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Macroeconomics and Health: Progress and Future Initiatives

Report of the Regional Consultation
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Annexes

1. Introduction and background

Since the report of the Commission on Macroeconomics and Health (CMH) presented to the Director- General of the World Health Organization on 20 December 2001, several countries in the WHO South-East Asia Region have established National Commissions on Macroeconomics and Health, whereas some others have entrusted work in the area to existing national mechanisms. The CMH report highlighted evidence to stress the importance of universal access to essential health services, prioritizing the needs of the poor, mobilizing more funds for public health, increasing the effectiveness of health investment, expanding domestic budgetary spending on health, greater commitment of funds and assistance from donor countries, and multi-lateral organizations including WTO, the World Bank and WHO and private sector involvement in expanding drug availability.

A Regional consultation on Macroeconomics and Health was held in the WHO Regional Office for South-East Asia, New Delhi, in August 2003. In 2004, WHO/SEARO developed a Regional Macroeconomics and Health Framework which focused on the low health expenditure, much of it financed by out-of-pocket expenditure by individuals in the Region and the inaccessibility of primary and essential curative services for the poor and those located in remote areas. It recommended that governments in the Region should take bold action on resource mobilization and allocation.

In SEAR, the CMH report has been discussed at various other forums as well, including in meetings of Health Secretaries, Health Ministers and Parliamentarians. CMH has also been on the agenda of the Regional Director's meeting with WHO Representatives. Most recently, the subject was discussed at a meeting of the Asian Civil Society Conference on Macroeconomics and Health, held in Colombo, Sri Lanka in April 2004. The meeting discussed the role and contribution that civil society organizations can make in furthering the objectives of CMH.

WHO/SEARO has been actively promoting the CMH's work in countries of the Region. Many activities in the field of Macroeconomics and Health, particularly focusing on pro-poor interventions, have been

undertaken at country level, relating to planning, research and dissemination, involving different stakeholders.

This Regional Consultation to Review Progress on Macroeconomics and Health was held in Colombo, Sri Lanka, on 08-09 June 2006, to evaluate the progress made by Member countries in the Region in the implementation of Macroeconomics and Health (MH) activities and identify challenges, opportunities and actions needed both at the country level and jointly for scaling up the activities in the field of MH, including implementing pro-poor interventions.

The consultation was organized with the following objectives:

1.1 General objectives

To assess achievement related to the Member countries' work on Macroeconomics and Health, particularly its impact on national health budget and pro-poor health services development and developing the future agenda, including a plan of action and institutionalization.

1.2 Specific objectives

(1) To review and discuss progress on macroeconomics and health in SEAR countries, particularly on national health budget and pro-poor health development, including challenges and opportunities.

(2) Share country experiences with the Regional Macroeconomics and Health Framework.

(3) To identify strategy and actions at Regional and national levels, including support expected of the Regional Office.

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

(a) Global overview of Macroeconomics and Health.

(b) Regional update: Scaling Up Investment and Improving Equity in Health. A note on macroeconomics and health work the in South-East Asia Region.

(c) Regional Overview: Macroeconomics and health in the context of the new development agenda and evolving global health architecture.

(d) Status reports of the countries of the SEA Region on macroeconomics and health.

(e) Discussion on concrete actions for moving forward and WHO support in this regard.

The consultation brought together representatives from the ministries of health, finance and/or planning from Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. The other participants included concerned staff from WHO Headquarters, the Regional Office and country offices.

2. Inaugural session

The inaugural session began with the lighting of the traditional oil lamp by Mr Ranjith Maligaspe, Secretary, Ministry of Health and Nutrition, Sri Lanka, and other distinguished guests.

In her introductory remarks, Dr Sultana Khanum, Director, Health Systems Development, WHO/SEARO, highlighted the role of the CMH and the promises, declarations and recommendations that had emanated from this major report. Referring to the three health-related goals in the MDGs, she said the year 2005 had not seen much change with regard to the poor and their welfare. There was still insufficient investment in health and there was a need for increasing the efficiency of health systems. She said, it was time to revisit these issues, to take stock of the events post-CMH, to draw on the experiences of the countries with National Commissions for Macroeconomics and Health (NCMH) and to face future challenges. She stressed the need for making the CMH recommendations a reality for the poor, by focusing on identifying the poor, prioritizing their health issues and determining the strategies and means of financing the cost of such measures.

Mr Ranjith Maligaspe, Secretary of Health, Sri Lanka, welcomed the participants on behalf of the Ministry of Health and expressed the Minister of Health's regret at his inability to participate at the event. Mr Maligaspe stressed that this was a very timely meeting in the context of the vicious

cycle between poor health and poverty that was well recognized. He was happy that the Ministry of Health had initiated many activities relating to Macroeconomics and Health.

The address by Dr Samlee Pilanbangchang, Regional Director, WHO South-East Asia, was delivered by Dr Agostino Borra, WR Sri Lanka.

The Regional Director said that based on the CMH report, the WHO Regional Office for South-East Asia had developed its own framework in 2004. Five countries in the Region had set up National Commissions on Macroeconomics and Health. The CMH had been responsible for a paradigm shift that centred on macroeconomics and health activities with breaking the vicious cycle of poor health and poverty as its core objective. Evidence of this vicious cycle was particularly clear in the area of HIV/AIDS. Likewise, the CMH focused on causes of death and the link between poverty and diseases such as malaria, tuberculosis, childhood illnesses and malnutrition.

Increasing health spending was crucial in achieving the CMH objectives as well as the MDGs. The consultation provided an opportunity to identify practical strategic activities and recommended actions and best practices to promote equitable and efficient health care provision for the poor, the Regional Director added.

Mr Ranjith Maligaspe, Secretary of Health, Sri Lanka, was nominated as the Chairperson and Dr Amala de Silva, Senior Lecturer in Economics, University of Colombo was nominated as the Rapporteur for the consultation.

3. Gist of the presentations

3.1 Global CMH update

Mr Louis J. Currat, Senior Economist and Adviser, WHO-HQs, the main conclusions of the CMH report that had been endorsed by the World Health Assembly in 2002. He also referred to the importance of health investment in contributing to economic development and fighting poverty and the establishment of National Commissions of Macroeconomics and Health in Member countries to spearhead this action.

He underlined that substantial efforts had been made in a number of countries despite limited resources, while 46 countries had undertaken national follow-ups during 2001-2006, 18 countries had established a NCMH or similar body. Many countries were also confronting the economic challenges of reaching the MDGs and planning the best possible use of resources through increasing health investment, focusing on the health of the poor and by increasing efficiency and effectiveness of foreign aid in health. These initiatives were running concurrently with the macroeconomics and health activities of these countries.

Mr Currat emphasized the need for taking different cross-cuts at the macroeconomics and health work in countries in order to identify the achievement of objectives, for instance the matching of NCMH work with different operational levels (international/national/local/community, MOH/inter-sectoral). He posed a number of questions with regard to NCMH work in the future: what minimum levels of human and financial resources were needed by NCMHs to achieve their priority tasks? How would they finance the cost of their secretariats? Would the formulation of a common framework for comparison of achievements be a useful strategy? And what form could collaboration between the work of the NCMHs and the work of the Commission on Social Determinants of Health take? All these would be crucial issues in harnessing national macroeconomics and health activities in the achievement of the CMH objectives, he added.

3.2 Regional CMH update

Dr Gunawan Setiadi, STP-Health Systems, WHO/SEARO, presented an overview of work in countries in the Region on macroeconomics and health. He highlighted that the links between ill health and poverty were well known. Unfortunately, this understanding had not been translated into an increase in the national health budget. Most countries in the Region were spending less than 5% of GDP and/or less than the US$ 35 per capita per year as recommended by the CMH. He underlined that domestic as well as external resources should be mobilized to increase investment in health. First, Governments who contribute less than 50% of the total health expenditure should increase their contribution through, for example, increasing and earmarking “sin” tax, shifting non-health untargeted subsidies to health subsidies targeted to poor households. Second, governments who already contribute more than 50% should find ways to increase peoples’ contribution through pre-payment mechanisms.

He also highlighted that lack of financial resources for health was only half the problem. The limited and inadequate funding for health was often spent on providing services with limited public health significance and was often urban non-poor-biased. He underlined some lessons learnt, to be considered in institutionalizing the CMH work in the future. These included: (a) Country initiative, design and leadership in follow-up activities, (b) high-level global, Regional and national advocacy (c) an intensive multi-stakeholders collaboration, and (d) support for analytical exercises. The lessons learnt from the global, Regional and country experiences on CMH work, both successes and failures, needed to be converted into explicit knowledge and disseminated to all WHO Member countries.

3.3. Macroeconomics and health in the context of the new development agenda and evolving global health architecture

Dr Alaka Singh. Short-term Professional, Health Care Financing, Department of Health Systems Development, WHO/SEARO, focussed on the new development agenda. She highlighted three aspects that would be important for the macroeconomics and health effort: first, the need for frameworks that support strategic planning for health in development; secondly, the necessity for increased commitment to international development financing and, finally, the need for initiatives to improve effectiveness of external development assistance.

The new global health architecture involved bringing all the aspects together in Global Health Partnerships (GHPs). These networks could be for financing, research and development, technical assistance/service support and advocacy. The prominent GHPs included the Global Alliance for Vaccines and Immunization, the Vaccine Fund (1999), the first International Finance Facility set up for immunization (IFFIm) and the Global Fund to fight AIDS, TB and Malaria.

Dr Singh also focused on the key implications for the macroeconomics and health effort of four cross-cutting issues. Firstly, with regard to financing modalities, she highlighted the fact that the traditional emphasis on programme support had now switched to budget support. Secondly, with regard to the importance of the predictability of funds she drew attention to

the fact that this issue had been emphasized by both recipient countries and donors in recent meetings. Thirdly, under the heading of additionality of funds, she drew attention to the fact that the flow of foreign funds could have an adverse impact on health systems in situations where internal resources were reduced in response to the external aid flows and where a large influx of funding led to the skewing of national plans and strategies to one area resulting in the neglect of other priority areas. Finally, under the issue of absorptive capacity she highlighted the capacity constraints in effectively utilizing the expanded funding available to countries.

3.4. Status reports of SEAR countries on macroeconomics and health

Bangladesh

The Government of Bangladesh has undertaken a number of CMH-related activities with the Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MOHFW) and has chosen the HEU to serve as the CMH focal point. Among the activities undertaken under the CMH umbrella were: the preparation of a background paper on the poverty reduction strategy in 2001 (which carried the basic CMH idea that per capita health expenditure must increase steadily over time)l a high level inter-ministerial (involving senior officials from the MOHFW, MOF, University of Dhaka and the country office of DFID) global study tour in 2002; a dissemination workshop on the CMH report involving 107 participants from other ministries, NGOs, development partners and civil society, Bangladesh's response to the report of the CMH in Geneva in 2002 where a commitment was made to implement the key CMH recommendations; attendance by three senior officials from the Ministry of Planning, MOHFW and MOF at the regional consultation on Macroeconomics and Health in New Delhi in 2003 and the formation of the Bangladesh NCMH in 2004. This was termed the National Commission on Macroeconomics and Health-Poverty Reduction Strategy (NCMH-PRS) in recognition of its conjoint nature with PRS activities. As the NCMH-PRS Secretariat the HEU set up a documentation centre dedicated to Macroeconomics, Health and Poverty issues.

Under the NCMH-PRS Secretariat, the following activities were undertaken during 2004-2005: the constitution of the NCMH-PRS - a number of dissemination workshops to sensitize government officials

regarding the CMH report; workshops on community insurance, research studies; five working groups to draw up recommendations and a technical committee to finalize national-scale recommendations to be presented in 2006 to the NCMH-PRS at the end of its stipulated time period. In addition, activities related with the NCMH-PRS documentation centre at the HEU and training programmes by the HEU for government officials on health planning, health economics, financing and budgeting continue. Plans have also been drawn up for CMH follow-up activities post-2006, mainly in the form of planning exercises and research studies.

Bhutan

There was no need perceived in Bhutan to establish another organization to cater to the social needs of the country as there was a Planning Commission Secretariat mandated to plan and allocate resources for the Five Year Plans. The line ministries nominate a senior level official as the Planning Commission Member with the Chairmanship being held by the Head of Government, the Prime Minister. The Commission provides a clear framework for development of the five year plan and it is operationalized through annual budgets approved by the National Assembly.

Bhutan currently faces no financial constraints in the provision of health. It allocates around 10% of its plan funding to the health sector. The total health care expenditure is around 4% of GDP. The average monthly household expenditure on medical and health services was around 49 Ngultrum in 2000. Donors play a significant role in supporting the health sector. However the government has been taking steps to bear the major share of this cost. The emphasis in health care provision has been on close-to-client services, as recommended by the CMH. More than 90% now have access to basic health services, particularly through the 160 Basic Health Units, 461 Outreach Clinics and the 1500 village health workers. The indigenous system has been promoted and integrated and complements to the modern health care system.

India

The Government of India established a NCMH in March 2004 with the overall objective of formulating a long-term plan for improving health sector investments to scale up essential interventions. The NCMH comprised of the Finance Minister and the Health Minister as the Co-chairs, the

Secretaries of Finance, the Planning Commission, Health, Family Welfare and AYUSH, the Chief Economic Adviser of the MOF, DGHS, economists, public health experts, researchers and clinicians, a few representatives form selected NGOs, country heads of the World Bank and WHO, the Chairman of the Sub-Commission and a Secretary to the Commission. A sub-commission was also set up which comprised of a public health expert as the chair, 3-4 economists and two other public health experts with a senior MOH official acting as its Secretary.

Among the findings and conclusions presented in the final report were: a set of priority health conditions identified through comprehensive causal analysis; the need for three levels of packages of health interventions including preventive, promotive and curative services,: emphasis on scaling up PHC; the extent of the resource gap for scaling up interventions in health and health related sectors; management problems in the health sector, poor linking of evidence with intervention strategies at present; insufficient capacity for managing and planning resources and implementation at all levels; incomplete devolution of authority between the central government, states and districts and disjointed and unregulated use of the private sector in public health care.

The involvement with the NCMH in India reflects the government's ongoing commitment to increase health investment towards strengthening disease control and primary health care. This was important as an advocacy mechanism for promoting health sector investments and planning. The NCMH activities also encourage extensive research and comprehensive costing relating to the delivery of essential health interventions. The NCMH like the National Rural Health Mission (NRHM) emphasized PHC, community-based services, the integration of traditional medicine (AYUSH) and focused on the need for upgrading basic health interventions and increased flexibility in funding mechanisms in response to changing local needs. In addition, the findings relating to costing of essential interventions and the scaling up of infrastructure provided the basis for the NRHM initiative. The NCMH report provided a systematic and comprehensive synthesis of information to policy makers that supported an increase in funding of public health in India. Its importance also lay in its recognition that scaling up of essential health interventions necessitates a multi-disciplinary and inter-sectoral approach

Indonesia

The percentage of the health budget in the national budget has been rising over time but is relatively small and the proportion of loans to the national health budget has been declining over time. There has, however, been an increase in the budgetary allocation for poverty alleviation programmes. Poverty is a major problem in Indonesia, made worse by the inequity in the different Regions as reflected by the percentage of the poor in each Region. The Human Poverty Index, and its components, has not improved significantly over the period 2001-2005.

Utilization of health services varies significantly with income level, as reflected in a comparison of utilization of different health facilities by the bottom and top 20% of the population. A pro-poor health package has been envisaged that mainly involves minimizing treatment costs for the poor but includes focusing on priority disease that affect the poor, non-personal public health services, access and quality of services, resource reallocation and participation and consultation. Health insurance for the poor is managed on a non-profit basis to cover comprehensive health services.

Maldives

Government approval has been obtained to establish a national commission on Macroeconomics and Health. However, at present the planning framework is addressing the issues of macroeconomics and health, health financing and pro-poor intervention.

The key health indicators have improved significantly and the country is confident of achieving the MDGs. Maldives has been able to eradicate malaria and has most communicable diseases under control. Health expenditure as a percentage of GDP is 6.5%. Government health expenditure as a percentage of the national budget is 9%. However, tertiary care is mainly paid for with out-of-pocket payments. These out-of-pocket payments result in about 40% cost recovery of the national budget. Health insurance schemes are in place with welfare payments to the poor and medical allowances for government employees taking care of the welfare aspect. However, the issue of financing the poor through a proper social security mechanism still needs to be addressed as does the need for a proper legal framework.

Myanmar

The National Working Group on CMH was formed in 2002 chaired by the Director-General of Health Planning in the MOH and including 14 senior officers from health and health-related ministries. The key issues addressed by the CMH included the MDGs, increasing total health expenditure as a percentage of GDP and improving close-to-client health care provision.

In Myanmar both state and household health expenditure has been rising significantly over time. Total health expenditure as a percentage of GDP has however remained static at around 2.2%. It is expected that government health expenditure will rise to 3.5% of GDP in 2030 compared to the current level of 0.5%. Private health expenditure is also expected to increase in this period. External assistance received by the country is very low compared to other developing countries. In 2000, it was $ 2.2 per capita in comparison to $ 3 in South Asia and $ 6.7 in all developing countries. However, efforts are being made to expand donor funding through participation in processes such as GAVI, GFATM, GDF for TB etc. Per capita total health expenditure in purchasing power terms is $ 24. The government appreciates the CMH report and is working in line with the CMH concept. It is willing to cooperate with the international community in following up on CMH recommendations.

Nepal

A NCMH was established in Nepal in 2003 and a working committee was established to prepare an action plan. A National Coordination Committee and a Task Force were also established. Activities involved a situation analysis; a planning workshop; outlining investment plans for the poorer districts and studies. A pro-poor District and Health investment Planning Group has been formed but is yet to be formally approved.

Nepal now has pro-poor policies and strategies in place but the implementation has been slow partly due to political instability, inadequacy of institutional and managerial capacity and weaknesses in inter-sectoral coordination. Recent political changes, however, are expected to create an enabling environment. The challenges faced by the health system are cutting down out-of-pocket expenses; introducing and sustaining alternative health care financing schemes, developing an equity-based resource

formula to ensure sufficient funding of underdeveloped and rural areas and introducing a health social security scheme to cover the poor and vulnerable segments of society.

Sri Lanka

Sri Lanka initiated the first NCMH in the Region in November 2002. This NCMH was established by a decision of the National Health Council, chaired by the Prime Minister. A planning committee chaired by the Secretary, Health, was appointed under the NCMH to design Macroeconomics and Health (MH) activities. A secretariat was set up in the MOH to coordinate and implement MH decisions. Two working groups, one on financing and the other on budgeting were set up under the NCMH including some Members drawn from the NCMH as well as others involved in health activities and research. Research was a major activity undertaken by the NCMH. In addition to the two working groups, six studies were commissioned after calling for proposals through a newspaper advertisement.

While considering the future, the factors contributing to success in the context of the NCMH in Sri Lanka were highlighted. These included the traditional importance given to the health sector and health development, the commitment of the Minister and Secretary of Health following their participation in the First Global consultation, commitment of the Co-chair of the NCMH, technical assistance and financial support by WHO Hqs and the key role played by the WHO Sri Lanka Office and WHO/SEARO, concurrent efforts in the development of strategic plans with technical assistance and financial support from JICA and the World Bank, regular meetings of the planning committee, regular meetings of the working groups and a dedicated secretariat. The major factors which could affect the functioning of the NCMH are a shortage of human resources at the secretariat level, the need to develop a more systematic identification of priority actions to be undertaken under NCMH, as well as their synergies, interdependence and optimal time frame and the need to identify detailed indicators of performance at the central, provincial and district levels to monitor outcomes.

It is important to understand that the NCMH activities in the country occur alongside a number of other planning and development exercises: among the recent initiatives are: finalizing of the Health Master Plan with

phase 2 involving evidence-based management studies and the World Bank Health Sector Development Project 2004-2009. Government policy too, as reflected in Mahinda Chintanaya, (President's manifesto), stresses the importance of "preserving the free health service and safeguarding the right of every citizen to the benefits thereunder. In this regard immediate action will be taken to enhance these services both qualitatively and quantitatively through increased budgetary provisions". It is indeed heartening in the context of the CMH objective of increasing the percentage of GDP spent on health to note that the Sri Lankan percentage of health expenditure to GDP has increased, with the medium-term budget estimates of the Ministry of Health recording government health expenditure as a percentage of GDP to be 1.8% in 2004 with the estimate for 2008 being 2.3%.

Thailand

The Ministry of Public Health (MoPH) in Thailand responded to the CMH report in September 2002 by setting up a Working Group on Macroeconomics and Health (WGMH) comprising of high level health administrators, health planners, health economists, representatives from the National Economics and Social Development Board, the Ministry of Finance and the WHO Representative's Office in Thailand with the Bureau of Policy and strategy of the MoPH as its secretariat. The proposed NCMH has the Ministers of Health and Finance as its co-chairmen with a planning committee steering the WGMH with its Secretariat in the MOPH. Two major units under the NCMH will be infrastructure and human resources for health and health insurance.

A investment project was adopted by the government in 2005 that involves investing almost 94 billion baht in the health sector during the next four years. Of this, 36 billion Baht will be for medical excellence centres, 4.8 billion Baht for the production of vaccines and 3 billion Baht for human resources with most of the budget being allocated to upgrade health infrastructure in rural areas such as Regional and provincial hospitals and health centres (48 billion Baht). The expected outcomes and impact of this major health investment in Thailand include universal access to quality close-to-client care, reduction of health risks and disease burden, long healthy life expectancy (currently 71.57 years) and income generation through becoming the 'medical hub of Asia'.

Timor-Leste

Timor-Leste has not yet established a Commission on Macroeconomics and Health but the National Development Plan and Health Policy Framework are very much in line with the CMH objectives. However, there is a Sector Investment Programme (SIP) to implement the national health policy of the MOH that is used in negotiating with donors. Under the health policy framework it has already determined that 60% of the health budget is for primary care services and 40% for hospital care.

In 2004, the GDP growth rate was 1.8% and was expected to rise to around 5% in 2005 and 2006. Per capita income is low with non-oil per capita income estimated at $ 365. A survey in 2001 indicated that about 40% of the population was below the poverty line. This is likely to have increased slightly in recent years. The estimated oil revenue per year for 2006-2009 is $ 250 mn (around 40% of GDP). The government has established a petroleum fund to ensure stable revenue and economic stability. Current levels of public and private investments are insufficient to ensure sustained growth so it is planned to raise public investment to around $ 150 mn by 2010. This high investment is expected to generate growth rates of around 7% to 9%. With the expected rise in investment, institutional and capacity scaling up becomes imperative. The government has identified development of a more comprehensive budget framework for revenue generation and expenditure management as crucial. Currently, the MOH share of Consolidated Fund for East Timor stands at 14% (around 11.6% of overall government budget) excluding the bulk of funding for drugs and medical supplies which are financed under the Trust Fund for East Timor.

4. Group work

Group presentations

Group 1

This group conducted the discussion under five main headings: how to sustain NCMH activities; what the link between NCMH and the Commission on Social Determinants of Health (CSDH) should be; what the link should be with donors; what Regional activities should be proposed for the future; and how WHO could assist in macroeconomics and health work.

With regard to sustaining the NCMH it was felt that the current situation where some countries had established secretariats while others used existing mechanisms into which they had integrated NCMH activities rather than setting up separate commissions was satisfactory, since most countries had been carrying out work in line with the CMH objectives in the last few years. However, the group felt that it was important to harness resources, both human and financial, for such activities. In particular, there was a need for coordination of activities and, in some countries in the Region, there was a shortage of trained staff. On the financial front there was a resource gap, both in terms of carrying out the priority activities in the macroeconomics and health arena, particularly in the context of stepping up pro-poor interventions and in funding the work of the secretariat as well.

The work of the Commission on Social Determinants of Health was considered to cover many aspects, including many of the issues covered by the NCMH, with an even greater inter-sectoral emphasis. It was felt that there would be an overlap with much of the NCMH work and that, rather than setting up a parallel unit, the solution lay in integrating the activities of the NCMH and CSDH.

The group felt that it was crucial in the context of the macroeconomics and health activities to create some linkages with donors, and that this activity could be carried out at a Regional level as well as at country level, since some countries do not have provision for the MOH to directly approach the donors but need such consultations to take place through the Ministry of Finance or the Planning Commission. The harmonization/alignment of donor funding with country-specific requirements was stressed. Such a meeting with donors could pursue the possibility of multi-lateral funding for NCMH activities and also assist in reducing the administrative barriers to funding programmes.

While discussing Regional activities the group felt that there should be a focal point in SEARO to organize, facilitate and coordinate macroeconomics and health activities, and facilitate exchange programmes between countries in the Region that would support the sharing of experiences and information. It could also facilitate donor coordination meetings. SEARO could also play a major role in technical backstopping and financial support. WHO country offices could also assist in mobilizing resources and providing technical support. It would also be important to devise key performance indicators that would allow WHO/SEARO and the countries themselves to monitor the achievement of CMH objectives.

Group 2

The key issue in carrying out macroeconomics and health activities with a pro-poor bias is the definition of poor, which should include all categories of persons who are unable to access health. The issue of evaluation of performance was discussed. The development of a mechanism to evaluate policy to assess whether it had a pro-poor focus was important. In this regard it was proposed that a core team from within the Region examine the issue of poverty and health indicators.

The main challenges identified by the group in carrying out the macroeconomics and health activities in the Region were the resource gap in terms of both financial and human resources. In the context of financial resources it noted that there was a need to reduce out-of-pocket expenses, to harmonize inter- and intra-sectoral allocations, to ensure the timely flow of funds from foreign donors and to have equity and evidence-based allocations. With regard to human resources, capacity building and technical training were crucial. It was also important to develop infrastructure in line with meeting the MDGs goals and strengthening basic health infrastructure. Inter-sectoral linkages need to be strengthened as well.

The group focused on the options with regard to creating linkages between NCMH and other development planning processes in the country. In this regard, the need to internalize the macroeconomic process into the policy making process was emphasized. It was also important for WHO to continue to support the respective focal points to converge MDGs, CSDH and Poverty Reduction Strategy Programme activities to achieve the objectives of NCMH.

In order to institutionalize this process of investing in health with a pro-poor bias it was important to devise a framework for the allocation/distribution of resources and mechanisms by which global funds could be shared in their entirety between the different priority objectives. The need for transparency in the allocation and accounting of donor funds was also stressed by the group.

Group 3

This group assessed the aspects in which Commission on Macroeconomics and Health has assisted in developing the health systems of countries in line with the developmental and pro-poor intervention objectives. In this context

it considered the financing and non-financing gaps faced by such countries, the latter relating to the difficulties in effective service delivery to rural and remote areas, shortages of human resources and drug availability and affordability. In considering the CMH activities the group concluded that many countries were working with a pro-poor focus, and that the CMH report had strengthened advocacy and policy initiatives, increased awareness, garnered policy support and commitment and, in the case of some countries, had actually led to an increase in government funding of the health sector.

With regard to sustaining this work in the future it was considered important for the NCMH to incorporate work relating to achieving the MDGs since they too cover related and major health issues such as poverty, MCH, disease control and stress on partnerships as well. It was also important to link with other initiatives such as CSDH and to have regular monitoring and evaluation by a focal unit.

Desirable future action with regard to financing would include greater mobilization of funds both internally and externally, allocation/distribution according to CMH objectives and the efficient and effective utilization of funds. In the area of human resources there was a need to focus on both internal and external migration of health workers as well as on capacity building at country level. Drug availability was a major issue with both access to essential drugs and price controls and affordability being crucial factors.

In focusing on how WHO can assist the process of taking the work of the CMH forward it was suggested that WHO could provide a Regional focal unit and organize a Regional Macroeconomics and Health Network. It could also organize a donor meeting at the Regional level. Providing technical support to Member countries for capacity building was another aspect in which WHO could strengthen the NCMH process. The development of a website which is continually updated regarding the NCMH activities in the countries would help in the dissemination of information and in building links between groups working on macroeconomics and health issues.

5. Conclusions and recommendations

5.1 Country-specific suggestions

(1) Countries need to continue and further strengthen work on macroeconomics and health through institutionalizing those

efforts and strengthening and expanding existing national mechanisms.

(2) Several key features of national work on macroeconomics and health, such as: (a) country initiative, design and leadership in undertaking the endeavour, (b) high level advocacy, and (c) intensive multi-stakeholders collaboration supported by analytical exercises, should be considered.

(3) Countries should expand their fiscal capacities for scaling up investment in health through, among other measures, increasing and earmarking "sin taxes", facilitating healthy public policy and scrutinizing mis-targeted national subsidies.

(4) Countries need to focus on the development of human resources, through capacity building, training and focusing on internal and external migration issues.

5.2 Recommendations

The strategic actions agreed on at the Regional Consultation to Review Progress on Macroeconomics and Health, were presented to the participants under the heading 'Macroeconomics and Health: The Way Forward'.

The progress thus far was summarized as being the achievement, both at global and country levels, of advocacy on the importance of health in the development agenda (reinforced for example by parallel agendas such as MDGs, PRSPs) and the common acceptance of the need for a pro-poor focus in health policy. There was agreement on the need for increased financing to achieve the (pro-poor) health agenda and for addressing the non-financial constraints, particularly with regard to human resources and essential drug availability. However, it was noted that this progress has largely been with respect to creating awareness, political 'commitment' and encouraging evidence-based planning rather than substantial progress in the implementation of the CMH recommendations.

What is needed is the translation of these 'commitments' into action by identifying a feasible set of deliverables since the CMH recommendations are very broad in scope. With regard to financing this would involve increasing the volume of domestic and external financing and increasing the efficiency of its use, through the development of structures and financing architectures for the more efficient allocation/distribution of resources, management of

funds and resource tracking. In the context of human resources for health, the development of incentive structures to support the retention of staff in underserved/poor areas, focusing on issues of internal and external migration and capacity building reflecting the required skill mix including the strengthening of community health workers was needed. Drug availability is a major constraint in the area of health care development in many countries in the Region. Addressing the issues of pricing and procurement, distribution within health systems as well as global negotiations, in the form of attempting to provide a Regional platform for the discussion of WTO/GATTS and TRIPS, with the hope of formulating a collective Regional response, would be important.

Initiatives for strengthening and developing the Macroeconomics and Health work in the Region could best be supported by capacity building at the country level to support key activities in this area, with attention also being paid to follow-up activities, the exchange and dissemination of information and encouragement to regularly monitor and evaluate Macroeconomic and Health activities based on identified performance indicators. In carrying out these activities, the respective ministries of health need to link with other health-related sectors as well as the finance and planning ministries. Links also need to be created with other supportive processes such as the MDGs, PRS and CSDH with the work being carried out in an integrated manner rather than through parallel processes. The WHO country offices could assist in these processes. WHO/SEARO could play a major role in ensuring the achievement of the CMH goals: firstly, through providing a focal point for macroeconomics and health and CSDH activities in the Region; secondly, through the creation of a web-based virtual secretariat (which could later be looked after by the countries on a rotational basis); thirdly, through assisting in capacity building at country and regional levels and, finally, through providing platforms for the exchange of experiences and information between the countries in the Region. WHO/SEARO could also take the lead in initiating a meeting with donors to discuss better means and processes of providing joint financing to the countries for Regional macroeconomics and health activities, including the functioning of the secretariats.

The agreed immediate actions suggested were that WHO/SEARO would prepare a report, including listing the strategic actions arising from this meeting that could be submitted to the Health Secretaries in June, the Ministers of Health in August and to the WHO-HQ and that the WHO-SEARO would initiate a web-based virtual Secretariat, for the countries of the Region.

Annex 1

List of participants

SEAR Countries

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Annex 2

Programme

Thursday, 08 June 2006

0800 - 0900 hrs	Registration
0900 - 1015 hrs	Opening/Inaugural Session • Introductory Remarks – *Dr Sultana Khanum*, Director, Health Systems Development, WHO South-East Asia Regional Office • Welcome address – *Mr Ranjith Maligaspe*, Secretary-Health, Ministry of Healthcare & Nutrition, Sri Lanka • Inaugural Address – *Dr Samlee Plianbangchang*, Regional Director, WHO South-East Asia Regional Office (to be delivered by *Dr Agostiono Borra*, WHO Representative to Sri Lanka) • Introduction of Participants – *Dr Gunawan Setiadi*, Ag Regional Adviser-Health Systems, WHO South-East Asia Regional Office. • Nomination of Chair, Co-chair, Rapporteur and Drafting Committee Announcements/Group Photo
1015 - 1045 hrs	Coffee break
1045 - 1300 hrs	**Session I** **Plenary 1 - Update** • Update on global CMH activities • Update on SEAR CMH • Macroeconomics and health in the context of the new development agenda and evolving global health architecture • Country presentations
1300 - 1400 hrs	Lunch

1400 - 1530 hrs	**Session-II** **Group Discussion-I** **Topic**: What has been the experience with profiling health in development and increasing investment in health through the NCMH process? • Country experiences - brief presentations (5-10 minutes each) • Follow-up group discussions on key lessons learnt and best practices for strategic action in the future
1400 - 1530 hrs	**Session II** **Group Discussion II** **Topic**: What has been the experience with refocusing country health planning towards the poor through the NCMH process? • Country experiences - brief presentations (5-10 minutes each) • Follow-up group discussions on key lessons learnt and best practices for strategic action in the future
1530 - 1600 hrs	Coffee break
1600 - 1730 hrs	**Session III** **Group work** (continued)

Friday, 09 June 2006

0900 - 1030 hrs	**Session IV** **Group work** (continued) Preparation for presentations
1030 - 1100 hrs	Coffee break
1100 - 1300 hrs	**Session V** **Plenary 2** • Presentations of Group Discussions • Discussion • Preparation of summary presentation by Rapporteur, Drafting Committee and WHO technical staff
1300 - 1400 hrs	Lunch
1400 - 1500 hrs	Session VI Plenary 3 • Summing up: Key points for strategic action in the future • Closing remarks