

The global update is intended as a reference guide to the key events and activities of the last six months in the health and development arena. If you would like to join the Institute mailing list and receive this update regularly, as well as notifications of our regular publications, e-mail Claudia Sambo: claudia.sambo@hlsp.org

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GLOBAL FINANCIAL CRISIS

The global financial crisis has overshadowed key events such as the UN High Level Event on the MDGs in September and the Doha Conference on Financing for Development in November/December. Earlier this year developing countries were hit by a food and fuel crisis; they now face a new challenge from the global financial downturn. Hard-won gains on the MDGs might be reversed, with millions sliding back into extreme poverty. It is estimated that 100 million people have already been driven into extreme poverty, and that each one percent drop in developing country growth could add another 20 million to this number.

The impacts on the most vulnerable could last beyond the immediate crisis (e.g. the effects on nutrition and schooling of children) so it is important to get the response right. Martin Ravallion examines **social policy options** for mitigating the impacts on the world's poorest families, what we know about what works, and what does not.

Bailing out the world's poorest, Martin Ravallion, October 2008 <http://econ.worldbank.org/>

It is difficult to generalise about the **effect on health** of the economic recession, a WHO Bulletin article notes using examples from Thailand, Korea, Mexico and other countries. Total health expenditure has tended to fall in countries affected by recession – but not always. Governments may decide to take new social protection measures. For example, during the 1997-98 crisis Korea expanded health care programmes as part of a broader policy to extend the safety net for disadvantaged groups; the crisis in Mexico led to health reform in 2003, and to the establishment of the *Seguro Popular* universal health insurance scheme.

Health amid a financial crisis: a complex diagnosis <http://www.who.int/bulletin/volumes/87/1/09-010109.pdf>

The fear that **aid budgets** will be cut – as happened after the recession in the early 1990s – has prompted several calls on States to keep their commitments for development and humanitarian assistance – by the UN, the OECD, the WHO Director General and others. DAC donors have responded positively to a call from the OECD Secretary-General and DAC Chair to join an 'Aid Pledge' that would confirm existing aid promises and avert cuts in budgets for development aid. The OECD will monitor performance of donors against this pledge. The World Bank in the meantime has set up a **new facility** to speed funds to the poorest countries. The money (\$2 billion initially) will support safety nets, infrastructure, education and health. <http://go.worldbank.org/WH4CK46A40>

Next steps

At Doha (see also page 2) it was agreed that the UN will hold a high level conference on the world financial and economic crisis and its impact on development, and that its modalities will be defined by March 2009 – a disappointment for those expecting a firm commitment to hold the conference in 2009.

Health and development: global update

Italy, which takes up the G8 presidency in January 2009, will host a 14-state summit in March to discuss the 'human dimension' of the world financial crisis. The meeting will bring together G8 leaders as well as those of six emerging nations.

The World Economic Forum Annual Meeting takes place in Davos-Klosters, Switzerland, from 28 January to 1 February 2009. The meeting will be focused on the current crisis and how to shape the post-crisis agenda, from economic reform to climate change. Kofi Annan will be one of the co-chairs. <http://www.weforum.org/en/index.htm>

Reform of the financial architecture

The international financial architecture, which has remained more or less what was decided at the Bretton Woods conference of 1944, has come under scrutiny in the context of the financial crisis, with insistent calls for reform. Two key events will take place in April 2009.

The 'Commission of Experts on Reforms of the International Monetary and Financial System' a UN task force chaired by Joseph Stiglitz, will report to UN General Assembly in April 2009. Background on the commission is at <http://www.un.org/ga/president/63/letters/doha281108.pdf>

Reform of the World Bank and International Monetary Fund will also be discussed at the next G-20 special summit in April 2009, which will be chaired by UK Prime Minister Gordon Brown. It follows the special G-20 financial summit held in Washington in November 2008, with the participation of the IMF, World Bank, the EU Presidency, and the Chairs of the International Monetary and Financial Committee and the Development Committee.

AID EFFECTIVENESS

Aid financing

Doha – Follow-up International Conference on Financing for Development

Commentators have described the conference held in Doha, Qatar, from 29 November to 2 December 2008, as a disappointing 'non-event'. The conference was due to review the Monterrey Consensus agreed in 2002. The outcome document (full text at <http://www.un.org/esa/ffd/>) has been analysed by Eurodad:

- **Aid volumes:** no progress. The long-standing commitment of Northern countries to reach the 0.7% of GDP for ODA is reaffirmed, but with only a mention of the need for 'rolling indicative timetables'.
- **Aid effectiveness:** no progress, despite the hope that some of the issues that could not be agreed in Accra (such as stronger language on the need to stop policy conditionality or fully untie aid) would be resolved in Doha.
- **Debt:** considered one of the most disappointing sections, and even a step back from Monterrey.
- **Capital flight, illicit flows and taxation:** some progress, but document weaker than expected. Disappointment that the document does not mention the outflows related to tax avoidance and evasion by multinational corporations, rather than just from corruption, money laundering and other criminal activities.

Eurodad analysis of the Doha UN Financing for Development Outcome Document:

<http://www.eurodad.org/whatsnew/articles.aspx?id=3218>

Aid levels

According to the latest figures published by the OECD in advance of Doha, aid continued to increase in 2007 (once exceptional debt relief is excluded), but only by 2% compared to 2006. This is much too slow if donors are to meet their commitments to increase aid by 2010, and in particular commitments made at the Gleneagles summit in 2005.

Figures show that five countries exceeded the UN target of 0.7% of GDP: Denmark, Luxembourg, the Netherlands, Norway and Sweden, and that aid is increasingly poverty-focused: total net ODA to the Least Developed Countries has nearly doubled in real terms over the last ten years, reaching \$32.5 billion in 2007 – about a third of total aid.

Aid targets slipping out of reach? OECD, November 2008

<http://www.oecd.org/dataoecd/47/25/41724314.pdf>

Capital flight

In another paper prepared for the Doha conference, ActionAid argues that although more and better aid remains necessary, another solution deserves attention: stopping the outflows. About as much money flows out of developing countries through illicit capital flight as comes in through aid and foreign direct investment. If this money were retained, much of it could be taxed and the revenue could support development. ActionAid reports that every day an estimated \$1.3-\$2.2 billion escapes through the back door – but that these figures tend to be masked by headlines about increasing aid and record foreign investment in developing countries.

Poor data, lack of transparency, unclear definitions and little official scrutiny make the study of such outflows difficult. With the exception of the World Bank's Stolen Asset Recovery Initiative, and the UN's World Economic Prospects report, most international bodies concerned with global finance and development have virtually abandoned attempts to try to measure or estimate flows of capital out of the developing world and tend to focus on inflows.

Hole in the pocket: why unpaid taxes are the missing link in development finance. ActionAid, November 2008. http://www.un-ngls.org/site/IMG/pdf/ActionAid_Hole_in_the_pocket.pdf

Aid for health

Health systems financing task force

The High Level Taskforce on Innovative International Financing for Health Systems held its inaugural meeting on 1 December 2008 in Doha. The Task Force will report to the Italian G8 summit in 2009, recommending a mix of innovative international financing mechanisms to mobilise the extra resources required to achieve the health MDGs.

Action for Global Health has produced a position paper, looking at existing 'innovative' financing mechanisms in the health sector. It recommends that the Task Force looks at existing structures instead of establishing another potentially duplicating mechanism. It also expresses the concern that innovative mechanisms could end up as a way for donors to avoid delivering on their commitments, rather than as a means to generate the necessary additional funds.

Examples of innovative financing schemes

Innovative in the way that finance is raised:

- **UNITAID**: financed primarily from the proceeds of a solidarity tax on airline tickets which ensures a steady flow of contributions; additional new source of funds.
- **IFFim** (International Finance Facility for Immunisation): financed primarily through emission of government bonds. Good for ensuring stability and predictability of funds, but concerns have been raised about what will happen in 2015 when donors will start to honour their legally-binding payment obligations, and on whether it is ethical to put the final burden on future generations.

Innovative in the way resources are used:

- **Advance Market Commitments (AMC)**: improving access to future treatments which are in development.
- **Affordable Medicines Facility for malaria (AMFm)**: focus on decreasing prices of effective medication to affordable levels.

(However, there are continued debates about whether, and how, these two mechanisms will create appropriate incentives):

Innovative financing mechanisms: lessons learnt from the health sector is at http://www.actionforglobalhealth.eu/files/publications/position_paper_on_innovative_financing_mechanisms; the Task Force website is at: <http://www.internationalhealthpartnership.net/taskforce.html>

Debt2Health initiative

In an agreement signed on the sidelines of the Doha conference, Germany has written off €40 million of Pakistan's debt on the condition that the country invests €20 million in domestic health programmes supported by the Global Fund to Fight AIDS, TB and Malaria.

Debt2Health was launched in 2007. This mechanism goes beyond traditional financing for development, by combining the well-known instrument of debt swaps with the tested and proven disbursement mechanisms of the Global Fund, through programmes fully owned by the recipient country.

Health and development: global update

Pakistan is the second country to benefit from the initiative. In 2007, Germany agreed to cancel €50 million of Indonesian debt, allowing half that amount to be invested by Indonesia in Global Fund-supported programmes. Press release: http://www.theglobalfund.org/en/pressreleases/?pr=pr_081130

High Level Forum on Aid Effectiveness

The 3rd High Level Forum (HLF) held in Accra, Ghana, in September 2008, has taken stock on progress and identified actions to deepen implementation of the Paris Declaration. Details on global progress can be found in the report *Effective aid by 2010 - what will it take?* <http://www.oecd.org/dataoecd/58/41/41202121.pdf>

Key issues and commitments from the HLF outcome document – the Accra Agenda for Action (AAA) – include:

- **Use of country systems:** partner country systems will be used to deliver aid as the first option, rather than donor systems. When donors do not use these systems, they commit to transparently stating the reasons for avoiding them. Donors share plans for use of country systems and provide staff guidance. Donors also re-affirm their commitment to provide 66% of aid as programme based approaches (PBAs). They will aim to channel 50% or more of government to government assistance through country fiduciary systems (including by increasing the percentage of assistance provided through PBAs).
- **Reducing fragmentation:** donors and partners will work on good practice principles on country-led division of labour, and elaborate plans for maximum coordination of development cooperation. Dialogue on international division of labour will start by June 2009.
- **Predictability:** donors will provide 3-5 year forward information on their planned aid to partner countries, and full and timely information on annual commitments and disbursements.
- **Untying aid:** donors commit to further untie their aid (but there is no specific target), and to promote the use of local and regional procurement.
- **Conditionality:** donors will switch from reliance on prescriptive conditions about how and when aid money is spent to conditions based on the developing country's own development objectives.

The next High Level Forum will take place in **Beijing in 2011**. The full text of the AAA is at <http://www.oecd.org/dataoecd/58/16/41202012.pdf>.

Sectoral applications of the Paris Declaration

Health

The paper prepared by the Task Team on Health as a Tracer Sector for the Accra meeting is essential reading for anyone working in the health sector. It argues that greater adherence to the Paris Declaration would accelerate current progress towards the MDGs still further. The achievements so far need to be extended to more countries and broadened to include a wider group of aid actors.

Analysis of trends over the last ten years shows aid for health is fragmented into large numbers of small projects; more than two-thirds of all commitments were for less than US\$500,000. Relatively little is provided directly into countries' budgets, and an important proportion of funds are channelled into multi-country and regional projects. This makes it harder for developing countries to influence what aid is provided for or how it is provided. In countries where solid national plans are emerging (e.g. Mali), aid for health is becoming more coordinated and coherent. But at the global level, there needs to be a better match between the needs of individual countries and the support they receive from donors to address them. In addition, some developing countries are becoming dependent on individual donors, and increasingly vulnerable to any changes in their behaviour.

The report is structured in four parts. *Part 1* examines trends in aid for health from a global perspective, focusing on financing trends, modalities and patterns that impact on the implementation of the Paris declaration. *Part 2* looks at practical country experience – including Rwanda, Uganda, Cambodia, Vietnam, Ethiopia, the Kyrgyz Republic, Mali and Tanzania. *Part 3* examines current issues and future directions, including new work on predictable financing, developments in mutual accountability through country compacts, and innovations in cross-cutting issues such as gender and human rights. *Part 4* summarises the key messages and recommendations following the structure and format of the Accra Agenda for Action.

Effective aid, better health. WHO, OECD, World Bank, September 2008
http://www.who.int/hdp/publications/effectiveaid_betterhealth_en.pdf

AIDS responses

A report by UNAIDS presents a brief synopsis on the progress made towards implementation at country level of the 'Three Ones' principles, Global Task Team, and other UNAIDS-sponsored initiatives that support the application of the Paris Declaration.

Lessons learnt from aid effectiveness in AIDS responses	
Country ownership	<p>Ownership through strong national systems and support from partners leads to effective and sustained national responses (as shown by Malawi, Mozambique and other countries).</p> <p>Meaningful engagement of civil society in the planning process and in implementation strengthens the results of national AIDS responses.</p>
Alignment	<p>More robust and prioritised National AIDS Frameworks with costed operational plans can facilitate greater donor alignment. But few of these plans are costed and prioritised, and donors are reluctant to base their support on them. Country capacity for developing robust plans remains severely limited: donors need to strengthen support for capacity initiatives.</p> <p>Examples of alignment are found mainly in countries with strong ownership and good strategies and systems. From the international partners' side, success factors often cited relate to personal attributes of country-level staff (e.g. interpersonal skills, strong vision on joint working, ability and willingness to "troubleshoot" at country level; recognition of the need for participatory team-building processes for change, shared responsibilities and common understanding; strong working relationships between the different representatives; and clear, unambiguous support from heads of agencies or partner country offices.)</p>
Harmonization	<p>The Technical Support Division of Labour has proved to be a successful model for improving coordination and harmonization of UN technical support to the AIDS response. There is widespread agreement that the Division of Labour is a major step forward, and broad support for the roles assigned to the UN agencies. The Division of Labour and the experience of country-level joint team working and programmes serve as a model for the 'One UN' and for other similar efforts.</p> <p>Initiatives to improve UN and international partner organizational cultures, systems and structures highlight the importance of incentives for joint working at country level. Change in behaviour is slow and needs to be speeded up. An example is the setting up of joint UN teams on AIDS, building on previous experience with UN theme groups and technical working groups.</p>
Managing for Results	<p>Joint Programme Reviews are essential in monitoring progress of country strategic plans towards nationally set Universal Access targets.</p>
Mutual Accountability	<p>Experience with accountability for joint working on AIDS at country level in the UN, indicates the importance of the joint team approach. Individual team members from UN agencies need to be formally assigned to the Joint Team, and their responsibility included in their job profiles as well as performance evaluations. Ensuring that agencies and individuals are accountable against indicators of harmonization and alignment is essential for progress.</p> <p>The Country Harmonization and Alignment Tool (CHAT) has shown that developing a shared comprehensive view on harmonization and alignment can support dialogue to address existing obstacles. Addressing identified unhelpful partner behaviour and improving weaknesses in the partnerships around national responses, for instance in a joint review process, will make the CHAT more than a diagnostic tool.</p>

Summarised from: *Enhancing results by applying the Paris Declaration at sector level: progress update and lessons learnt from aid effectiveness in AIDS responses*, UNAIDS, August 2008 (pp 6–27) http://data.unaids.org/pub/Report/2008/20081023_accraprogressupdate_en.pdf

International Health Partnership (IHP+)

A Ministerial Review of the IHP and related initiatives (IHP+) will take place early in February 2009. So far, two country Compacts have been signed, by Ethiopia in August 2008 and Mozambique in September 2008. The aim of Compacts is to improve coordination between donors and to unify donors behind country-led health plans. The process involves agreement on targets (drawn from the countries' own health plans and priorities), which are then set them down in a memorandum of understanding, or 'compact' with partners. The documents can be found at:

http://www.internationalhealthpartnership.net/ihp_plus_documents.html

IHP+ opportunities for global initiatives

A short paper prepared for the GAVI Alliance Board meeting in October 2008 elaborates on the potential implications of the IHP+ for the GAVI Alliance. It notes that currently GAVI support is not as harmonised or aligned as it could be; it relies upon separate proposal and reporting mechanisms, based on GAVI's business cycle. As happens with other global initiatives, this means, for example, that many efforts are spent on tailor-made reporting, draining resources which could be applied to delivering immunisations, or other health services. GAVI plans to pilot approaches to align more with country planning and budgeting through opportunities offered by IHP processes. This could improve GAVI's effectiveness (by ensuring support is not delivered in a parallel manner), efficiency (by ensuring that support is provided in line with country planning cycles and with other donors, not requiring extra proposals and reports) and transparency (by using common mechanisms that include other donors and development partners).

Strengthening the GAVI business model through the International Health Partnership +

<http://www.gavialliance.org/about/governance/reports/index.php> (go to 29 October 2008 reports)

Global Fund news

A number of initiatives affecting the Fund's architecture and business model are in various stages of development. The Fund is now an autonomous international institution with its own administrative systems, following the end, in December 2008, of the arrangement through which WHO provided a range of administrative and financial services to the Fund.

In November 2008, the Board endorsed a review of the Fund's architecture. The aim is to reduce the burden on countries when they interact with the Fund. In practice, this will mean replacing Rounds-based and Rolling Continuation Channel grants with a '**single stream of funding**' model.

The Board approved **Round 8** – the largest round in the history of the Fund, and well over twice the size of any previous round. The majority of resources (51%) go to malaria programmes. But there are issues of resource availability, and all recipients have been asked to reduce their budgets by 10%. Similarly, there are question marks about resources for **Round 9**, launched in October, and whose deadline for applications was subsequently postponed. The Board also endorsed the Fund's hosting of the **Affordable Medicines Facility for Malaria (AMFm)**, formerly known as the Global ACT Subsidy.

Five Year Evaluation. The reports for study area 1 (effectiveness and efficiency) and 2 (country performance and partnership) have been completed; study area 3 (on impact) is under way.

<http://www.theglobalfund.org/en/terg/>.

The Fund has also released 40 case studies into the work of **Country Coordinating Mechanisms**, covering eight thematic areas. The studies and a synthesis report are at

<http://www.theglobalfund.org/en/ccm/studies>

Other reports

Viet Nam: graduating from low-income to middle-income country status

Viet Nam will attain middle income country (MIC) status around 2010, assuming that the global and national economic situation permits it. As a result, some development partners have begun to plan their exit strategies, and the country's access to concessional lending from the International Development Association will be reduced. Much aid for health is guaranteed until at least 2012, but beyond 2013, health aid budgets are likely to decline significantly.

An HLSP study, commissioned by WHO in Viet Nam explores the implications of the transition to MIC for external support to health and HIV, presents scenarios for how funding patterns may change in the future, and makes recommendations for ensuring the sustainability of key public health programmes. *How external support for health and HIV will evolve as Viet Nam becomes a middle-income country* Javier Martinez, September 2008

http://www.un.org.vn/index.php?option=com_docman&task=doc_details&gid=77&Itemid=141

DAC report on multilateral aid

The multilateral aid system has become increasingly complex, with a growing number of agencies and instruments in operation. This has brought multilateral aid allocation processes and performance, and their ability to adjust to this century's development challenges, under scrutiny. Reforming the multilateral system is high on DAC member countries' agendas.

In 1940 only 15 international organisations were eligible to receive ODA; their number has risen to 263.

Just 5 of the 263 ODA-eligible agencies account for two-thirds of all multilateral funding, while over 100 agencies account for only 2% of the total.

A forthcoming report maps out the current landscape of multilateral aid – mainly from DAC member countries – including financial flows and multilateral aid strategies and policies. It also touches upon issues such as fragmentation, multilateral effectiveness, reform processes and partner country views.

2008 Report on Multilateral Aid. Forthcoming at <http://www.oecd.org/dac/>

UK news: Health is global

The new UK global health strategy, launched in September 2008, sets out how the UK Government intends to work with others to tackle many of the key challenges the world faces, and that have a link with the health, economic prosperity and security of its own citizens. The strategy outlines action points in five key areas: global health security; health systems; effectiveness of international institutions; trade; use and development of evidence and innovation. Implementing the strategy will require coherence and consistency in government policy and collaboration among key UK government departments, as well as coherent global partnerships on an unprecedented scale. The summary of departmental responsibilities and the action plan are included in a separate annex.

Health is global: a UK Government strategy 2008-13

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088702

MILLENNIUM DEVELOPMENT GOALS

High-level Event on the MDGs,

The MDGs summit took place in New York on 25 September 2008. At the event, overshadowed by the unfolding of the financial crisis, significant commitments and funding pledges were made; the full list is at: <http://www.un.org/millenniumgoals/2008highlevel/commitments.shtml>

With regard to the health goals, there were significant commitments to MDG 4 and 5. These include a joint statement from **WHO, UNFPA, UNICEF, and the World Bank**, who have developed a joint framework of responsibilities to harmonise approaches, based on each agency's comparative advantage, to ensure universal access to family planning, skilled attendance at birth, and basic and comprehensive emergency obstetric care.

http://www.who.int/mediacentre/news/statements/2008/who_unfpa_unicef_joint_country_support.pdf

Significant new funding commitments for malaria were also announced – coinciding with the launch of the **Global Malaria Action Plan** by Roll Back Malaria <http://www.rollbackmalaria.org/gmap/index.html>

MDG8

The progress report on MDG8 (to create a global partnership for development) focuses on the gaps between global commitments and their actual delivery. Future reports will focus on the 'coverage' and 'needs' gaps. The current report finds that delivery on commitments in the areas of trade, official development assistance (ODA), external debt, essential medicines and technology has been deficient and has fallen behind schedule. Overall, the gaps remain large:

- **Trade:** the largest implementation gap, due to failure to conclude the Doha round of negotiations.
- **ODA:** large gap. In 2007, total ODA fell short by over \$10 billion compared to what needed.
- **Debt sustainability:** great progress in debt cancellation, less in making progress sustainable.
- **Access to affordable essential drugs:** evidence suggests the gap is large; assessment is difficult because there is no quantitative target.
- **Access to new technologies:** progress in the mobile phone sector, but large gaps in other key technology; the digital divide between developed and developing countries is widening. No numerical targets to measure progress.

Delivering on the Global Partnerships for Achieving the Millennium Development. MDG Gap Task Force Report 2008 <http://www.who.int/medicines/mdg/MDG8EnglishWeb.pdf>

MDGs and national planning processes

Integrating the MDGs into national planning has not been straightforward. Even when governments are committed to the full MDG agenda, they still face choices about timing and resource priorities. A recent paper examines whether donor and developing country governments have taken 'ownership' of the MDGs, and whether they are being pursued through the countries' main policy instruments. It finds that most donor policy statements and poverty reduction strategies (PRSs) use MDGs as consensus objectives. Most PRSs also use MDGs as planning targets, but without adapting them to local conditions and priorities. In most cases where MDG targets are set, they are in line with the 2015 targets, but this is not necessarily a sign of 'ownership' because the targets are not accompanied by coherent action plans. If the MDGs are to be used as planning targets for resource allocation purposes, the international community could develop a more consistent and effective approach to the local incorporation of MDGs into national planning and priority setting.

Are the MDGs priority in development strategies and aid programmes? Only few are! UNDP International Poverty Centre, October 2008 <http://www.undp-povertycentre.org/pub/IPCWorkingPaper48.pdf>

PUBLIC HEALTH AND HEALTH SYSTEMS

The second half of 2008 has seen the release of three substantial reports: the World Health Report, complemented by the 'alternative' report by civil society, and the report of the Commission on Social Determinants of Health.

BBC Global Health Debate

If after reading those reports you are in need of something more lively, you may want to watch the debate which culminated *Survival*, the documentary series made for BBC World News. The panelists are Clare Short (former UK Secretary of State for International Development), Mukesh Kapila (International Federation of Red Cross and Red Crescent Societies), Francisco Songane (Partnership for Maternal, Newborn and Child Health) Tachi Yamada (Bill and Melinda Gates Foundation), and Julian Lob-Levyt (GAVI Alliance). The Global Health Debate (aired in November 2008) is at <http://www.survival.tv/>

World Health Report 2008

"Health systems seem to be drifting from one short-term priority to another, increasingly fragmented and without a clear sense of direction," says the new World Health Report 2008. Through this report, WHO hopes to start revive the debate on the effectiveness of primary health care (PHC) as a way of reorienting national health systems. So what is different today from 30 years ago, when the approach was officially launched?

1978: early attempts at implementing PHC	2008: current concerns of PHC reforms
Extended access to basic package of interventions/essential drugs for the rural poor	Transformation and regulation of existing health systems, aiming for universal access and social health protection
Focus on mother and child health	The health of everyone in the community
Improvement of hygiene, water and sanitation at village level	Promotion of healthier lifestyles and mitigation of effects of social and environmental hazards
Simple technology for volunteer, non-professional community health workers	Health workers facilitate access to and appropriate services and use of medicines
Participation through local health committees	Institutionalised participation of civil society in policy dialogue and accountability mechanisms
Government-funded and delivered services	Pluralistic health systems operating in globalised context
Managing growing scarcity and downsizing	Guiding increasing resources for health towards universal coverage
Bilateral aid and technical assistance (mainly delivered through project aid)	Global solidarity, better alignment with national health plans and joint learning
Antithesis of the hospital	Coordination of comprehensive response at all levels
Cheap and requiring only modest investment	Not cheap, but better value for money than alternatives

(Adapted from the World Health Report – the original table is on page xv of the report.)

WHO proposes four core principles to guide countries in decisions related to the health system (see figure 1):

1) Universal coverage: regardless of ability to pay. Health inequities produce decades of differences in life expectancies not only between countries but within countries. Inequities raise risks, especially of disease outbreaks, for all. Providing coverage to all is a financial challenge, but most systems now rely on out-of-pocket payments which is the least fair and effective method. WHO recommends financial pooling and pre-payment, such as insurance schemes, and reports that progress is possible. Brazil began working towards universal coverage in 1988 and now reaches 70% of its population.

2) People-centred services: Health systems can be reoriented to better respond to people's needs through delivery points embedded in communities. Iran's 17 000 'health houses' – staffed by a team that includes a general practitioner, midwife, nurse and several health technicians – have succeeded in providing access to health for over 90% of the rural population, and in a sharp drop in mortality over the last two decades, with life expectancy increasing to 71 years in 2006 from 63 years in 1990. Cuba's 'polyclinics' have helped give Cubans one of the longest life expectancies (78 years) of any developing country in the world. Brazil's Family Health Programme provides quality care to families in their homes, at clinics and in hospitals.

3) Healthy public policies: Much of what impacts health broadly lies outside the influence of the health sector, but generally little attention is generally paid to decisions made by ministries of trade, environment, education and others that have impact on health. WHO believes that a 'health in all policies' approach needs to be integrated throughout governments. This will require a shift in political calculations since some of the greatest health impacts can be achieved through early childhood development programmes and education of women, but the benefits are unlikely to be seen during a single politician's term or terms in office.

4) Leadership: Existing health systems will not naturally gravitate towards more fair, efficient and effective models, so leadership has to negotiate and steer. All components of society – including those not traditionally involved in health – have to be engaged, including civil society, the private sector, communities and the business sector.

Health leaders need to ensure that vulnerable groups have a platform to express their needs and that these pleas are heeded. Wise leadership requires knowledge of what works. Health systems research – often severely under funded – is needed to generate the best evidence.

Primary health care: now more than ever. The World Health Report 2008

<http://www.who.int/whr/2008/en/index.html>

The alternative World Health Report

The idea of an alternative World Health Report was developed by a number of civil society organisations and networks who felt that the WHO reports were inadequate, that there was no report that monitored the performance of global health institutions, and that the dominant discourse in public health policy also needed to be challenged by a more people-centred approach highlighting social justice. The first of such reports was published in 2005, and the second in October 2008, to coincide with the launch of the 'official' World Health Report.

This year the report is divided into three main sections, looking at a) the factors that undermine health systems, and what makes a 'good' health system; b) other determinants of health; and c) accountability, with an overview of the global health landscape and analysis of specific organisations and agencies (WHO, the Global Fund, the Gates Foundation, the World Bank, US, Canadian and Australian aid).

Global health watch 2: an alternative world health report. People's Health Movement, Medact and Global Equity Gauge Alliance, 2008 http://www.ghwatch.org/ghw2/ghw2_report.php

Social determinants of health

The Commission on Social Determinants of Health, set up in 2005 by former WHO Director-General Lee Jong-wook, reported in August 2008 making strong arguments for tackling inequities in health.

Fig. 1: The four primary health care goals

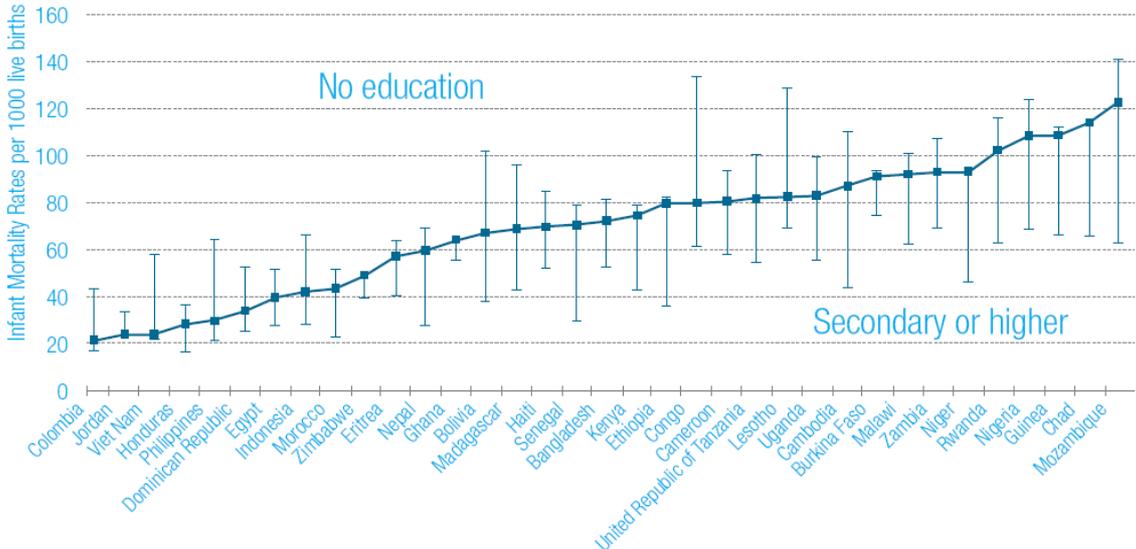


These are avoidable health inequalities which arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness, which are, in turn, shaped by political, social, and economic forces. For example, children born to women with no education have a clear survival disadvantage (Figure 2). The Commission states that “The poor health of the poor, and health inequities within and between countries are fundamentally structural in nature, caused by unequal distribution of power, income, goods, and services, globally and nationally... the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics”.

Inter-sectoral action to address health inequities is essential but problematic, due to lack of policy coherence at all levels, and weak incentives (e.g. budgets, financing instruments, institutional arrangements) to encourage and enable governments and other stakeholders (including the multilateral system) to address the social determinants of health. Aid for health is often narrowly limited to providing health care and rarely promotes inter-sectoral action.

The Commission agrees that the MDG framework provides the platform for improved coherence in the multilateral community. It recommends that both the MDG framework and other existing global development frameworks are adapted to enable health equity measurement and targets, based on the Commission’s proposed health equity framework. MOHs and WHO would have a leading role in stewardship to ensure that health inequities are measured, monitored and addressed using indicators from an internationally agreed health equity surveillance framework.

Fig. 2: Inequity in infant mortality rates between countries and within countries by mother’s education



The continuous dark line represents average infant mortality rates for countries; the end-points of the bars indicate the infant mortality rates for mothers with no education and for mothers with secondary or higher education. Source: WHO.

As a starting point, the Commission proposes three new **targets for 2040**:

- Target 1: Reduce by 10 years, between 2000 and 2040, the life expectancy at birth (LEB) gap between the one third of countries with the highest and the one third of countries with the lowest LEB levels, by levelling up countries with lower LEB.
- Target 2: Halve, between 2000 and 2040, adult mortality rates in all countries and in all social groups within countries.
- Target 3: Reduce by 90%, between 2000 and 2040, the under- 5 mortality rate in all countries and all social groups within countries, and reduce by 95%, between 2000 and 2040, the maternal mortality rate [sic] in all countries and all social groups within countries.

The proposal to create a health equity surveillance system is new. The Report’s health equity framework and monitoring indicators draw heavily upon, inter alia, UK experience. It is an important but challenging proposal, given the weak capacity for statistics and routine data required to inform even the ‘minimum’ proposed health equity framework. Such a system would help leverage influence

for investment in pro-poor approaches in health and other sectors, within the General Assembly, the UN, and at the national level, for equity sensitive PRSPs and sector strategies. Championing the collection and monitoring of stratified data on health outcomes and the social determinants of health across the UN system is an important role for WHO. However, the Report also makes clear that there are significant issues with respect to WHO capacity and ways of working.

Closing the gap in a generation: health equity through action on the social determinants of health

http://www.who.int/social_determinants/final_report/en/index.html

Executive summary: http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf

Other publications

Medicine prices

In developing countries, medicines are the largest family expenditure after food, as they are largely purchased through out-of-pocket payments. Inefficiencies in purchasing and distribution systems, and inappropriately high mark-ups make medicines unaffordable for large sections of the population and a major burden on government budgets.

A study by WHO and Health Action International, based on 45 surveys in 36 countries, analyses prices and availability for a basket of 15 core medicines. Findings include:

- Public sector availability of medicines was consistently low, with an average public-sector availability of only 38% across surveyed countries.
- Availability in the private sector was consistently higher, but in many countries it was also low, which together with high private sector prices could further hinder access.
- Low procurement prices do not always translate into low prices for patients. In some countries, similar prices are seen in public and private facilities, suggesting that some public facilities are using medicine sales to subsidise other parts of the health care system. A similar practice was observed in the NGO sector in Senegal, Kenya, and Uganda, where revenue from medicine sales is being used to cover general operating expenses.
- Medicines for chronic disease are largely unaffordable in many countries. Patients might be able to afford treatment for acute illness as a one-time expenditure, but they may not be able to afford continuous treatment.
- Add-ons by wholesalers, distributors and retailers, plus government taxes and duties can double the public-sector price of medicine. In the private sector, wholesale mark-ups ranged from 2% to 380%, and retail mark-ups ranged from 10% to 552%.

Medicine prices, availability, and affordability in 36 developing and middle-income countries. Lancet, Early Online Publication, 1 December 2008 http://www.who.int/medicines/news/MedPrices_Word2.pdf

Have reports on immunisation coverage been inflated?

In a much debated article published in the Lancet, researchers from the Institute for Health Metrics and Evaluation analyse discrepancies between vaccination rates from two sources: those obtained officially from governments and those estimated directly and unofficially from household surveys from the same countries. The concern raised is that financial incentives lead to over-reporting. The researchers find that the crude coverage of DTP3 immunisation based on surveys is not as high as that suggested by the countries' official reports or the WHO and UNICEF estimates, and that improvements in coverage have been far more gradual than suggested by officially reported, or the WHO and UNICEF estimates. They suggest that target-oriented universal childhood immunisation campaigns and performance-based payments used by GAVI contributed (in some – but not all countries) to the differences in coverage data, by giving incentives for over-reporting of the performance indicator.

There is consensus that GAVI and all performance-based programmes must be a lot more careful about measurement, but disagreement about interpretation of the new study. A commentary in the Lancet looks at the reasons behind the discrepancies between household surveys and administrative data, and argues that the pattern of discrepancies is not strong enough to suggest that over-reporting did happen. Other similar commentaries can be found in the Global Health Policy blog by Ruth Levine and Mead Over (<http://blogs.cgdev.org/globalhealth>).

Tracking progress towards universal childhood immunisation and the impact of global initiatives.

Stephen Lim et al, Lancet, vol. 372 (9655), pp. 2031–2046, 13 December 2008

Global initiatives in universal childhood immunisation David M Bishai Lancet, vol. 372 (9655), pp. 2004–2005, 13 Dec. 2008 (<http://www.thelancet.com>, registration required).

HIV and AIDS

Universal testing and treatment – WHO modelling study

Universal voluntary HIV testing once a year of all people older than 15 years, combined with immediate antiretroviral therapy (irrespective of clinical stage or CD4 count), could have a major effect on generalised epidemics – reducing new HIV cases by 95% within 10 years, and laying the conditions for elimination. These findings, published in the *Lancet* in November 2008, come from a modelling exercise developed by a group of HIV specialists in WHO, and do not affect WHO guidance. Rather, the researchers aim to stimulate discussion and research on how to better tackle the AIDS epidemic and the role of antiretroviral drugs.

The researchers note the restrictions of their model, and the implementation challenges that their theoretical strategy would pose – financing and health systems challenges, side effects and drug resistance, and the protection of individual rights. However, their preliminary cost calculations also suggest that there could be substantial yearly and long-term cost savings between now and 2050, by which time HIV infections could be reduced to very low and manageable amounts. They argue that the cost of implementing this strategy for the test-case country is much less than what UNAIDS projected for universal access to prevention, care, and treatment.

WHO will convene a meeting early next year bringing together ethicists, funders, human rights advocates, clinicians, prevention experts and AIDS programme managers to discuss this and other issues related to the wider use of antiretroviral therapy for HIV prevention.

Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model RM Granich et al, *Lancet*, Early Online Publication, 26 November 2008 [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(08\)61697-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61697-9/fulltext)
For a discussion of the findings see also *Could HIV treatment stop the epidemic?* HATIP #123, 27 November 2008 <http://www.aidsmap.com/cms1282662.asp>

HIV: know your epidemic, act on its politics

It is common sense to think that HIV policies are subject to the influence of interests and political incentives, but interaction among these factors remains under-explored. According to an editorial published in December 2008 in the *Journal of the Royal Society of Medicine*, politics, ideology and ignorance have, in many countries, proved far more influential on HIV policy than evidence and best practice guidance.

The authors, Michel Sidibé, UNAIDS, Kent Buse, UNAIDS and Clare Dickinson, HLSP Institute, argue that ‘knowing your epidemic’ is in itself not enough to act upon it. The failure to appreciate the political dimensions of HIV can frustrate efforts to promote and implement evidence-informed policy.

The editorial is based on an analysis of literature on policy change in low and middle income countries published by the HLSP Institute in October 2008. The findings aimed to help advocates and policy-makers take more strategic decisions about future policies and their implementation.

HIV: know your epidemic, act on its politics. Kent Buse, Clare Dickinson, and Michel Sidibé: *Journal of the Royal Society of Medicine* 101(12): 572–573 (subscription only).

Understanding the politics of national HIV policies: the roles of institutions, interests and ideas. Clare Dickinson, Kent Buse, October 2008 <http://www.hlspinstitute.org/projects/?mode=type&id=234626>

www.hlspinstitute.org

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The HLSP institute aims to inform debate and policy on global health issues and national health systems in order to reduce inequalities in health