World Health Organization

THE ROLE OF HEALTH IN ENHANCING PRODUCTIVE CAPACITIES IN LDCs

Background and Issues for Discussion

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by the
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THE ROLE OF HEALTH IN ENHANCING PRODUCTIVE CAPACITIES IN THE LDCs

INTRODUCTION

1. A health crisis afflicts the least-developed countries that is thwarting their prospects for economic growth and human development. This paper describes the nature and magnitude of the health crisis in LDCs and lays out an agenda for action.

2. It is now clear that there are strategic interventions which, if implemented effectively, have the potential to reduce suffering and promote prosperity – contributing to a more secure world. However, it is equally evident that success will require a sizeable increase in the international response, and in the level of resources available to LDCs.

3. Globalization – as it affects the flow of products, people, services and information – must be made to work for the poor. In this context, initiatives to address health needs at country level needs to be linked with enabling actions globally, which, among other things, can influence the price of essential drugs and commodities, and ensure the availability of new tools and technologies for the future.

4. If better health can fuel the engine of development, what are the priorities for action by countries and the international community? What are most effective programs and interventions to improve health in LDCs? What is the scale of resources needed in LDCs to implement such programs effectively? What is the right balance between health care investments and those in other areas such as nutrition, clean water, sanitation, occupational safety and the environment, which have a pay-off in public health? What mechanisms are needed to transfer external resources in ways that ensure speed, transparency and country ownership? What kind of economic and policy environment will maximize the potential returns available from investment in health? What arrangements are needed globally to support effective action at country level?

5. These issues will be discussed at the special session at the UN LDC-III meeting on Brussels on “Enhancing Productive Capacities: The Role of Health.” This paper serves as background to that discussion.

THE ECONOMIC RATIONALE FOR HEALTH INVESTMENT IN LDCS

6. Ill health and poverty are closely linked with the cause-and-effect running in both directions. That is, sick people are more likely to become poor, while those who are poor are more vulnerable to disease and disability. The reverse is also true; people in good health are better able to learn, earn a living and be more productive than those who are sick.

7. The economic evidence which confirms this relationship for individuals[1] is now joined by a growing body of data which support a similar link between better health and higher productivity at the macro-level of national economies. For example, health improvements may have accounted for as much as a third of the East Asian "economic miracle".[2] While previous research has shown a broad correlation between average GDP and life expectancy, it is not necessarily true that higher wealth leads to better health. WHO-sponsored research indicated that income growth was less important to improved health outcomes from the 1950s to the early 1990s than other factors, such as access to health technology (WHO, World Health Report, 1999).

8. By contrast, recent research shows that malaria slows economic growth in Africa by up to 1.3% each year; with malaria-free countries averaging three times higher GDP per person than those with malaria, even after controlling for government policy, geography and other factors affecting economic growth.[3] Compounding the problem is HIV/AIDS, which disables and kills mostly adults in the prime of their lives as workers and parents. The World Bank has estimated that with an average HIV prevalence rate of 8.6% in 1999, Africa's income per capita growth rate of 0.4% in the 1990-1997 period was three times less than it would have been otherwise – about 1.1% per year. For countries with very high HIV prevalence rates, the economic cost is even more devastating. "In the case of a typical sub-Saharan country with a prevalence rate of 20%, the rate of growth of GDP would have been 2.6 percentage points less each year."[4]

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[1] Strauss and Thomas, 1998. "Health, Nutrition and Economic Development," *Journal of Economic Literature* Vol. 36: 776-817.

[2] Bloom and Williamson, 1998. "Demographic Transitions and Economic Miracles in Emerging Asia,", *World Bank Economic Review* 12(3): 419-455.

[3] Gallup and Sachs, 2000. "The Economic Burden of Malaria," Center for International Development, Harvard University, CID Working Paper No. 52, July.

[4] Bonnel, R., 2000. "Economic Analysis of HIV/AIDS", Background Paper for the Africa Development Forum 2000, World Bank/UNAIDS, September.

9. There are several pathways through which good health contributes to economic development: [5] a) **Higher labour productivit**y -- Healthier workers are physically and mentally more productive, earn higher wages, and are miss fewer days of work than those who are chronically ill. In addition, a healthy workforce creates incentives for foreign companies to make long-term investments; b) **Higher rates of investment and savings --** People who live longer are more likely to put away funds for retirement, which in turn provides funds for capital investment. Aggregate savings increase as the share of the population in their prime coincides with their peak savings years (in the 40s); c) **Higher educational attainment --** Healthy children are better able to learn and miss fewer days of school. As health improves, parents invest more in educating their children; and d) **Demographic changes --** Improvements in health lead to lower rates of fertility and mortality in the population. The lag between declines in mortality and fertility produces a "baby-boom", which can contribute to economic growth if policies allow these extra workers to be productively employed.

10. Better health alone is necessary but not sufficient to produce high economic growth rates. Increasingly, it appears that its impact depends on the economic and political environment in which health improvements take place. To illustrate the complexities of the relationship between health and economic growth, Amartya Sen cites two sets of contrasts. Among high economic growth countries, some have seen significantly improved health status (e.g. South Korea and Taiwan) while others have not (e.g. Brazil). Among countries that have had dramatic health gains, some have had high rates of economic growth (e.g. again, South Korea and Taiwan) while others have not (e.g. Sri Lanka and the Indian State of Kerala).[6] In other words, a country need not be rich to be healthy, and countries can become wealthier, without parallel gains in health.

11. Improving health and wealth at the same pace requires a mix of complementary economic, social, and health policies. As Sen noted, while there is an association between economic progress and gains in health, much depends on how the income generated by economic growth is used, "in particular, whether it is used to expand public services adequately and to reduce the burden of poverty." At the same time, he stresses that even in low-income economies, major health gains can be made by using available resources in productive and efficient ways.

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[5] Bloom and Canning, 2000, "The Health and Poverty of Nations: From Theory to Practice," October.
[6] A. Sen, "Health in Development", Keynote Address to the 52nd World Health Assembly, May 1999.

12. Further elucidating the causal relationships between health and economic growth is the task of the WHO Commission on Macroeconomics and Health. An update from the work of the Commission will be presented at the UN-LDC III conference.

THE HEALTH CHALLENGE IN LDCs

13. The LDCs have made some progress on health status indicators over the last 40 years. Life expectancy increased from under 40 years on average in the 1960s to over 50 years in 1998. In addition, there has been a substantial reduction in overall mortality among children under five years of age in LDCs, from a 1960-64 average of 268 per 1000 live births to an average of 160 per 1000 in 1995-99.[7]

14. However, LDCs still have among the lowest scores on most indicators of human development, including those related to health. On average between 1995 and 1999, 16% of all children born in LDCs do not reach their fifth birthday – a rate more than triple the developing country average of 5% for that same period. Among the 48 LDCs, only four are on target to meet the International Development Goal of reducing the 1990 level of infant mortality by two-thirds by 2015.[8] The average life expectancy in LDCs of 51 years compares to 65 years for the developing countries and 78 in OECD countries.[9]

15. Preventing and treating communicable diseases is a high priority for improving the health of the poor and lessening poor-rich health differences, according to a recent analysis by the World Bank of the burden of disease for the world's poorest 20 percent.[10] The study found that in 1990, communicable diseases as well as maternal and perinatal conditions, accounted for 59% of all deaths and 64% of disability-adjusted life years (DALYs) lost among the global

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[7] Ahmad, O, et. al., 2000. "The decline in child mortality: a reappraisal," *Bulletin of the World Health Organization*, 78(10):1175-1191.

[8] Calculation by UNCTAD; see UNCTAD LDC 2000 Report, p. 16. In addition to the infant mortality goal, the health-related International Development Goals include: 1) reducing the 1990 under-five **child mortality** rate by two-thirds by 2015; 2) reducing the 1990 **maternal mortality** rate by three-quarters by 2015; 3) attaining **universal access to reproductive health services** no later than 2015.

[9] UNCTAD, Least Developed Countries 2000 Report.

[10] Gwatkin, D. and M. Guillot, 2000. *The Burden of Disease among the Global Poor*, The World Bank. Burden of disease is a summary measure of population ill-health that combines data on mortality and nonfatal health outcomes. To calculate burden of disease among the global poor, the estimation used data from the world's countries or regions with the lowest income per capita, including India and China states or provinces. While this does not correspond to the LDC population, it is a reasonable proxy for the health situation in the poorest countries.

poor, compared with 34% of deaths and 44% of DALY loss for the global population. Diseases such as respiratory infections, diarrheal diseases, maternity-related and childhood diseases were the leading causes of death and DALY loss among the global poorest. Unintentional injuries were the third highest cause of DALY loss among the global poorest, about the same as that for the richest 20% globally. With respect to gender differences, "communicable diseases account[ed] for a higher proportion of death and disability among poor women than among poor men, *even after maternal conditions are removed from consideration."* (emphasis added*)*[11]

16. All projections, including the World Bank 1990 burden of disease estimates and its projections to the year 2020 for the global poor, have underestimated the scale and impact of the HIV/AIDS pandemic. As of 2001, 36 million people were living with HIV/AIDS, over 95% of them in developing countries. AIDS has become the leading cause of death in Sub-Saharan Africa. In many LDCs, HIV/AIDS is destroying the health gains of the previous 50 years, leading to declines in life expectancy in 11 LDCs during the 1990s, with "[t]he AIDS epidemic an important contributory factor in these reversals."[12] With the exception of Uganda among LDCs, adult HIV prevalence has increased since 1990, and in some of the most affected countries, adult mortality rates have doubled. The AIDS epidemic poses a threat not only to public health, but to development itself, by robbing countries of people in the prime of their lives, decimating the workforce, slashing productivity, and depriving families of parents and breadwinners. A few LDCs – notably Senegal and Uganda – are on target to achieve the International Conference on Population and Development +5 goal of a 25% reduction in HIV infection rates among 15-25 year olds by 2005. Most others are far behind the rate of progress needed to reach this goal.

17. Though it is adults that are most affected by HIV/AIDS, infants and children are increasingly at risk. According to UNAIDS estimates, about 14 million women of childbearing age currently have HIV infection or AIDS, increasing the risk of children born with HIV. In countries with very adult HIV prevalence (at least 5%), directly-related under-5 child mortality rates also increased.[13] The rapid rise in adult

[11] Gwatkin and Guillot, 2000, p. 10.
[12] UNCTAD, Least Developed Countries 2000 Report.
[13] Adetunji, J., 2000. "Trends in under-5 mortality rates and the HIV/AIDS epidemic," *Bulletin of the World Health Organization* 78(19):1200-1206.

deaths from AIDS is leaving a huge number of orphans – 12 million in Africa alone.

Weakened & Poorly Funded Health Systems

18. The trends in health status are, in part, related to health spending in the LDCs. In the early 1980s, per capita health expenditure in the LDCs was on average just over $11, while for other developing countries the average was just below $100, and in high-income OECD countries, the average per capita health expenditure was more than $1700. While between 1990 and 1998 the other developing countries managed to increase their per capita health expenditure to nearly $180, the expenditure in African LDCs actually fell to just over $8 per person. Asian LDCs (excluding Afghanistan), most of whom were among the fastest growing LDCs, on the other hand managed to increase their per capita health expenditure to just over $25, which is still only one seventh of the other developing countries average.[14] National health account data recently collected by WHO for nearly all of its Member States, showed that in 1997, LDCs spent $55 per capita (in international dollars; $40 at official exchange rates), but just $33 in public expenditure in international dollars. Sixteen LDCs spent $15 or less per capita in public expenditure.[15]

19. In many LDCs, health systems are very weak. Their disease surveillance and reporting systems are barely functional making it difficult to identify, much less respond to, the most urgent health needs. They cannot provide universal access to even the most basic health services, as facilities are poorly staffed, inadequately supplied, and lacking in basic infrastructure. Efforts to mobilize the resources of non-profit private sector providers to combat priority health problems are under-developed. WHO's assessment of country health system performance found that only 5 LDCs ranked among the top 100 countries in achieving health system goals related to level of health, responsiveness to population expectations, and fairness in financial contributions.[16]

[14] UNCTAD, Least Developed Countries Report 2000, based on calculations from World Bank, *World Development Indicators, 2000.*

[15] World Health Organization, *World Health Report 2000, Health Systems: Improving Performance*, National Health Account Indicators (Annex Table 8)

[16] World Health Organization, *World Health Report 2000, Health Systems: Improving Performance*, Health system attainment and performance in all Member States, estimates for 1997, (Annex Table 1)

20. Those countries with high rates of HIV/AIDS prevalence (i.e. above 10%) have experienced tremendous stress on their health care systems, outstripping their capacity to respond. In many of these countries, health infrastructure was already inadequate but HIV/AIDS makes the fact even more painfully obvious. At the same time, health staff in many of these countries are infected by the epidemic, threatening or removing the people most needed to combat the disease. Effective human resource policies to cope with the epidemic have yet to emerge.

21. Two other key indicators of health systems performance tell a similar story. Children's immunization status has improved in virtually all countries over the last decade due to concerted public vaccination campaigns. Globally, the percent of children immunized against measles rose from 53% in 1987 to 82% in 1997. The LDCs as a group have achieved measles immunization rates among children that are almost 50% more children in 1997 than they were in 1987, with at least six now having rates that are greater than 90%. But 10 LDCs actually had declining rates of measles immunization amongst children, and overall, the 1997 rate of 66% is far below the rate of 87% for other developing countries. With regard to access to essential medicines, only 6 LDCs (12%) have more than 80% of their population having adequate access, while nearly half of all developing countries have attained or exceeded this level.

WHAT WORKS TO IMPROVE AND PROTECT HEALTH IN DEVELOPING COUNTRIES

22. Despite the considerable health problems facing LDCs, much is known about what is needed to improve the health of poor people. An immediate priority is to focus on preventing and treating the major communicable diseases in LDCs, which will save the most lives in the short-term, and contribute the most to productivity in the long-run. Delivering critical interventions for these diseases depends on well-functioning health systems. Disease control campaigns show the importance of better water, sanitation, and education, as critical complements to advances in health technology and services. And the association between higher income and better health indicates that economic policies that ensure the benefits of economic growth reach the poor are necessary.

23. This report distils the evidence about what works to improve health in LDCs. To reduce deaths and disability from the major diseases affecting the poor -- malaria, HIV/AIDS, TB, childhood diseases, and maternal and perinatal conditions – requires consensus on a framework for action based on four key principles:

- the need for better links between global enabling actions and country policies;
- political leadership at all levels;
- policy coherence across sectors, both nationally and internationally; and
- a clear focus on what works, adapted to people of different ages, genders, cultural norms, and carefully sequenced

24. Better and faster progress is possible if these principles are adopted and focused on a set of closely orchestrated actions by LDC governments and the international community. The actions fall into seven major categories, shown in the matrix on next page, which together constitute a framework for action.

25. Implementing this framework for action in the LDCs requires clear recognition of the significant political, economic, institutional, and human resource challenges and constraints in these countries. The remainder of this paper therefore focuses on the key implementation issues and questions facing both sets of actors.

- First, it discusses elements of the framework for action *within the health sector*, or those requiring close

coordination between health sectors and finance, planning, and other government authorities.

- Second, it discusses elements of the framework for action *beyond the health sector*, where government authorities in other key sectors have prime responsibility.

Questions for possible discussion at the UN-LDC III special thematic session on health are highlighted.

PROMOTING HEALTH IN LDCs – A FRAMEWORK FOR ACTION[17]

Action Component	Global Enabling Action by the International Community [18]	National Policies and Programs by LDC Governments
1. Mobilize additional resources for health priorities	Raise additional funds from existing donors; complemented by global trust fund(s) – to provide a political focus for fund raising and to attract new funding partners.	Review priorities in medium-term budget and expenditure frameworks and increase health budget to maximum extent possible; utilize savings from debt relief for health investment and seek efficiency savings.
2. Channelling and managing funds efficiently and equitably	Mechanisms for transferring money *to* LDCs characterized by speed of action, transparent and fair allocation criteria and procedures, low transaction costs, and decision- making at country level. Use existing channels where they work well.	Mechanisms for managing additional funds *within* countries based on strong national financial management systems; promote integration with development processes such as PRSPs; and enable public, private, and voluntary organizations to access resources.
3. Global Public Goods	Strategic partnerships between public and private entities to (i) provide incentives for research and development for new drugs and vaccines, (ii) reduce the price of key medicines, (iii) purchase and distribute key commodities, (iv) compile and disseminate key evidence and information, (v) increase technology transfer and technical assistance.	Participate in priority setting, the production and distribution of global public goods for health.
4. Developing effective health systems	Investment in, and coordinated donor support for, health systems development linked to better outcomes; tools and methods for assessing performance; promoting consensus on standards and strategies; sharing experience and best practice	Strengthen government stewardship; coordinate efforts across public, private, traditional and voluntary providers; link funding to performance; community participation; solidarity in financing rather than user fees; increased attention to human and institutional capacity building.
5. Measuring Progress	Independent and authoritative mechanisms for reviewing progress against agreed targets	Strengthen local capacity to collect data on agreed indicators; use results to modify and improve programs; share lessons in global & regional fora.
6. Advocacy and social mobilization	Global and regional advocacy and public awareness campaigns to create and maintain political support among donors.	National and local advocacy and public awareness campaigns to create and maintain political support at country

[17] This framework was developed by WHO and improved by inputs from participants in the UN-LDC III, Preparatory Meeting on Health, Ottawa, Canada 28-29 March 2001, co-sponsored by the Canadian International Development Agency and the Malawi Ministry of Health.

[18] International actors include multilateral agencies, bilateral donors, and private contributors

		level.
7. Policy coherence across sectors	Promote coherence in international development policies and multilateral rules and treaties in the areas of trade and investment, economic development, environment, intellectual property protection, and labour policies – across UN agencies and within OECD countries.	Within the context of PRSPs, promote complementary policies and investments in key health-related sectors, e.g. education; food security and safety; safe water and sanitation; clean household energy sources; taxes, trade and investment policy; and micro-credit.

Framework for Action – The Agenda *Within* the Health Sector

26. Worsening AIDS, TB and malaria epidemics are *not* inevitable, shown by many successful strategies deployed in developing countries to reduce the incidence of these diseases, and prevent the deaths they cause. A recent report by six UN agencies[19], describes health programs that are effective in combating AIDS, tuberculosis, malaria, childhood diseases and maternal and perinatal conditions, even in resource-poor settings.

27. Several LDCs are noteworthy for their success in implementing effective health programs. **Uganda** has significantly lowered its high HIV infection rates as a result of a broad-based national effort, involving safe sex education programs in schools and on the radio, increased condom use through subsidized prices or free distribution, and same-day voluntary counselling and testing services. In the Tigray region of **Ethiopia**, over half a million people are treated for malaria each year by a network of volunteer health workers. And a program that teaches mothers how to diagnose and treat malaria in the home led to a 40% reduction in overall death rates among children under age five. In **Malawi**, government commitment has helped to increase measles immunization coverage from 50% in 1980 to almost 90% now, dramatically reducing measles cases and deaths.

28. The UN report identifies six important characteristics of programmes that have succeeded to control diseases of poverty:

- ***political commitment*** at the highest level is key to achieving results and sustaining programmes;
- successful disease and mortality prevention has often involved new ways of working, e.g., entering into ***partnerships*** with the private sector, non-governmental organizations, and UN agencies;
- ***innovation***, born out of a pragmatic approach to achieving results, has made all the difference in some countries;
- promoting the ***home as the first hospital*** helps reduces child deaths. In particular, the training and education of mothers has been a key to success;
- widespread ***availability of supplies***, medicines and other low-cost tools at community-level is essential;
- ***measuring results*** is key to planning control measures.

[19] *Health, a Key to Prosperity: Success Stories in Developing Countries*, WHO, UNICEF, UNESCO, UNAIDS, UNFPA and the World Bank, 2001.

29. There remains, however, a massive gap between the resources needed to help poor communities tackle the priority health problems, and the funding and human capacity currently available to them. An additional $1 billion a year, well spent, is needed to reach targets for rolling back malaria in Africa. For TB, at least half a billion dollars per year is needed in high burden countries. For HIV/AIDS the gap is even larger – probably in the order of $3 billion for stepping up prevention, treatment and support in Africa alone. Add in anti-retrovirals and the costs rise even more dramatically. Early results from WHO's Commission on Macroeconomics and Health suggest that the total cost for scaling up critical interventions is on the order of $10 billion per year. Most of this money must come through increased development assistance as well as debt relief. It must be *new* money, not taken from that being spent on other development priorities.

30. Many LDCs have the potential to achieve good health results, but cannot organize, deliver, or purchase critical services due to weakened or non-functioning health care systems. All health systems share common goals: improved health, responsiveness to legitimate expectations of the population, and fair financial contributions. WHO's World Health Report 2000, *Health Systems: Improving Performance,* identifies four core functions needed to achieve these goals: 1) organizing service delivery, 2) producing the right mix of key health system inputs and resources, 3) financing, and 4) exercising strong stewardship -- governments taking responsibility for ensuring that all sectors, policies, and public and private actors contribute to key health system goals. Better performance of these four functions can make substantial gains towards the goals possible in countries at all levels of development.

31. Access to health care, especially for the poor, depends on its affordability. One key recommendation from the report is for countries to ensure access to care for the poor by financing health care for as large a percentage of the population as possible through prepayments, rather than out-of-pocket payments at the time of service delivery. In countries without prepayment financing for health expenses, out-of-pocket payments for health care consume a large fraction of income and many families have to go into debt if one of their family members becomes seriously ill. Prepayment protects people from falling into poverty if they are seriously injured or develop catastrophic illness. Prepayments come in several forms – taxes, social security or insurance premiums, or fees paid in advance. Most social

health insurance programs in low and lower middle-income countries do not benefit the poor, and low-income countries often lack the capacity to administer insurance programs. Community-based prepayment schemes may be viable in some cases, but in no country do they extend coverage nationally and by requiring up-front payments, do not reach the poorest households. Thus, tax-based health financing systems, supported by external aid, appear to be both the most equitable and the most feasible option in low-income countries.

32. Many of the health needs in LDCs can only be met at the international level, through the provision of global public goods.[20] Among the most critical global public goods for health are the generation and dissemination of knowledge of epidemiological research and effective health system reforms, and transfer of new technologies. Indeed, it is in the arena of technological innovations where the global divide between rich and poor nations is becoming most stark. LDCs are technologically "disconnected" relative to the rest of the world, not only in telecommunications, but also in new medical technologies. Research and development of new drugs, vaccines and other technologies are desperately needed to prevent and control diseases that primarily affect LDCs. The costs are beyond their means, yet the benefits would accrue globally. At present, very little of the estimated US$60 billion spent on pharmaceutical R & D is focused on health problems that most affect LDCs; greater investment in the diseases that most affect LDCs is therefore critical.

Implementation Issues and Challenges *Within* the Health Sector

33. *Domestic Financing for Health.* Public sector health expenditure in many LDCs is less than US$10 per year per capita, making it difficult to afford even the relatively modest costs of drugs and supplies needed to scale up effective interventions. Raising additional funds for public sector health spending from domestic sources may be possible to the extent that economic growth increases total GDP and income per capita. But with current per capita incomes averaging US$300 in LDCs, the realistically achievable financing for health in such countries, from both public and private sources, is likely to be about 5% of average annual

[20] Public goods are those that are not adequately provided by private market forces alone because the benefits are available to everyone (no one can be excluded), diminishing the incentives for private actors to provide them. Public goods become global in nature when the benefits flow to more than one group of countries, and no country can be effectively denied access to those benefits.

income, or just $15 per capita per year.[21] Even then, a package of essential health interventions is likely to cost as much as four times that amount, highlighting the gap between the health needs in LDCs and current resources.

- ***In countries where health spending per capita is less than 5% of GDP, is this a realistic goal? Is the issue increasing overall health spending, or increasing the public share of total health spending? If the latter, what are the implications for shifts in public budget allocations away from other sectors? Can other sectors' contribution to health be better quantified?***

- ***What are the macroeconomic implications and practical constraints to raising domestic revenues for health from: general taxes, earmarked taxes (e.g. social security), and private spending (user fees or health insurance)? Is it possible/realistic to expect LDCs to raise more revenues for health from general or earmarked taxes? Are tax reform initiatives likely to help?***

34. *International Financing for Health.* The international donor community currently gives around US$50 billion per year in official development assistance (ODA), of which US$3.5 to $4 billion (about 8%) is for health, population and nutrition activities. This represents a near-doubling of health's share of total development assistance from 1990 when it was 4%. Increases in the amount of funds for health, and its share in total ODA, reflect growing international consensus on the importance of health to development. However, LDCs' share of health ODA funds dropped slightly during the 1990s, from an average of 40% of all health ODA funds between 1990 and 1992, to 36% between 1996 and 1998. LDCs still receive three times more aid to health per capita than the other country income groups on average.

- ***Despite the positive trends in health ODA relative to total ODA, current ODA allocations for health remain far below the estimated funding needs in LDCs. How should the total funds needed for health be calculated in LDCs?***

- ***How can the drop in LDCs' share of total health ODA be reversed? Simply by increasing total ODA allocated to health in LDCs? Or, should funds be established to support global public goods for health, in which most***

[21] WHO Commission on Macroeconomics and Health, Preliminary Findings, November 2000.

funding goes to LDCs? What are the implications for other developing countries?

- ***What can be done to increase the amount of health ODA to LDCs in the form of grants (rather than loans), so that ODA does not undermine efforts to relieve countries of their debt burdens? (see next point)? Will a sudden increase in ODA create problems with absorption capacity?***

35. *Debt Relief and the Health Dividend.* The huge debt burden of most LDCs constitutes a major barrier to greater spending in a number of key sectors, including health. Many LDCs have been deemed eligible for greater debt relief from the World Bank and IMF, under revised HIPC 2 criteria. To qualify for debt relief, countries must develop a long-term Poverty Reduction Strategy Paper (PRSP). Countries may submit Interim PRSPs which, if approved, qualify the country for immediate debt-service reduction. To the extent that debt relief proceeds free up government funds to be used for non-debt payment purposes, it creates the potential for additional spending on the social sectors, including health.

- ***Is it reasonable to require HIPCs to invest some of the proceeds from debt relief into the health sector, or should they be free from such externally-imposed conditions? Are specific "health conditionalities" warranted to ensure that any health investments that are made will be directed towards the poor?***

- ***To the extent that the HIPC/PRSP process does not fully address the debt crisis in developing countries, and HIV/AIDS represents a economic and human crisis of enormous proportions, should the international community consider debt relief for health that goes beyond debt relief as currently structured?***

36. *Aid Coordination.* Problems with aid coordination in the LDCs are long-standing, with both sides responsible for many of the difficulties. To resolve these problems, several countries and donors are experimenting with new approaches to improve aid coordination, for example through sector-wide approaches (SWAps) that seek to rationalize donors' contributions in support of nationally-developed and government-owned health policies and priorities. This process is under way in many African LDCs and a few in Asia. In addition, PRSPs offer a vehicle to bring together donors in support of poverty reduction plans designed by countries themselves. While most countries are still in early stages of

these processes, they hold promise for strengthening governments' ability to oversee the entire health system (in the case of health SWAps), for integrating health into overall development and poverty reduction plans (in the case of PRSPs), and ensuring that donors' contributions support government priorities.

- ***Are sector-wide planning approaches to health system reform a significant improvement over other donor coordination efforts? What incentives or tools can be used to focus aid coordination on pro-poor health improvement? Do health-sector SWAps help or hinder cross-sectoral poverty reduction efforts?***

- ***To what extent has the PRSP preparation process, or that of the UN Development Assistance Framework, improved aid coordination across sectors? Are PRSPs a useful vehicle for integrating health sector reforms with development plans in other sectors, in support of poverty reduction? Is cross-sector poverty reduction planning of this sort sustainable in the long-run?***

37. *Resource Allocation Within the Health Sector.* With low levels of resources from both domestic and international sources, it is incumbent upon national governments to make the best use of they funds they have to achieve the greatest health gains. This requires cost-effective and more equitable distribution of funds to achieve a better balance between primary and hospital care, between regions and districts within the country on the basis of need, and among health care interventions that will lead to the greatest health and productivity gains.

- ***What can be learned from national efforts to reallocate funds between districts within countries on the basis of need, rather than population or historical patterns, to improve equity? Are such efforts compatible with decentralization initiatives? Are there some useful models for achieving consensus among key stakeholders – local government, civil society, health practitioners – on how to allocate health resources equitably and efficiently?***

38. *Role of Private Expenditures & User Fees*. Large out-of-pocket health spending represents a disproportionate burden for the poor and contributes to poverty in cases of catastrophic illness. User fees or charges – both official and unofficial -- can deter the use of essential health services especially by the poorest. In view of the large

informal sectors in most LDCs, which make it administratively infeasible to collect health insurance premium taxes, formal health insurance schemes are likely to benefit only the well-off. For these reasons, careful consideration must be given to the issue of user fees and private health insurance. User fees were found to be the least preferable among all possible financing sources by the *Addis Ababa Consensus on Principles of Cost Sharing in Education and Health* (UN Economic Commission for Africa, 1997). The Consensus recommended that if user fees are used, exemptions, sliding fee scales, and other means of protecting the poor should be implemented.

- ***As most attempts to exempt the poor from user fees have failed, are user charges still valid in LDCs? If so, under what circumstances? What can be done to reduce the practice of charging unofficial user fees ("under-the-table" payments)? What can be learned from efforts to establish community-based prepayment schemes for health financing? Are such community-based schemes a viable building block towards larger health insurance pools in LDCs?***

39. *Improving Health Human Resources.* In many LDCs, health care workers' salaries have been stagnant or declining for many years, from an already low base. Thus, it is common for health care workers to "supplement" their meagre wages with unofficial fees and charges that create problems in access to care by the poor. To address this problem, it is undoubtedly necessary to increase official salaries. But questions have been raised about whether that means across-the-board increases in salary scales by civil service/public employment authorities, or carefully structured plans to link higher salaries with performance (i.e. higher quality of care) or service in remote locales. The latter requires close coordination between Ministries of Civil Service and Health, and with public labour unions. Meanwhile, challenges remain in recruiting and retaining qualified health personnel, who are increasingly emigrating to countries where they can earn more.

- ***What can be learned from developing countries that have tried to link higher wages with improved performance, or service in remote locations? Are there non-monetary incentives or rewards that have proven effective in the raising the number or skills of health human resources in developing countries?***

- ***As LDCs cannot offer salaries competitive with those for health professionals in more developed countries, what else can be done to retain health professionals? Should***

LDCs seek commitments from developed countries to prevent health professionals, trained partly or wholly at public expense, from obtaining visas unless they have completed public service requirements?

40. *Greater Production and Equitable Distribution of Global Public Goods for Health.* Currently, there is vigorous debate about the effectiveness of intellectual property protection in stimulating research and development of new drugs and vaccines for diseases that primarily affect the poor. Some believe that such R & D will be performed only if IP rights are strongly protected, while others maintain that without the guarantee of substantial profits, R & D will continue to be concentrated in products for rich-country markets.

- ***Is there a need for "push" incentives, such as challenge funds or purchase guarantees to encourage pharmaceutical R & D to increase efforts on diseases primarily affecting the poor? If so, how should they be structured?***

- ***What should the international community do to ensure that resulting innovations are available and affordable to LDCs? Should LDCs create alliances with multinational firms to increase technology transfer?***

- ***What systems can be used to protect the rights of holders of traditional knowledge and medicinal practices? How should the custodians of such knowledge be compensated if it is adapted by industry for commercial purposes?***

Framework for Action – The Agenda *Beyond* the Health Sector

41. Even if universal access to health services were possible, it would not be sufficient to eliminate the differences in health between rich and poor. The reason is that many of the determinants of ill-health, and thus the means for making significant improvements in the health of the poor, depend on actions beyond the health sector. This requires improved access to safe and adequate food, clean water, sanitation, and basic education. Outside the traditional domains of health care and public health, the health of the poor can also be improved by reducing their exposure to violence and environmental hazards, and that lessen the devastating impacts of conflicts and natural disasters.

42. *Basic Infrastructure for Safe Water and Sanitation.* Despite progress over the last decade, 1.1 billion people remain without access to safe water supply and 2.4 billion without access to any sort of improved sanitation facility. With estimated global population growth of over one billion people in the next 15 years, pressure will only increase on services that are already overwhelmed, especially in urban areas. The current challenge in water supply is straightforward in principle - to meet demand – but complex in practice, involving key government institutional inputs and economic and financial incentives to encourage greater investment. In contrast, the construction and maintenance of sanitation facilities is often a more community and individual affair, requiring education for behavioural change and community participation.

43. *Food and agriculture policies.* Food security and food safety issues are nearly inseparable in LDCs. On the food security side, malnutrition or under-nutrition affects an estimated 235 million people, or 40% of all people in LDCs, and accounts for as much as a third of the burden of disease in Sub-Saharan Africa. Food represents on average 15% of total merchandise imports in LDCs. As most LDCs' economies are dependent on agriculture, food production is critical for domestic consumption and for export expansion. On the food safety side, assuring the safety of food is critical not only to protect public health domestically, but also to meet international standards so that LDCs can take advantage of export market openings. LDCs need to strengthen their food safety control systems and capacities to: a) implement WTO SPS provisions to meet the demands of export trade, b) conduct risk assessments to identify and prioritize food safety risks and opportunities, and c) develop focused plans that will reduce the biggest food safety risks, thereby targeting limited resources to the domestic and export-oriented problems of greatest concern. At the same time, LDCs need more help to increase their participation and effectiveness in international food safety organizations, so that their concerns are taken into account in setting standards.

44. *Gender-Sensitive Poverty-Reduction Strategies and Basic Education for Girls.* Women are essential for ensuring the food security, nutrition, and health of their families, indicating the need for special efforts to target poverty reduction strategies to women. Without strengthening education for girls, and providing access to basic health, education, (micro)credit and land ownership rights, families' basic survival can be at risk In addition, concrete action is

needed to integrate health information and services with initiatives to increase access to basic education in LDCs, especially for girls, to help reach the goals of the World Education Forum's Dakar Framework for Action.

45. *Energy Policies and Programs.* The energy sector plays a significant role in the health of the poor. Indoor air pollution, arising from use of wood, coal and crop residues for cooking and heating fuel, is responsible for a significant proportion of disease and disability in developing countries. Resulting health problems, including acute respiratory infections, burns, poisoning, and chronic lung disease, primarily affect poor women and young children. Household energy projects conducted in the last decade have tried to replace bio-mass with more efficient forms of fuel and to improve cook stoves. These programs have reduced bio-mass consumed as fuel by 30 to 70%, freeing up household funds for other critical needs, while reducing pollution from smoke emissions by 40%.[22] National clean household energy programs have been implemented in several LDCs and are being promoted to reduce the health risks from environmental pollution.

46. *Fiscal Policies.* Through fiscal policies, Ministers of Finance can also make important contributions to health improvement in LDCs. For example, they can support micro-credit lending policies that acknowledge the importance of health in repaying loans. In Burkina Faso, where diarrhoea is a major cause of death, those seeking micro-credit loans must attend an education session on the importance of personal hygiene, and in eastern and southern African, many micro-lending programs promote condom use. To reduce the burden-of-disease due to tobacco consumption, finance authorities also can increase the sales taxes on cigarettes. At the international level, Finance Ministers can lend their support for adoption of key elements in the Framework Convention on Tobacco Control involving elimination of duty-free sales of tobacco products, to strengthen the hand of LDCs in reducing demand for cigarettes.

47. *Trade and Private Investment Policies.* Health-and-trade linkages in LDCs hold promise for both economic development and improved health. To date, however, trade expansion has tended to harm, or insufficiently benefit, health or health systems. For example, country efforts to make use of public health protection safeguards in international trade rules on intellectual property rights have been hindered by trade

[22] GTZ, Household Energy Program, 1997.

sanction threats and lawsuits by multinational pharmaceutical companies. Meanwhile, some developing countries train health professionals for "export" to generate remittances, but this exacerbates health professional shortages in the countries of origin. Many countries also seek to attract private investment, but the entry of foreign for-profit private health providers and insurers can cause more harm than good if it siphons off professionals from the public sector, or undermines equity in health financing. Finance and trade officials that advocate greater domestic or foreign private investment in health should be aware that health markets operate differently from other markets. Strong regulation is needed to ensure that such investments do not undermine efficiency, quality or equity goals for the health system. Trade and health officials must work together to design national policies that take into account both economic development and health needs.

48. *Employment and Labour Policies.* The capacity to work depends on the health of workers. Yet, the ILO estimates that more than 1.2 million people die from work-related accidents or diseases each year, with work-related accidents estimated to be over 250 million each year. When family breadwinners experience episodes of ill-health, long-term disability, or death, the results can be disastrous, as the entire household suffers due to the loss of income and the high cost of medical care. Maintaining the health of workers is increasingly seen as critical by employers as an essential business investment. Governments can assist by promoting safe and healthy work settings, for men and women in both formal and informal sectors. This involves development, adoption and enforcement of occupational health and safety standards in line with international ILO standards. At the same time, the ILO needs greater powers to enforce minimum occupational safety and health standards adopted by Members, to protect workers from exposure to workplace hazards and reduce deaths and disabilities from occupational injuries. For those who fall ill or are injured at work, social security systems should be put in place to temporarily replace income and cover medical costs. Community-based health and social services for sick workers would provide new sources of employment, and ensure that workers need not take off work to care for sick family members.

Implementation Issues and Challenges Beyond the Health Sector

49. *Need for International Policy Coherence*. While much of the policy coherence agenda is focused at the national level,

such efforts need support and reinforcement at the international level. Several recent UN conferences, including the Millennium Summit and the World Summit on Social Development +5, emphasized the need for greater policy coherence between international policies in different sectors to achieve more progress towards poverty reduction and the International Development Goals.

- ***What mechanisms can be used to examine the coherence between international economic or social policies and public health objectives before their adoption? Would health impact assessments be useful?***

50. *LDC Participation in International Organizations.* International policies in support of poverty reduction are most useful to LDCs if their concerns and needs are adequately reflected. This requires LDCs to fully participate in decision-making processes of major international organizations. Yet, most LDCs lack the capacity to do this due to limited means or lack of technical knowledge, or insufficient political power to affect the outcome of policy debates. Efforts are under way by several international agencies to expand their technical assistance resources and better target their technical assistance to the needs of LDCs, but to date progress has been slow.

- ***What changes – e.g. technical capacity building, formal institutional structures, or changes in decision-making processes – could enhance the participation and influence of LDCs in international negotiations?***

51. *Multilateral Trade Agreements and Health.* The increasing influence of multilateral trade rules on health in many areas demonstrates the importance of ensuring that public health objectives are taken into account in both in national trade policies and in multilateral trade agreements. At the global level, some have suggested that changes may be needed in the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) to ensure that developing countries can more easily make use of legally available exceptions to make patented life-saving drugs more available or affordable. Others stress the importance of shielding developing countries from undue pressure to make market access commitments in health services and insurance under the General Agreement on Trade in Services (GATS) that would permit or expand the entry of foreign providers, if doing so would undermine national health equity efforts.

- ***How can LDCs ensure that national health and trade policies are mutually supportive for economic and social development? How can LDCs use trade in health goods or services for economic growth, while ensuring it does not weaken national health capacity or compromise health equity? What do LDCs need to be able to regulate and manage foreign investment in health services?***

- ***Which provisions in existing WTO agreements on TRIPS or GATS should be changed or strengthened to ensure that LDCs do not experience adverse effects on their health systems? Should the public health safeguards in the TRIPS Agreement be modified to ensure that LDCs can import essential drugs at an affordable price? Are there new provisions that would protect LDCs from potentially adverse effects of liberalization in trade in health services?***