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MACROECONOMICS AND HEALTH: THE WAY FORWARD IN THE AFRICAN REGION

Report of the Regional Director

EXECUTIVE SUMMARY

1. In January 2000, the WHO Director-General established the Commission on Macroeconomics and Health (CMH) to study the links between increased investments in health, economic development and poverty reduction.

2. The Commission's analysis revealed that:

(a) ill-health contributes significantly to poverty and low economic growth;
(b) a few health conditions account for the high proportion of ill-health and premature deaths;
(c) a substantial increase in the use of cost-effective interventions in addressing priority health problems can potentially save millions of lives per year;
(d) a close-to-client (CTC) system is required to increase cost-effective interventions targeting the poor;
(e) the current level of health spending in Member States is not sufficient to help implement cost-effective interventions.

3. The Commission recommended enhanced political commitment, at both national and international levels, increased investments in close-to-client health systems and greater use of cost-effective interventions in addressing priority national health problems. Given that different Member States face different challenges, this paper suggests generic steps that can be taken to develop investment plans for increasing the use of cost-effective interventions to address priority health and health-related problems.

4. The Regional Committee is requested to review and endorse the generic steps proposed in this document for implementing the Commission on Macroeconomics and Health recommendations at country level.

CONTENTS

Paragraphs

INTRODUCTION

1. Improved health is not just an end in itself but also an essential means of reducing poverty and achieving sustained economic growth. In the WHO African Region, health outcomes must be significantly improved because the current huge burden of disease largely undermines socioeconomic development.

2. In recognition of the above, the WHO Director-General established the Commission on Macroeconomics and Health (CMH) in January 2000 to study the links between increased investments in health, economic development and poverty reduction. The findings of the Commission, published in December 2001,[1] demonstrated that judicious investments in health can help increase economic growth in developing countries.

3. The Fifty-fifth World Health Assembly, held in May 2002, commended the CMH action agenda as a useful approach to the achievement of the Millennium Development Goals (MDGs)[2,3] and the targets of the New Partnership for Africa's Development (NEPAD).[4]

4. This document attempts to put the key CMH findings in the African perspective. It aims to provide guidance to Member States in the African Region on generic steps for implementing the action agenda recommended by CMH, within the context of national development plans and poverty reduction strategies.

RELEVANCE TO THE AFRICAN REGION OF THE FINDINGS OF THE COMMISSION ON MACROECONOMICS AND HEALTH

5. *Ill-health contributes significantly to poverty and low economic growth (and vice versa).* The economic value of lost life years in 1999 due to AIDS was estimated to be 12% of the gross national product of sub-Saharan Africa. Average economic growth in malaria-free zones is at least 1% higher than in malaria-endemic areas.[5] Furthermore, it is estimated that for every 10% increase in life expectancy at birth there is a corresponding rise in economic growth of at least 0.3%–0.4% per year.

6. *A few health conditions account for the high proportion of ill-health and premature death.* In the year 2000, 70% of the 10.7 million deaths that occurred in the African Region resulted from the ten causes shown in Figure 1.[6] HIV/AIDS, lower respiratory tract infection, malaria, diarrhoeal diseases and maternal and perinatal conditions alone accounted for 54% of the deaths and 51% of disability-adjusted life years. This heavy burden of disease and its

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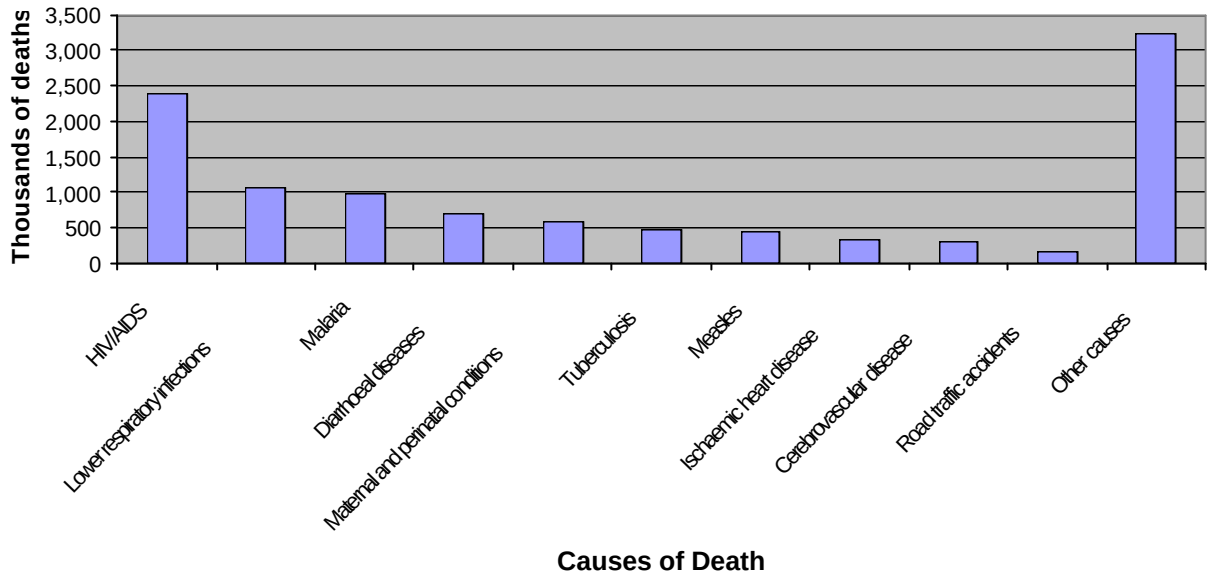
[1]WHO, Macroeconomics and health: Investing in health for economic development, Geneva, World Health Organization, 2001.
[2]Resolution WHA55.19, WHO's contribution to achievement of the development goals of the United Nations Declaration, May 2002.
[3]UN, UN Millennium Development Goals (MDG), New York, United Nations, 2000.
[4]NEPAD, NEPAD's Human Development Programme: NEPAD Health Strategy, Pretoria, South Africa, 2001.
[5]Gallup JL and Sachs JD, The economic burden of malaria, *American Journal of Tropical Medicine and Hygiene*, Jan–Feb; 64 (1–2 Suppl): 85–96, 2001.
[6]WHO, The World Health Report 2002, Geneva, World Health Organization, 2002.

multiple effects on productivity, demography and education have contributed significantly to Africa's chronically poor economic performance.[7]

Figure 1: **Leading causes of death in the WHO African Region**



7. *Substantial increase in the use of cost-effective interventions to address priority health problems can potentially save millions of lives each year in the Region.* Currently, the average access of the populations to health services is estimated at 53%, and less than 30% of the people have access to essential drugs.[8] Many cost-effective interventions (e.g. use of insecticide-treated materials, directly-observed treatment, short-course (DOTS), condoms, vaccines against childhood killer diseases) are available and yet they are not reaching the poor. There is, therefore, need to substantially increase the use of such interventions.

8. *A close-to-client (CTC) system*[9] *is required to scale up cost-effective public health interventions targeting the poor.* CTC systems consisting of health centres, health posts and outreach points are capable of delivering the key cost-effective interventions[10] required to reduce the burden of disease and improve health conditions in the Region. Developing an effective CTC system requires increased investments in infrastructure and health personnel capacity building.

[7]Bloom DE and Sachs JD, Geography, demography, and economic growth in Africa, *Brookings Papers on Economic Activity*, 2: 207–295, 1998.
[8]WHO, WHO medicines strategy: Framework for action in essential drugs and medicine policy 2000–2003, Geneva, World Health Organization, 2000.
[9]A health system that provides affordable promotive, preventive and basic curative care in localities inhabited mainly by the poor.
[10]Cost-effective interventions are public health interventions with the least cost per unit of effectiveness.

9. *Opportunities exist to improve current resource allocation within health systems by increasing the proportion of resources allocated to CTC systems.* By undertaking significant health sector reforms, more resources can be reallocated from over-resourced, less cost-effective systems of care to more cost-effective CTC systems. There is also growing evidence in the Region that hospitals[11] and health centres[12] can attend to more patients if the resources available to them are better managed.

10. *Despite efforts to improve efficiency in the use of available resources, the level of health spending in Member States is not sufficient to scale up cost-effective interventions.* Government expenditure per person per year is between US$ 1 and US$ 9 in 29 countries; US$ 11 and US$ 23 in eight countries and; US$ 37 and US$ 294 in nine countries.[13] The CMH report estimates that a minimum government expenditure of US$ 34 per person per year will be required to provide an essential package of public health interventions in order to achieve both the relevant MDGs and NEPAD targets. Thus, governments in the 37 Member States currently spending less than US$ 34 on health per capita per year will need to increase their budgetary allocations to reach the recommended minimum health spending.

11. *Member States can increase their domestic resources for health,* Heads of State of African countries made a commitment in Abuja to allocate at least 15% of their annual budgets to the health sector.[14] Yet, in 2000, four countries spent less than 5% of their annual budget on health; 23 countries spent between 5.1% and 10.3% of their budget; and 15 countries spent between 10.6% and 14.6% of their budget on health. Only two countries spent over 15% of their budgets on health.[15] This means that 44 countries spent less than 15% of their national budgets on health and will need to take appropriate steps to honour the commitment given by their respective Heads of State.

12. *In spite of the increased allocation of domestic resources to health, a financing gap will still need to be filled from external sources.* It is estimated that, globally, US$ 27 billion per year (as measured against the current US$ 6 billion) will need to be mobilized from international donors to complement domestic resources. Therefore, Member States need to advocate, individually and collectively, at the international level, for a fair share of such funds. In addition, there will be need to significantly improve the management of resources and the capacity to use the additional resources in a manner that especially benefits the poor.

13. *Investment in health-related sectors must be increased.* It is currently estimated that 47% of the population in the Region lack access to adequate sanitation facilities; 40.2% lack safe drinking water; 40% of adults in the Region are illiterate; primary school enrolment is 63%

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[11]Kirigia JM, Emrouznejad A and Sambo LG, Measurement of technical efficiency of public hospitals in Kenya: Using data envelopment analysis, *Journal of Medical Systems,* 26 (1): 29–45, 2002; Asbu EZ, McIntyre D and Addison T, Hospital efficiency and productivity in three provinces of South Africa, *South African Journal of Economics*, 69 (2): 336–358, 2001.

[12]Kirigia JM, Sambo LG and Scheel H, Technical efficiency of public clinics in Kwazulu-Natal province of South Africa, *East African Medical Journal,* 78 (3): S1–S13, 2001.

[13]WHO, World Health Report 2002: Reducing risks, promoting healthy life, Geneva, World Health Organization, 2002.

[14]OAU, Abuja declaration on HIV/AIDS, tuberculosis and other related infectious diseases. Addis Ababa, Organization of African Unity, 2000.

[15]WHO, The World Health Report 2002, Geneva, World Health Organization, 2002.

and secondary school enrolment is 21%.[16] This underscores the need for increased investments in sectors such as water, sanitation, education and agriculture, all of which have an impact on health in order to achieve the relevant MDGs.

14. *Investment in global public goods[17] relevant to priority diseases should be increased at country level.* It is estimated that out of the US$ 70 billion spent globally on health research and development, only 10% is spent on research relevant to the health problems of the poor which make up 90% of the world's health problems.[18] Member States and the international community should work together to strengthen national research institutions so that they can generate evidence and information needed to improve health policies and strategies, health interventions and service delivery in the African Region.

REGIONAL AND NATIONAL RESPONSES TO THE REPORT OF THE COMMISSION ON MACROECONOMICS AND HEALTH

Regional response

15. In June 2002, the Regional Health Economics Capacity Strengthening Workshop took place in Windhoek, Namibia. A total of 103 senior economists, planners and public health specialists from 43 countries participated in the workshop which critically examined the CMH findings and recommendations; the health component of Poverty Reduction Strategy Papers (PRSPs); health care financing; national health accounts; and health systems performance assessment.

16. The participants felt that countries planning to implement the CMH action agenda might face the following challenges:

(a) limited capacity of ministries of health to undertake advocacy and negotiate with other sectors and partners;

(b) weak national health management information systems;

(c) need to revise the health component of PRSPs to include strategies for scaling up the essential package of interventions;

(d) proliferation of committees at the national level;

(e) attrition of human resources resulting from brain drain;

(f) lack of sustainable health care financing mechanisms;

(g) making health systems responsive to the needs and expectations of the poor;

(h) coordination of donor support to enhance contributions to the attainment of national health developmental goals.

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[16] UNDP, Human development report 2002, New York, Oxford University Press, 2002.

[17] Public goods are jointly consumed by everybody; thus, their consumption is non-rival and nonexclusive. Examples of public goods are research findings, water in rivers and lakes, public parks, etc.

[18] Global Forum for Health Research, The 10/90 report on health research 2001–2002, Geneva, World Health Organization, 2002.

17. A summary of the issues and recommendations emanating from the Windhoek workshop and the CMH report were distributed to countries.

National responses

18. As at March 2003, only two countries had taken substantive steps to implement the CMH recommendations. The responses of those two countries are reviewed below.

Ghana

19. Following Ghana's participation in the June 2002 consultation held in Geneva by the headquarters of WHO, the Minister for Economic Planning and Regional Cooperation held a meeting with the ministries of health, finance, local government and rural development as well as bilateral and multilateral agencies based in the country to discuss the findings and recommendations of the CMH and the way forward.

20. Subsequently, the President of Ghana launched the Ghana National Macroeconomics and Health Initiative (GMHI) in 2002, involving:

(a) the creation of an advisory committee to provide guidance on the formulation of the plan for scaling up priority interventions and to advocate, at national and international levels, for increased investments in health;

(b) the setting up of a technical committee to undertake a health situation analysis, and an economic analysis of alternative health interventions and financing options.

21. Under the GMHI, the following themes were identified for detailed analysis: (a) health expenditure; (b) health insurance; (c) health issues in the Ghana Poverty Reduction Strategies (GPRS); (d) environmental sanitation and waste management; (e) rural and urban water and sanitation; and (f) mobilization of resources for scaling up health interventions. After the analysis, technical reports were produced and subsequently reviewed at a workshop of local and international stakeholders.

22. The GMHI is currently in the process of developing an investment plan to facilitate the revision and accelerate the implementation of the health component of the GPRS.

Ethiopia

23. In November 2002, a team from WHO and Columbia University undertook a one-week mission to Ethiopia to sensitize the country's policy-makers and other partners to the key CMH findings and recommendations. The team met with the relevant ministers, members of parliament, heads of regional health bureaus, representatives of UN agencies, donor groups, the Christian Development Relief Association, the heads of the Ethiopian Public Health Association and the Economists Association.

24. Consequently, the Ministry of Health, in collaboration with WHO and Columbia University, developed the Macroeconomics and Health Plan of Action covering the first six months of 2003. Plans are underway to set up a multisectoral macroeconomics and health

technical group operating under the direction of the Minister of Health and a central joint steering committee to implement the macroeconomics and health process.

25. A number of advocacy activities are planned, including:

(a) a consensus-building workshop for relevant officials of government ministries to discuss pertinent issues regarding macroeconomics and health;

(b) a workshop of the Health Sector Development Programme (HSDP) to discuss ways in which the Macroeconomics and Health initiative can catalyze implementation of the HSDP and the Sustainable Development and Poverty Reduction Programme (SDPRP);

(c) participatory education seminar(s) for parliamentarians on the importance of health to economic development;

(d) seminars bringing together government officials, NGOs and donors to discuss how partnerships can help improve access to health care services;

(e) use of the mass media to inform both the public sector and the private sector about the Ethiopian initiative on macroeconomics and health.

26. The six-month preparatory phase of the macroeconomics and health process is expected to lead to a long-term investment plan for accelerating implementation of the Health Sector Development Programme and the Sustainable Development and Poverty Reduction Programme.

THE WAY FORWARD

27. The CMH report recommends enhanced political commitment, at both national and international levels, to increased investments for scaling up the delivery of essential health interventions using close-to-client health systems. Given that different Member States face different challenges, and considering the experiences of Ghana and Ethiopia, this paper suggests steps that can be taken to implement the CMH recommendations. The steps suggested below should be implemented within the framework of:

(a) existing national policies, development plans and poverty reduction strategies;

(b) administrative, planning, implementation and monitoring structures and processes existing in individual countries.

28. The suggested steps to be taken at the country level are as follows:

Step 1: Dissemination, at country level, of the findings and recommendations of the Commission on Macroeconomics and Health and consensus building on their relevance

29. Ministries of health, with support from the WHO country offices, may organize a meeting of key stakeholders to disseminate the CMH findings and recommendations and build consensus on their relevance to the national health situation. This would potentially set in motion a process that would build greater political and financial commitment to the health sector.

Step 2: Making institutional arrangements to facilitate implementation of the recommendations of the Commission on Macroeconomics and Health in the countries

30. Individual Member States may set up an interministerial national steering committee on macroeconomics and health or, where appropriate, expand the terms of reference and composition of existing committees performing similar functions to take action on the CMH recommendations. This committee may spearhead the scaling up of priority health interventions and, at national and international levels, undertake advocacy for increased investments in health. Its membership may consist of ministers responsible for health, economic planning and regional cooperation, finance, local government and rural development, works and housing as well as parliamentarians, representatives of civil society, the private sector, UN agencies, and bilateral and multilateral donors.

31. A technical committee, acting as the secretariat of the national steering committee on macroeconomics and health, may be established to undertake a health situation analysis and an economic analysis of alternative health interventions and financing options. This committee may comprise a health economist, representatives of ministries of health (including public health specialists and planners); water supply and sanitation; finance; economic planning and regional cooperation; local government and rural development; as well as representatives of the donor community and WHO country offices.

Step 3: Analysis and strategy development

32. Drawing on the recommendations of CMH and other national strategic plans such as the Poverty Reduction Strategy Papers, the technical committee will carry out analyses of: the national health situation; national health policies, including human resource policies and plans; health system performance (goals and functions); national health accounts (or national health expenditure) to quantify the financial contribution to health from the activities undertaken by all the sectors; and macroeconomic (including poverty) indicators to facilitate the development of a sound strategy for scaling up health interventions. The emerging gaps in information and health systems performance can be addressed in a multi-year strategic plan. The main purpose of this plan is to extend the coverage of essential health and health-related services after taking into account synergy with other health-related sectors. It should ensure consistency with sound macroeconomic policy framework and provide the basis for filling information gaps through adequate investment in operations research.

33. The plan should contain:

(a) an analysis of health and health-related sectors;

(b) a set of priority national health problems;

(c) a package of cost-effective essential public health interventions for addressing problems;

(d) current levels of coverage of various essential interventions;

(e) the target coverage of individual essential health interventions;

(f) the cost of scaling up the use of essential interventions to the desired levels including the cost of strengthening close-to-client health services;

(g) an estimate of the current level of spending (broken down by source) on essential interventions;

(h) an estimate of the expenditure gap (i.e. item "f" minus item "g" above);

(i) an indication of how the expenditure gap would be financed (from domestic and international sources);

(j) a monitoring and evaluation section.

34. The relevant ministries and agencies primarily responsible for specific components of the defined essential public health interventions will need to devise proposals for scaling up such interventions.

Step 4: Filling expenditure gaps

35. The technical committee will, on the recommendation of the national steering committee, develop scenarios of how expenditure gaps can be bridged. The advantages and disadvantages of each scenario should be carefully examined and considered. The scenarios may include: reduction of the technical and allocative inefficiencies within and between health-related sectors and subsectors; termination of least cost-effective diagnostic procedures and health interventions; national social health insurance[19] funded from "sin" taxes (e.g. on tobacco and alcohol); a dedicated tax for health; reallocation of budgetary resources from other sectors such as defence; reduction of subsidies for the export-oriented manufacturing industry; funds expected from the highly-indebted poor countries (HIPC) initiative; soft loans and grants from multilateral and bilateral donor agencies; development of project proposals for submission to the Global Alliance for Vaccines and Immunizations (GAVI), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Multicountry AIDS Programme of the World Bank.

Step 5: Using the multi-year strategic plan (step 3) to revise the health and health-related sector development plans and the relevant components of PRSPs

36. The health and health-related sector development plans (e.g. health, water supply and sanitation, education) and the relevant components of PRSPs will need to be revised to accommodate the scaled-up plan developed in Step 3 above.

Step 6: Implementation of the multi-year strategic plan

[19] Carrin G, Desmet M and Basaza R, Social health insurance development in low-income developing countries: New roles for government and non-profit health insurance organizations, Ch.10 in Scheil-Adlung X, Building social security: The challenge of privatization, London Transaction Publishers, 2001.

37. The ministries and agencies with primary responsibility for specific components of the strategic plan (e.g. health services, water, sanitation, nutrition) will scale up their respective interventions.

Step 7: Monitoring, evaluation and reporting

38. The national steering committee on macroeconomies and health will monitor the implementation of the strategic plan as well as the proposals developed by each lead ministry or agency. To that end, the national steering committee will develop key indicators and decide on a frequency of reporting consistent with the national reporting mechanisms. As a guide, the national steering committee may consider meeting half-yearly to review progress in the implementation of the strategic plan and its relevant proposals. The lessons emerging from these reviews will then be used to revise the plans.

WHO support to countries

39. WHO will harness its comparative advantage in health to support countries to implement the CMH recommendations. Specifically, WHO will:

(a) disseminate the key CMH findings and recommendations to ministers of health and other relevant development partners;

(b) support countries to develop or strengthen existing national institutional mechanisms for planning, implementing and monitoring the CMH recommendations;

(c) provide technical support to the national steering committee and lead ministries or agencies to enable them to develop plans and proposals for scaling up relevant national interventions;

(d) strengthen Member States' capacity to collect, analyse, document, disseminate and utilize relevant health and economic evidence;

(e) monitor and document lessons emerging from the implementation of the CMH recommendations in different countries and facilitate shared learning among countries.

Support from other partners

40. Alliances will be built and maintained at all levels, to ensure that Member States receive appropriate support when developing, implementing, monitoring and evaluating multi-year plans for scaling up pro-poor health investments. Such alliances would involve stakeholders such as the relevant UN and bilateral development agencies, the World Bank, the African Development Bank, the NEPAD Secretariat, civil society, international and national NGOs, private organizations, academics and global initiatives, e.g. GFATM, GAVI, Stop TB, Roll Back Malaria.

CONCLUSION

41. This document has attempted to put the key findings of the CMH within the context of the African Region. It has also proposed seven broad steps that countries interested in implementing the CMH action agenda can follow.

42. By working closely with health development partners, Member States can better their economic prospects through greater investments in close-to-client health systems and increased use of cost-effective interventions in addressing priority national health problems.

43. The Regional Committee is requested to review and endorse the generic steps proposed herein for implementing the CMH recommendations at the country level.