



CHATHAM HOUSE

Chatham House, 10 St James's Square, London SW1Y 4LE  
T: +44 (0)20 7957 5700 E: [contact@chathamhouse.org.uk](mailto:contact@chathamhouse.org.uk)  
F: +44 (0)20 7957 5710 [www.chathamhouse.org.uk](http://www.chathamhouse.org.uk)

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## Meeting Summary: Centre on Global Health Security

# The Commission on Macroeconomics and Health: Ten Years On

Charles Clift

Senior Research Consultant

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## **INTRODUCTION**

The Centre on Global Health Security at Chatham House hosted an international conference, on 9 December 2011, to mark the tenth anniversary of the December 2001 publication of the report of the Commission on Macroeconomics and Health (CMH). The meeting was an opportunity to consider the significant changes in international health policies, institutions and financing that have occurred in the last decade, and what should be the priorities for improving health outcomes internationally in the next ten years, given today's very different economic and political circumstances.

The purpose of the day was not to analyse the extent to which the CMH recommendations have been put into practice, nor the reasons why they might not have been. However, setting the report recommendations against what has actually happened provided a useful framework for consideration of future policies, and for highlighting key relevant issues.

### **Objective**

The principal objective of the conference was to consider what are the key issues confronting those interested in maintaining progress in meeting global health goals in the current economic environment. A secondary objective was to help Chatham House decide how it could usefully contribute to new policy thinking through convening, in 2012, one or more working groups on important themes identified during the conference.

### **Format**

The first session was an introductory review of the CMH, its impact and implications for future policy. Jeffrey Sachs, who was the Chair of the Commission, gave the keynote address. The second session considered the central issue raised by the CMH of national and international financing. The third examined the question of innovation and access to medicines, and the final session focused on what should be done now.

## SESSION ONE

### **The CMH Report – Ten Years On: Perspectives on the Report and its Impact**

*The central thesis of the CMH report is that investing in health is good for economic development. On that basis it recommended massive increases in health spending by governments and donors. It also made recommendations on the configuration of national health services to deliver essential healthcare interventions, on strengthening investment in research and development, and on measures to promote access to medicines by the pharmaceutical industry in concert with international organizations. The opening session provided an opportunity to consider the validity of the report's central propositions and its impact in the light of ten years of unprecedented investment by national governments and donors in health. It also provided an opportunity to highlight the major policy issues in improving health outcomes in the next decade in the light of today's very different circumstances.*

Open: **David L. Heymann**, *Head & Senior Research Fellow, Centre on Global Health Security, Chatham House*

Chair: **Richard Horton**, *Editor in Chief, The Lancet*

Keynote Address: **Jeffrey Sachs**, *Director, The Earth Institute, Columbia University*

Panellists: **Adesina Iluyemi**, *NEPAD Council*, **Dean Jamison** *University of Washington*, **Prabhat Jha** *University of Toronto*, **Mohga Kamal-Yanni** *Oxfam GB*, **Anne Mills** *London School of Hygiene & Tropical Medicine*

In his opening remarks David Heymann highlighted the significance of the CMH in adding weight to the argument that provision of medications to cure infections or prolong life was as important as investment in vaccines, which prior to 2000 had been the way that donors saw their cost-effective interventions.

In his introductory remarks **Richard Horton** noted the imminence of the Rio+20 Conference on Sustainable Development in June 2012. In that context, a focus on macroeconomics and health might be insufficient and account needs to be taken of the importance to health of the wider dimensions of population, climate, energy, agriculture and water. The global landscape has changed dramatically, not just because of the global economic recession but also because of threats to multilateral health institutions – in particular affecting the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the World Health Organization (WHO). There are also new agendas, in particular relating to non-communicable diseases.

**Jeffrey Sachs** opened by responding to his critics, reiterating his conviction that the path set out by the CMH was the correct one. The CMH was “science-based” politics and had succeeded in important ways in bringing about change, but not in everything it called for. At the end of the 1990s, there were three full-blown pandemics (AIDS, tuberculosis and malaria), but spending to address them was minimal. The CMH looked at the evidence linking health and economic development – the case was strong and irrefutable. It looked at what could be done, focusing on known and low-cost interventions that could address excess disease burdens. It then calculated what a package of interventions would cost. On that basis it concluded that the incremental cost required was about 0.1% of GNP of the rich world – roughly \$35-40 billion – equivalent to about 20 days of spending by the Pentagon. “People die for the absolutely stupid reason that what are macroeconomically tiny amounts are very, very difficult to raise”. He argued that he and the CMH had contributed to the creation of a number of institutions – the Global Fund, the President’s Emergency Plan for AIDS Relief (PEPFAR) and the President’s Malaria Initiative (PMI). In India the CMH process had contributed to the initiation of the National Rural Health Mission. The last ten years have demonstrated that global health works – millions of lives have been saved and hundreds of millions protected through interventions that have been made.

In his view, the current crisis has a number of components. Multilateral processes are failing – the Durban Climate Change Conference broke down and three important environmental treaties had failed in application. The Global Fund's cancellation of its 11<sup>th</sup> Round of grant-making is the single biggest setback to fulfilling the Millennium Development Goals. The United States is now failing in its leadership role – President Bush showed more leadership than Barack Obama has. There is a really serious crisis, even to hold on to gains already made. On the other hand, there are many positive trends. Our technologies - such as insecticide-impregnated bednets, diagnostic tests and use of smartphones with expert systems - are now vastly better than they were ten years ago. Economic growth in middle-income countries, where many poor people live, has increased resources available for health care.

He argued that applying the strategy and methodology used by the CMH would be a sound approach for the next ten years and that the “knowledge community” should “find the voice robustly to say that this can be done and it must be done”.

*Points made by **panellists** included the following:*

- The analytical approach of the CMH report has contributed in a very useful way to subsequent thinking about how best to strengthen health systems. This includes deepening the analysis in the High-Level Taskforce on Innovative International Financing for Health Systems in 2009. And more is now known about how well a variety of approaches to health-system strengthening works. Less positive is the very detrimental impact of the fragmented international aid architecture on country health systems. There has been little or no improvement. Secondly, there is no long-term system for supporting improved health outcomes at the country level. System-strengthening is not something that can be achieved in a few years. Thirdly, the emphasis of the CMH was very much on strengthening international financing – it could have been stronger in stressing the importance of impetus at the country level to strengthen health financing. An important focus now should be on how to achieve universal health coverage in countries and what mix of funding methods might be used to move towards this. Finally,

there is still a grossly inadequate evidence base to guide countries on how best to strengthen health systems. A large share of global poverty is now in middle-income countries. A central issue, in countries such as Mexico, is inequality, in general and in relation to health spending and outcomes. Mexico is extending health insurance to the poor as one way to address these inequalities, but out-of-pocket spending by the poor is still unacceptably high.

- There is still a lack of institutions in Africa to deliver health care effectively. Primary healthcare is a particular problem. Perhaps improved health care will only follow industrialisation. Better technology such as diagnostics and information and communications technology (ICT) innovations are needed to bypass geographical and workforce challenges.
- The proliferation of global health institutions was concerning. The focus should be on making what exists work better. In particular, WHO is in crisis but its total annual budget is approximately the equivalent to that of a hospital in the UK. A central concern was the emphasis placed on private health care as a possible solution, as that emphasis is based on ideology rather than evidence. Health needs to be as much a social investment as an economic one. Women's health should be supported because of the importance of women in maintaining the social fabric on which economic development depends. The importance of asserting human rights to health and education should be emphasised to governments.
- Child survival has improved over the last 40 years, and it is getting less costly to achieve over time. Similarly adult survival is improving, particularly in females, but it is getting more expensive to improve, in part as a result of meeting the costs of HIV and tobacco-related disease, but also because of the absence of global investments in the same strategies that secured reductions in child mortality over the last 40 years. Strategies that prioritize adult malaria could reduce malaria deaths even more. Tobacco deaths have reduced dramatically in developed countries, in particular through increased taxation. Innovations such as the polypill could cheaply address cardiovascular diseases. In the current economic crisis politicians must be convinced that

investment in health was as good a means of providing fiscal stimulus as other “shovel-ready” infrastructure options like public infrastructure such as bridges.

- The CMH argued for an evolutionary approach to dealing with health systems constraints, including recommending categorical (vertical) programmes as a transitional measure in capacity-weak environments, while recognising that there might also be positive learning and spillover effects on the wider health system. Whether the time for categorical programmes has passed, in favour of health-system approaches, is a debate still very much with us. The CMH emphasised the *instrumental* value of better health – how health could contribute to improved income and economic development. What it omitted was how to take account of its *intrinsic* value in terms of better or prolonged life, which is not captured by conventional methods of measuring development focused on national income.

*In discussion, points made included the following:*

- The Global Fund has become a very complicated financing mechanism and has to some extent lost its way in supporting national systems and institutions. It does not need to be reinvented, but reformed. Given donor commitment, it could indeed evolve into a mechanism for supporting countries more holistically.
- In the context of helping to promote the development of health systems, the Global Fund should become a Global Health Fund.
- The word “donor” needs to be rethought. “Funders” better describes a situation where the “donor” demands results and taxpayers demand accountability for the use of their money.
- The human resource implications of delivering a package of essential interventions were not sufficiently explored in the CMH report. It implied an impossible mix of skills in the health workers available at health centre level.
- It is countries that need to strengthen health systems, and that is a long-term endeavour requiring consistent support. The movement to increase aid effectiveness has largely failed because funders have not allowed countries to manage flows and

spend them according to their own priorities. The position of countries needs to be strengthened but that is very difficult without agreement and coordination on the part of donors.

- A special programme along the lines of the WHO Special Programme for Research and Training in Tropical Diseases (TDR) should be considered to address non-communicable diseases.
- The Financial Transactions Tax (FTT), often referred to as the Robin Hood Tax, should be implemented as a reliable source of funding for health and education.

## SESSION TWO:

### National and International Financing for Health

*The CMH recommended that health spending by national governments should increase by 1% of GNP by 2007 and 2% of GNP by 2015, and that international development assistance for health should increase from \$7 billion in 2001 to \$27 billion in 2007 and \$38 billion in 2015. Each country should set up a national commission to chart its own way forward in the light of its own circumstances. This session reviewed the overall record on health financing in the last decade, experiences in establishing national commissions, and that of international financing agencies. It also focused on prospects for future financing and the implications for policy.*

Chair: **Richard Feachem**, *Director, The Global Health Group, University of California, San Francisco*

Overview: **David Evans**, *Director, Department of Health Systems Financing, WHO*

Panellists: **Rifat Atun**, *Global Fund to Fight AIDS, Tuberculosis & Malaria*, **Alvaro Bermejo** *International HIV/AIDS Alliance*, **Tore Godal**, *Government of Norway*, **Nora Lustig**, *Tulane University*, **Sujatha Rao**, *former Health Secretary, Government of India*

In his introductory remarks the chair, **Richard Feachem**, noted the massive changes for good that have occurred in the last ten years in relation to, for example, childhood immunisation, HIV/AIDS treatment and malaria. The CMH contributed to that outcome. But now we are in the early years of a deep global financial crisis. Major funding bodies are flatlining or even beginning to decrease funding. And investments by countries are declining in real or relative terms. There is a real danger of moving backwards, and urgent consideration needs to be given to how to avoid that.

In his presentation, **David Evans** noted that the CMH target of per capita spending of \$34 by 2007 was met by only a minority of 61 low-income countries considered – 32 failed to meet the target by 2007 and 28 have still not done so, according to the latest figures. In terms of the CMH recommendation that developing countries increase spending by 1% of GDP by 2007, there was some increase in low-income countries, less in least developed countries, but the increase still fell short of the CMH recommendation. However, in terms of total domestic health expenditure, the least developed countries raised more than the \$4 billion proposed by the CMH. The difference between the proportional and absolute targets is explained by the inclusion of private spending and by the fact that economic growth was much higher than anticipated by the CMH.

The goals the CMH set for donors were not reached. Against an inflation-adjusted target of about \$27 billion in 2007, the 61 countries actually received about \$14 billion from external sources, according to OECD data. More comprehensive data that include, for instance, spending by foundations, suggest the total received may have been around \$20 billion. Including amounts estimated from general budget support provided by donors adds little to these figures.

Notable features from the data include the very large variations in per capita receipts between countries – the rationale for which was difficult to discern – and the lack of predictability in aid flows as demonstrated by annual variations.

In his personal view, although most of the CMH targets were not met, there is a case for saying that the political impetus to which the CMH

had contributed might be responsible for raising development assistance for health by some \$15 billion annually. There is a continuing need, even with the global economic crisis, to make the case that more resources are needed. But there is also a need to improve value for money in both national and international funding.

Spending on health care might push 100 million people into poverty every year. This needs to be emphasised in positioning health as a very important component in upcoming discussions on the promotion of sustainable development.

*Points made by **panellists** included the following:*

- Not only have large amounts of money been mobilised but there have been remarkable achievements in channelling these funds effectively into country programmes. However, these gains are fragile and there is a responsibility to maintain them. The Global Fund, GAVI and UNITAID effective platforms for channelling funds to countries. But issues remain, such as the asymmetry in per capita funding going to countries. It is also disappointing that innovative (non-donor) funding remains such a small proportion of total funding e.g. for GAVI and the Global Fund. This is where to look to generate new sources of funding, but using existing platforms.
- A large share of global poverty is now in middle-income countries. A central issue, in countries such as Mexico, is inequality, in general and in relation to health spending and outcomes. Mexico is extending health insurance to the poor as one way to address these inequalities, but out-of-pocket spending by the poor is still unacceptably high.
- The CMH, and the national CMH, had a huge impact in India. Before becoming Prime Minister, Manmohan Singh was a CMH member. Today health spending has increased from under 1% to 1.3-1.4% of GDP and the goal is to raise it to 3% of GDP. But the current position remains shameful in important respects; almost 40% of people going into hospital are pushed into poverty by the need to sell their assets. Donor funding, although being phased out, has been instrumental in important respects, for example in programmes for HIV/AIDS and malaria, and these programmes will be sustained by increasing domestic resources. Perhaps the

CMH paid less attention than it should have to the issues of domestic absorption capacity and the institutional reforms required to increase it. The CMH was a powerful instrument created by WHO but then WHO appeared to abandon it and the momentum was not sustained.

- The CMH performed an important function in providing technical articulation and legitimacy for the wave of activism that surrounded HIV/AIDS a decade ago. But it was an error to frame the debate in the development assistance paradigm. Now the economic crisis has revealed the mistake of relying on this paradigm. The definition of sustainability needs addressing – the UK National Health Service is defined as sustainable but relies on permanent importation of health workers from the developing world. A health system in a developing country that relies on an inflow of cash is described as unsustainable. There is a new momentum of activism caused by anger about the economic crisis and the continuing role of the financial sector. The financing of global health needs to shift from the development assistance paradigm to reliance on an FTT or similar mechanism that would be the financial expression of global solidarity and provide a predictable source of financing.
- Norway's foreign aid budget remains at 1% of GNP, but the way it is spent is changing. Norway is concentrating assistance on fewer low-income countries and adopting a different strategy for middle-income countries. It is also shifting from funding budget or sector support to aid channels, such as GAVI and the Global Fund, that give tangible results. It also supports Every Woman Every Child, which is notable for commitments amounting to \$40 billion from many countries, including \$8 billion from low-income countries themselves, and for its emphasis on accountability through an independent expert group. Going forward, consideration needs to be given to what the private sector can do. In Southern Sudan the infrastructure being put in place is for mobile phones. If the private sector can provide 6 billion mobile phones, this represents an opportunity for building on the private sector infrastructure. There is a need to consider and build on the comparative advantage of different stakeholders in the private and public sectors.

*In discussion, points made included the following:*

- There is a need for caution in how much emerging economies (such as the BRICS) can be expected to contribute to global health institutions.
- On the other hand, it is reasonable for these emerging economies to be held accountable for dealing with their own inequalities and disparities, and putting their own houses in order. There should perhaps be a monitoring mechanism for both international and national funding.
- While it might not be reasonable to expect them to contribute to global health needs proportionate to their incomes, they could add their political support to proposals such as the FTT.
- While the Global Fund in aggregate might sustain current levels of spending and outputs, this will not be the case for particular countries and lives will be lost. And countries will not, for example, be able to implement WHO guidelines for earlier treatment. That is why civil society is calling for an emergency replenishment.
- Innovative financing might be mobilised by focusing on targets people can understand (such as moving from 8 million to 30 million on AIDS treatment).
- Innovative mechanisms such as the International Finance Facility for Immunisation (IFFm) are justified by the benefits of frontloading – the case for frontloading is also very strong for HIV/AIDS given new evidence on the benefits of early treatment and the preventative impact of treatment.
- It is also important to consider also innovative financing mechanisms that countries can use as, for instance, illustrated in the 2010 World Health Report.
- A mechanism proposed by WHO is a solidarity tax on tobacco that could raise \$10.8 billion annually.
- Domestic financing is much more important than international financing in most countries – that is why dialogue between ministries of finance and health is important.

- The importance of predictability in financing was highlighted.
- The current food crisis and malnutrition could have a tremendous impact on health.
- More operational research is required, in particular to improve efficiency in healthcare delivery.
- There is a need for coherence - the donors that talk about the need for health system strengthening are the same ones that are insisting that the Global Fund concentrate on core tasks.
- There are areas of global health that should be outside the aid arena – and that applies to most of the non-communicable disease agenda. In summing up, **Richard Feachem** advocated for the pay-for-performance model of investment as a means of improving efficiency and urged a study of the damage and heightened risk and vulnerability presented by the Global Fund's decision to cancel its 11<sup>th</sup> grant-making round. Finally, a group of donors should discuss how the gains made to date can be sustained and a backward slide prevented.

## SESSION THREE:

### Promoting Innovation and Access

*The CMH recommended that at least \$3 billion annually should be allocated to research and development (R&D) directed at the health priorities of the world's poor and that \$1.5 billion of this should be channelled through a new Global Health Research Fund focused on basic research and capacity building. On access to medicines, the CMH's principal recommendation was that the global community should establish differential pricing in low-income markets as the operational norm and that industry and the international community should jointly agree guidelines on pricing and voluntary licensing of a set of essential medicines in low-income markets. This session provided an opportunity to review progress on innovation and access relevant to the world's poor and to consider future policy.*

Chair: **Hans Hogerzeil**, *former Director, Essential Medicines and Pharmaceutical Policies, WHO*

Panellists: **Seth Berkley** CEO *GAVI Alliance*, **Ellen 't Hoen** *Medicines Patent Pool*, **Bernard Pecoul**, *Drugs for Neglected Disease Initiative*, **Jon Pender** *GlaxoSmithKline*, **Dilip Shah** *Indian Pharmaceutical Alliance*, **Sophia Tickell** *Meteos*

The chair, **Hans Hogerzeil**, spoke of issues of access to existing medicines in terms of differences in price and availability between the public and private sectors. And there is a need for innovation where there are medicines or vaccines that are simply missing. There are also special issues relating to patented medicines needed in developing countries – HIV is one example, but cancer drugs might be important in the future.

*Points made by panellists included the following:*

- GAVI has helped to transform the vaccines market through a remarkably successful collaboration between public and private sectors. The delay in introducing vaccines into the developing world has been reduced; the new pneumococcal vaccine was launched in 2011 at the same time in the developed and developing worlds. One issue is how to apply differential pricing effectively outside low-income countries, particularly in middle-income countries with large poor populations. For the future, ministries of finance must be involved to get sustainable funding at country level for vaccine programmes. More attention must also be paid to market-shaping to promote the lowest possible prices that are also consistent with maintaining competition and multiple suppliers and allowing manufacturers to maintain quality standards. And funding for R&D, which is beginning to decline, must be maintained.
- There is now a much more mature debate about access to medicines than there was ten years ago, with a more constructive relationship between different stakeholders. The glass is half full and a positive outlook is required. Private-public partnerships are essential in hard times as well as good. Much has been achieved in the last ten years and this can continue with the right approach. Tiered pricing has become much more the norm as a sustainable

business model, but we must guard against too much downward pressure on prices, which could also reduce investment in R&D. Regulatory harmonisation is an important issue in promoting quicker access to quality medicines. And the shortage of front line health workers must be addressed.

- The reintroduction of the product patent regime in India, and ongoing challenges to India's current IPR regime, are threats to the supply of medicines to developing countries. At the same time there are limits to the extent to which Indian industry can lower prices if the industry is to be sustainable. Regional regulatory harmonisation is important for the generic industry as well. Intellectual property issues should be removed from trade agreements, as the former are trade-restrictive.
- Other important events for improving access to medicines occurred ten years ago, along with the publication of the CMH report. The Doha Declaration on TRIPS and Public Health was adopted; Indian generic producers offered HIV treatments at \$350 per patient; pharmaceutical companies dropped their case against the South African government's medicines legislation and WHO launched its pre-qualification programme for medicines and rethought its essential medicines list. All of these were crucial in making treatments more accessible, particularly for HIV, with prices being driven down by competition. It is now confirmed that treatment works and that it also works as prevention. Although the financial situation is difficult, the CMH showed that the costs are small in the greater scheme of things. And the money can be mobilised, for example through an FTT. The Medicines Patent Pool (MPP) is one way of addressing the proposal for greater voluntary licensing advocated by the CMH, and all relevant pharmaceutical companies and other organizations should license their HIV patents to the MPP. Seven companies are now in negotiation with the MPP and two agreements have been signed. How innovation is best financed needed consideration – delinking the costs of R&D from the price of products is an important way to promote both innovation and access.
- The pharmaceutical industry has seen great changes in the last decade. Companies are now making a much better effort to address access to medicines issues. Many existing medicines

developed a decade or more ago are going off patent. Developed markets have matured and now there is much more interest in the prospects in emerging markets. An important future issue is access to patented medicines for non-communicable disease, particularly cancer. There is an analogy with HIV – if the situation is not addressed then people are denied access, which is an unacceptable situation. In emerging markets, how can markets be effectively segmented to maintain commercial viability but to enhance access for low-income consumers? The pharmaceuticals market is extremely opaque, which makes it difficult to determine what is actually occurring within the marketplace – there needs to be more transparency. Optimism was necessary but a financial storm was engulfing the world. There was a need to find market-driven ways to minimise treatment costs and also to find ways to protect the most vulnerable in these very difficult times – otherwise existing inequalities would be exacerbated.

- There has been some progress in the development of innovations needed to treat diseases prevalent in developing countries, particularly by improving existing tools. But the new chemical entities that would transform treatments where current tools are inadequate have not been developed. There is still much to do in the R&D field and secure sustainable and predictable funding is needed. Any new funding source should have a suitable proportion, not necessarily large, hypothecated to R&D. A strong WHO was required to drive things forward and consolidate existing initiatives. A WHO group reporting soon will propose a binding convention on R&D and stress the importance of an open innovation environment. The role of the emerging economies will be very important in moving forward R&D relevant to their needs and those of other developing countries.

**Roger Kampf**, from the World Trade Organization, noted that the Doha Declaration had helped to demonstrate the compatibility between the TRIPS agreement and public health objectives. There is now much better data not just on pricing but also on patents on important products. There is also much better cooperation between WTO, WIPO and WHO, who are launching a trilateral study on innovation and access in 2012.

*In discussion, points made included the following:*

- The issue of data exclusivity in trade agreements needs to be addressed in the context of respect for the Doha Declaration.
- In answer to a question on the forum for regulatory reform, it was noted that WHO coordinates a biennial meeting of drug regulators. The issue is not structures, but getting meaningful discussion. The need for a strong WHO to drive reform was mentioned, but also that it ultimately depends on country willingness. Participants mentioned the importance of regional approaches rather than use of the International Conference on Harmonisation (ICH) dominated by the regulatory needs of developed countries. The point was also raised as to whether regulation should incorporate elements of health technology assessment so that it highlights the suitability of products and their availability at a specified quality.
- The Doha Declaration is often criticised because there has been little compulsory licensing. However, it has a profound influence on practice, for instance in encouraging procurement of generics by countries without fear of litigation from patent holders.
- Maintaining Indian patent law against attacks is important in avoiding the patenting of trivial innovations.
- Product Development Partnerships have been successful in addressing issues of access upfront as part of their business model.
- There was discussion of whether the poor should pay for R&D and how differential pricing could be managed to ensure that R&D costs were fairly distributed between different income groups. In particular, how can markets be effectively segmented within countries? How important is transparency, or can it be a barrier to tiered pricing in some circumstances? Different views were expressed.
- The importance of health workers for delivering medicines was highlighted – they constitute some 60% of healthcare costs.
- The apparently escalating cost of R&D and its implications for the business model of pharmaceutical companies was discussed.

Some thought the current model sustainable, others that large companies should exit R&D but that it is important that a viable alternative for needed R&D be found.

- The great potential of new technologies for medicine supply, such as mHealth and other ICT innovations, was recognised.

## SESSION FOUR:

### Where Do We Go from Here? Priorities for the Next Decade

*A new CMH established now would face a very different world. How would its analysis differ? How would its recommendations differ? What issues could Chatham House address as follow-up to the Conference?*

Chair: **David L. Heymann**, *Head & Senior Research Fellow, Centre on Global Health Security, Chatham House*

Panellists: **Dyna Arhin-Tenkorang** *Harvard University*, **Felicia Knaul** *Harvard Global Equity Initiative*, **Gorik Ooms** *Institute of Tropical Medicine, Antwerp*, **Tido von Schoen-Angerer** *MSF Access Campaign*, **Mark Walport**, *Wellcome Trust*

The chair, **David Heymann**, asked the panel members to address two questions, firstly if a new CMH was established today in a somewhat very different world, how would its analysis differ and secondly, how would its recommendations differ.

*Points made by **panellists** included the following:*

- The whole concept of international assistance has to change. Just as in Europe there is a permanent mechanism at the national level for redistributing income through taxation and social protection measures, the equivalent system needs to be put in place at a global level. There needs to be a contract between nations that avoids the current situation where funding decreases up, as happened with the Global Fund. A joint action and learning initiative is currently addressing four questions: What is the package? What is the national responsibility? What's the

international responsibility? And what is the mechanism to make it work?

- Consideration needs to be given to the determinants of health that lie outside the health sector, such as clean drinking water, sanitation, food and nutrition. And the lessons learned in the last decade about domestic financing mechanisms such as health insurance, and how they can reach the poorest people. A new Commission should be organized regionally to involve country decision-makers – that is why the CMH had such an impact in countries such as Ghana.
- The voice of the patient needs to be heard. In addition to science-based politics, we need science-based advocacy. There should be a “diagonal, integrated approach” combining strengthening health systems with an array of health priorities that include non-communicable diseases and chronic illness, including cancers. As infectious diseases are addressed, partly as a result of the work of the CMH, the world is confronted by chronic diseases as a major cause of illness, death and impoverishment. And there is tremendous inequity in how they are dealt with. Innovative ways of organizing human resources and integrating programmes to address these inequalities need to be examined. The current economic crisis is a great opportunity to catalyse change along these lines.
- There is no simple correlation between health and wealth. Some rich countries have rather poor health and some poor countries have rather good health. Rich country health systems are becoming increasingly unaffordable. Rich countries might need to learn from poor countries. The donor/recipient paradigm should be superseded by partnerships based on mutual commitment and accountability. Good value systems are important – good health does not come where they are absent e.g. Russia. Other determinants of health such as water, sanitation, infrastructure and education need to be addressed. Ideology-based health policy, of which the World Bank is often guilty, needs to be avoided in favour of policy based on data and research. There is no right answer as to whether private or public funding is best – most probably it should be a combination. “Crude exhortations simply to spend more” should be avoided. Accountability needs

to be demonstrated to persuade hard-pressed taxpayers to part with money. It is about people, governance, accountability and not thinking that health problems are solved by health programmes alone.

- The current funding emergency must be addressed in order to continue to scale up funding programmes. AIDS must be treated not as an exception but as an engine that can drive progress in other areas. An enlightened approach is lacking in dealing with middle-income countries. They are asked to fund international bodies and take care of their own problems, and to sign up to trade deals that threaten their generic industries. This is not a very smart approach and unlikely to get donor funding from countries such as India or China. More lessons can also be learned from these countries' approaches to providing universal health care, and about the treatment of diseases such as cancer in a low-resource environment. Moves in the WHO working group to start negotiations for a binding R&D framework are encouraging. There is a need to ensure that R&D meets priority health needs, that R&D costs are shared fairly and that the costs of R&D are delinked from the price of products. This is the only way to combine innovation with access needs effectively.

*In discussion, points made included the following:*

- PEPFAR had unintended consequences in weakening health systems and there is too much concentration on AIDS, TB and malaria, while the multiplicity of people's healthcare needs is being ignored.
- The results achieved need to be better articulated to justify further funding in these difficult times. Governance and accountability is important in low- and middle-income countries – countries need to increase their commitment and accountability. On the other hand, the fact that times are tough is no reason to give up on finding resources. The FTT is likely to become a reality, at least in Europe, and a significant share should go to global health.
- The finding of the Commission on the Social Determinants of Health that social injustice is killing people on a grand scale has been ignored. More than macroeconomics and health care was

needed to deal with growing inequalities. On the other hand, that Commission is lacking in practical recommendations.

- The donor/recipient paradigm should move to one of shared responsibility for funding and results. There is also a need to find a way to bring together the myriad initiatives in a coherent manner. This requires research on how best to integrate different programmes and develop optimal delivery models. There is also a need for more leadership, which should come from the south.

In his closing remarks, **Jeffrey Sachs** said the overall discussion sounded very pessimistic. Much had been achieved and there was more to do, and there is no reason to give up. There is a need to be persistent and avoid hand-wringing and squabbling. There is a lot of money outside the United States and Europe and with the private sector. An FTT is needed. And countries such as India will have the resources in a decade to be self-sufficient. The job we started should be finished; it is going in the right direction.

In summing up, **George Alleyne** said he did not, based on experience in the Americas, buy the argument that economic crisis would prejudice investment in health. He traced a link from the CMH to the Caribbean follow-up to the UN High-Level Meeting on Non-communicable Diseases. Also, he argued that the CMH had not ignored the intrinsic or constitutive value of health investment. But more analysis is justified in elucidating both these and the instrumental value of health. There is also room for innovation in more easily understood health metrics. Going forward, one disease must not be set against another, or communicable against non-communicable disease. The latter should be dealt with largely outside the aid arena. And there should be a focus on how health should be effectively integrated in the sustainable development agenda in Rio+20.

In his final remarks, **Richard Horton** complimented the Commission and others on the achievements of the last decade. One powerful idea had come out of the discussion – the notion of accountability. One of the difficulties faced by the Global Fund is the lack of independent evaluation by which its impact can be verified. Without

that there is no way to demonstrate success. Such verification is the logic behind the UN Secretary-General setting up an Independent Expert Review Group to provide formal oversight of programmes focused on women's and children's health. Accountability requires measurement and the capability to act on the results of measurement. It empowers people to hold countries and agencies accountable and agencies and countries to be mutually accountable. The next six months will be critical – in the 17 draft Rio+20 sustainable development goals “basic health” is No.17. That is why a lot of work is needed to inject the lessons of the last decade into the process of sustainable development.

“Accountability isn't just about accountability to a goal or a target or an initiative or a programme. It really is accountability to this idea of a progressive realisation in improving the rights of reaching the highest attainable standards of health. That isn't motherhood and apple pie. It's the core reason we are here today,” he said.