor. If already not done, some rapid sample surveys to identify the causes of poor access or inefficient delivery of interventions, as well as to understand the health seeking behaviour of different sections of the population would be necessary.
- A study of health manpower availability in relation to present and future requirements to identify the areas of shortage would be essential.
- Examination of the availability and pricing of essential drugs as well as the arrangements for standardisation and quality control should form an important component of this exercise.

Diagnosis of the main problems

The situational analysis would automatically throw up the main problems, for instance:

- The main causes of mortality and morbidity in different sections of population at present and the projections for the future in the light of the anticipated changes in the demographic and epidemiological profile.
- The main risk factors for the above causes and the effectiveness of the strategies for reducing them.
- The present arrangements for dealing with those causes and the main constraints in achieving better outcomes.
- The adequacy or otherwise of the current delivery systems, like primary health care along with referral arrangements, particularly for the poor, and the main reasons for their sub-optimal performance.
- The main reasons for gender differentials in health status, if any.
- The entire management and incentive structure for health manpower would need close examination to identify the reasons for shortages,

migration of qualified manpower, and low morale, to the extent applicable.

- The identification of the main weaknesses of the health system, whether due to poor leadership and management, inadequacy of financial resources, non-availability of essential drugs or non-availability of required manpower, or for any other reason.

The examination of options

- For each identified constraint to better outcomes, there would be many options for overcoming them. Each option needs to be closely scrutinised for its cost effectiveness, administrative feasibility and political acceptability in order to arrive at the best solution.
- On the basis of the situational analysis and the diagnoses of the main problems, it should be possible to identify the key interventions, which need substantial scaling up along with the improvement in the efficiency of their implementation. The main constraints to their scaling up, as well as to the improvement in their efficiency, would need to be identified, and all the options for overcoming them closely examined
- It would be of advantage to have projections developed for the important health indicators for three alternative scenarios:
 - On the basis of the programmes at the existing level,
 - Based on removal of all financial and non-financial constraints for optimal results.
 - Based on a realistic estimate of the feasible resources and system reform.

These exercises could greatly facilitate developing models which optimise benefits without losing sight of the realities.

- The evaluation of options would be greatly facilitated by studying the international experience in dealing with similar problems. The relevant literature, including the analyses of various options contained in the Working Group reports and papers commissioned by the CMH, would be made available by the MacroHealth Secretariat (MHS).

Financial resources

- An acknowledged cause for low level of performance and poor coverage is the very low level of public investment in health. The ideal situation would be to have access to national health accounts, which would not

only give complete information on fund flows to the health sector and their sources, but also on their actual deployment for various purposes. In its absence, a quick estimation over a period of time would need to be made by the study of the budget documents to discern the trends in both outlays and expenditures for various activities.

- An analysis of the both the potential for resource mobilisation and expenditure patterns would need to be undertaken. In respect of resource mobilisation, the possibility of reallocation of existing sources of revenue, or new or relatively undeveloped sources, like insurance, user fees or community financing making a contribution would need to be explored. Similarly, the expenditure patterns would need to be scrutinised to evaluate their rationale and justification in relation to the main causes of avoidable morbidity and mortality, as also the responsibility of the state to focus on the poor. This could result in some reallocation of resources to higher priority interventions.
- The potential for resource mobilisation would need to be carefully assessed keeping in view the political environment, the impact and political acceptability of measures like user fees and the availability of local leadership to manage community financing schemes.
- The feasibility of earmarking some levies on, say tobacco or alcohol, exclusively for some health related interventions would deserve consideration.
- The availability of additional resources for health as a result of debt relief or as a part of PRSP/SWAPs would need to be worked out in consultation with the concerned agencies.

External technical assistance

The requirement for external technical assistance would naturally vary widely between countries depending largely on the availability of local expertise in relevant disciplines. The external assistance could be sought for studies and analyses, as also for development of projects for scaling up of ongoing disease specific programmes. The request for external technical assistance should clearly specify the subject as well as the nature of assistance required. The external assistance could come from the Columbia University, which is actively participating in this exercise, or from the WHO, the World Bank or other development partners.

Preparation of the SFIP

- On the basis of the aforesaid examination and studies, the NMs should identify:

- The key interventions which need scaling up.
 - The policy and system changes needed for improving efficiency and managing the enhanced programme.
- The cost of the above interventions would need to be estimated carefully, and on the basis of a realistic assessment of the capacity for domestic resource mobilisation, the requirement of external financial assistance should be estimated. The need for external financial assistance would be directly related to the per capita income, the burden of disease, the macroeconomic situation, and the country's own capacity and willingness to mobilise additional resources for health.
 - The institutional mechanisms for better synergy between health and other related sectors.
 - The policies and mechanisms for better targeting the poor, the backward areas and the disadvantaged sections of society, including elimination of gender disparities.
 - Since an acknowledged significant contributor to the perpetuation of poverty is the burden of medical expenses on the poor, suitable arrangements would need to be considered for the protection of the poor from the medical costs of serious illness by mechanisms for risk pooling and insurance cover for hospitalisation expenses.
 - The role of the state as provider of healthcare would need to be reviewed in the light of available options. It would need to be considered whether the state could play the role of the financier leaving the actual provision of services to NGOs and private providers, wherever feasible, giving rise to new public-private partnerships.
 - The strategic framework should take into account the need for improving the quality of decision-making in the health ministries, and for that purpose capacity strengthening of the relevant organisations in disciplines, like epidemiology, health economics, health finance, and creating institutional mechanisms for utilisation of research outputs for evidence based policy making.

Main elements of SFIP

- (1) The document should comprehensively and intensively review the current health scenario to identify the main challenges and opportunities, discuss the strengths and weaknesses, and develop on the basis of available evidence, analyses and experience both domestic and international, a detailed strategy to greatly accelerate the progress towards better health outcomes.

- (2) This would contain policy and systems changes to eliminate/reduce misallocation of resources, improve monitoring and accountability, and create institutional mechanisms to raise the quality of decision-making by basing it on evidence and analyses.
- (3) An essential element would be community participation and ownership of health programmes and facilities and effective delegation of responsibility to local communities.
- (4) The focus of the strategy would be on the poor and the disadvantaged, including removing gender differentials in health status.
- (5) It would recognise the key role of related sectors like water supply, sanitation, nutrition and education and suggest institutional mechanisms for coordinated action.
- (6) The main emphasis would be on scaling up cost-effective interventions to control ailments, which account for a major burden of avoidable morbidity and mortality.
- (7) It would emphasise the key role of health in poverty alleviation strategies and try to build synergies with other related interventions.
- (8) It would contain an investment plan for 5-10 years, with clearly defined targets for faster progress towards better health outcomes and achievement of health related MDGs.
- (9) The investment plan should clearly exhibit a sincere effort to mobilise additional resources domestically on a sustained basis for the proposed activity along with attempts to reallocate resources from lower priority or poor performing programmes as well as cutting down wasteful expenditures. It would suggest systems and procedures to enhance transparency in procurement decisions to minimise the possibility of corruption and substandard supplies.
- (10) It would contain proposals for enhanced external support, indicating the likely sources based on the consultations with the development partners.
- (11) It would include in-built mechanisms for monitoring and periodic evaluation, preferably by an independent agency, on the basis of clearly defined targets and milestones.
- (12) An important element in the scaling up of the key interventions would be the availability of trained manpower. In planning the rapid expansion of key programmes, it needs to be ensured that the training requirements of health workers are adequately taken into account.

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- (13) The technical parameters of most interventions are well settled and their validity demonstrated globally. Yet the application of the interventions in different settings needs to be adjusted to local conditions and health systems. Particularly, the sustainability of the expanded programmes depends significantly on their integration with the primary healthcare system. While planning the scaling up of key interventions, this important factor should not be overlooked.