Two years after its secretariat was established within WHO, the Alliance for Health Policy and Systems Research has been joined by 310 research and policy partner institutions worldwide. The Alliance has developed and funded 53 projects (with an additional 30 in the pipeline), assisted over 100 researchers in proposal development, produced 10 case studies on research management and the research-to-policy process, published a quarterly newsletter in four languages, and developed an extensive Web portal linking 300 partners. These activities were undertaken with the support of, and in consultation with, our partners and four collaborating regional HPSR networks. The Alliance collaborates with WHO, the Council on Health Research for Development (COHRED), the International Clinical Epidemiology Network (INCLEN) and the Global Forum for Health Research to share resources and undertake joint activities. The secretariat has just welcomed a full-time economist in the person of Alaka Singh, complementing the manager and administrative assistant.

In 2002, the Alliance will focus on consolidating the research grants programme, while expanding capacity-strengthening activities. The first rounds of small grants will be completed, and further training will be provided on the dissemination and implementation of research-to-policy strategies, while a comprehensive capacity-strengthening programme will be initiated. Strategic research will be commissioned on human resources in health. It is hoped to open a new round of small grants by the fourth quarter of 2002, and the collaboration with regional networks will enter its second year after an assessment of achievements. The Alliance workplan calls for a minimum expenditure of just over US$1.58 million, with an option to increase to US$2 million if additional resources for capacity-strengthening are obtained.

The Alliance relies on its partners to help carry this programme through and, most importantly, to make it sustainable in the coming years. One key contribution is your institution’s profile on the Web site. This provides all partners with an overview of activities and priorities, thus helping us all to respond. In particular, it provides a picture of capacity which helps the Alliance to plead for greater funding for HPSR and for capacity development in this area. Moreover, funding agencies see partnership and its benefits as critical in their own funding decisions. Please visit the Web site to update your profile on line or by using a format which may be downloaded from the site or requested from us.
CASE STUDIES
Interaction between HPSR and policy-making

The case studies on the enabling environment in the research-to-policy process announced in Newsletter No. 4 are mostly finished and are being prepared for publication. The processes of priority-setting, support for research and demand for and utilization of HPSR by policy-makers were analysed.

Case studies seek to identify challenges for the setting of research priorities, decision-makers’ support for research and the benefits they gain from the research process and results. They investigate the interplay of institutional mechanisms which bring stakeholders together in an “enabling environment”. Attention is therefore given to the factors which help bring actors together to agree on funding, support and utilization of research. Three case studies ready thus far are summarized in this issue.

Colombia (Francisco Yepes)

In December 1993, the Colombian Government approved a radical health sector reform. A new national health insurance system was created, which changed the role of the Government from public provider to purchaser of health services. These changes made very clear the need for extensive and intensive HPSR. Today, Colombia’s health sector relies on two mechanisms to sponsor research: the Science and Technology Institute (Colciencias) and the Ministry of Health. While Colciencias sponsors mainly biomedical and clinical research proposed by the researchers, the Ministry supports operational research based on the demands of policy-makers and implemented by means of a mix of competitive and non-competitive commissioning. The two policies are in marked contrast, the former based on formal peer review, the latter on potential usefulness, judged mainly by implicit criteria. Throughout most of the 1990s, HPSR research received only 8% of total health research funding in the country.

From 2002, the resources for health research will be markedly increased, thanks to a new law which allocates a percentage of lottery revenue to health research. The Ministry of Health has to decide how these funds should be allocated. The case study analyses the advantages and limitations of the various resource allocation policies available to strengthen HPSR capacity.

The limitations of the Ministry’s current allocation mechanisms are shown by the US$60 million health policy research package implemented in the early 1990s as part of a health sector reform loan from the Inter-American Development Bank (IADB). The Ministry set a research agenda with an unprecedentedly large package of research projects. A complex process of public bidding was implemented, following IADB and Ministry rules. The bureaucratic overload led to several “non-assigned biddings”, loss of precious time, economic losses for many participants and inadequate use of resources. Only US$20 million of the US$60 million were spent. Furthermore, most of the commissioned projects did not respond to the immediacy of the policy questions raised.

Today, there is a broad consensus that the scale of research efforts should be much smaller. Furthermore, development banks should have greater flexibility to adapt their procedures to the capacity and requirements of research institutions. There is less of a consensus about the role of research funding institutes such as Colciencias, although they clearly have the capacity to match demand and supply efficiently.

The case study ends with a look at the evidence base behind the decision-making practices of the National Health Social Security Council, a key institution created to manage the health sector reform. The Council has at least three regular and important decisions to make, which should be based on research evidence: the amount of the capitation unit, the content of the compulsory basic package and the distribution of the legally determined cross-subsidy between better-off people and the poor. In spite of the importance of these decisions, Council members generally feel that decision-making is not sufficiently supported by research and that decisions are reached on the basis of opinions rather than evidence.

Egypt (Mahmoud A. Salem)

During the 1990s, Egypt was looking for better ways of organizing and financing health care. This search was motivated not only by economic, political and technical factors, but also by the need to find answers to the complex problems of the policy-making process. How was technical advice developed and actually used in policy decision-making? The roles of the Data for Decision-Making project (United States Centers for Disease Control), Partnerships for Health Reform project (United States Agency for International Development) and other international actors are analysed in the context of the monitoring of reforms and development of policy. One of the main benefits of this technical support at the formulation stage was to demonstrate that Egypt could solve its own problems and greatly strengthen its health system performance, thus helping to revitalize the Ministry of
Health as a guardian of this sector over the coming decades.

The policy reform strategies aimed to improve the financing, efficiency and quality of (and access to) health services over a four-year period at a cost of US$500 million, of which US$143 million was allocated to technical assistance of various kinds, including implementation of pilot projects. The effectiveness of technical support during implementation was greatly influenced by the content of the policies proposed, as shown by the proposal for the provision of a basic package of services compared with that for regulation of accreditation. Research and analysis for the former failed to produce a consensus and had little impact on policy. This was largely because of the difficulty of restricting the supply of services on the basis of cost-effectiveness criteria. In the case of accreditation, the recommendations provided a very clear and powerful incentive for improvement in the quality of care and therefore received a high level of support from policy-makers and health staff. This, in turn, led to a further building of research and analysis capacity and the establishment of a dependable research and accreditation experts with a well-developed and motivating professional career path.

The context of the health sector reforms and weaknesses in project monitoring undermined the potential value of research and analysis. These conclusions point to the need to strengthen research capacity at the national level and to improve links with policy-making.

Maharashtra, India
(C.A.K. Yuesudian)

Responding to grave complaints in 1989, the High Court of Maharashtra pointed out that the legislation concerning the regulation of the private sector had not been properly implemented by the Municipal Corporation of Greater Bombay. The Bombay Nursing Home Registration Act of 1949 was outdated and did not have adequate provisions and bye-laws to regulate the private health sector properly. The Municipal Corporation followed up by reviewing and revising the old legislation. The Municipal Corporation felt strongly that to set clear and valid criteria for registration, the new Act should be based on data and information. This consensus and clear demand for research provided the incentives for the Tata Institute of Social Sciences and the Centre for Enquiry into Health and Allied Themes (CEHAT) to undertake complementary research.

The Tata Institute’s approach was to assess the behaviour, infrastructure and quality of services provided by the private health sector. CEHAT built on these results to prepare draft legislation on the basis of further research, including an assessment of stakeholders’ perspectives. CEHAT was able to integrate the business wisdom of private-sector representatives with the knowledge produced by research through workshops designed to achieve a consensus. Advocacy groups further endorsed CEHAT’s research results. This led to draft legislation, issued in June 2001 as the “Maharashtra Clinical Establishment Act”. It remains to be seen whether the evidence will withstand the dynamics of the political process.

CEHAT did not stop at legislation, realizing the need for a voluntary accreditation body. The first step was to find out stakeholders’ opinions through more research and consultations. This led, in turn, to the establishment by CEHAT of the Forum for Health Care Standards as an embryo accreditation body.

Private research facilities in Maharashtra have taken a lead role, thanks to the wide-ranging recognition and trust accorded to them by many stakeholders. Their research capacity has been well developed, and they have demonstrated themselves to be very good policy entrepreneurs. Their ability to sense problems at the grass-roots level, to mobilize government and private actors and to create consensus has been outstanding. Funding has been readily available and existing resources have been put to good use.

Preliminary conclusions

The case study of Maharashtra is suggestive of the role that small, local nongovernmental agencies can play in supporting policy-making. Modest budgets and an entrepreneurial attitude can go a long way towards influencing policy-making when the institution produces high-quality and relevant evidence and is well placed to mediate between the various stakeholders.

On the other hand, the case studies in Egypt and Colombia point to the challenges faced by complex health sector reforms in allocating research funding efficiently and then benefiting from research results. There is a need to streamline resource allocation mechanisms and strengthen collaboration between national researchers and international consulting services. While top-level decision-making mechanisms can become more inclusive, this does not, by itself, ensure evidence-based decision-making and may, indeed, inhibit it, owing to the resulting complexity of the decision-making process.

These case studies suggest that specific institutions are needed to mediate between research and the policy process. These may take many forms, such as informal forums, small nongovernmental agencies to mediate between research and policy-making, or government units to “translate” research results into policy advice. In the next issue, the Alliance Newsletter will examine various options for institutions that fulfil these functions.
The Alliance invited a total of 32 researchers to develop their final proposals for research projects under the Small Grants Programme at workshops in Geneva during October 2001. Workshops were coordinated by Indra Pathmanathan and the facilitators were: Naeema Al-Gaseer, Carlos Cruz, Mario Dal Poz, Miguel A. Gonzalez Block, Patricia Hernandez, Debbie Muirhead, Alaka Singh, Barbara Stilwell and Pascal Zurn.

Proposals were peer-reviewed and scored by experts and 25 were then funded on the basis of scientific merit and the available resources. Funding was provided by the government of Norway and by the following WHO departments: Roll Back Malaria, Organization of Health Services Delivery, Injuries and Violence Prevention.

### Alliance Research Grants, Round 2001. Project Funded

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<th>Research topic</th>
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<td>Assessing the effects of financing schemes on equity in access to primary health care by the poor in Nigeria.</td>
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<tr>
<td>2 Edite de Mata-Machado</td>
<td>Assessing the impact of the PAB equity initiative on resource allocation and service inequalities across municipalities in Minas Gerais - Brazil.</td>
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<tr>
<td>3 Ramon Castaño Yepes</td>
<td>Assessing adverse selection in the social health insurance system in Colombia</td>
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<tr>
<td>4 Hector Ochoa Díaz-López</td>
<td>Analysing a poverty alleviation strategy from a health systems perspective: Progresa and indigenous populations in Chiapas, Mexico.</td>
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<td>5 Felicia Knaul</td>
<td>Impoverishing health expenditures in Mexico: Assessing their fairness and options for universal health insurance.</td>
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<td><strong>II. Innovative approaches to health financing for the poor</strong></td>
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<td>6 Fon Nde Peter</td>
<td>Studying the Njangi self-help community associations in Cameroon as gateways to community-based health insurance</td>
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<td>China’s drug pricing policy reform: Has it been effective in containing costs? Evidence from Shangdong.</td>
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<td>10 Mahmoud Salem</td>
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<td><strong>IV. Research on human resource development</strong></td>
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<td>13 Haichao Lei</td>
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<td>21 Carlos Agudelo</td>
<td>Assessing options for an innovative malaria control program on the basis of experiences with the new Colombian Health Social Security system.</td>
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<td><strong>VI. Research on road traffic injuries: policy development and implementation</strong></td>
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<td>22 Daniel Arán</td>
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<td>23 Agus Suwandocono</td>
<td>Analysing the epidemiology and policy opportunities of road traffic collisions in urban Indonesia.</td>
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<td>24 Cristina Inclan</td>
<td>Trust, reciprocity and caring for the common good: exploring their relevance for traffic injury prevention in urban Mexico.</td>
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<td><strong>VII. Other</strong></td>
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<td>25 Lalit Dandona</td>
<td>Assessing the demand for health policy &amp; systems research for national health programmes in India</td>
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Research-to-policy tool kit: update

The research-to-policy tool kit whose objectives were described in Newsletter No. 4 is now being developed as “Health Research for Policy, Action and Practice: a Collaborative Training Project”.

The Alliance, the Council on Health Research for Development (COHRED) and the International Clinical Epidemiology Network (INCLEN) have been joined on the Steering Committee by the Global Forum for Health Research.

A 16-member Advisory Committee of international health research experts and network representatives has been established.

We call on Alliance partners to contribute to the three modules on priority-setting, knowledge management and advocacy and leadership.

We welcome relevant materials, guidelines, case studies and experiences that may be used to define or illustrate the diverse problems and issues. In particular, we welcome your comments on the following question: Can HPSR priority-setting follow the methods employed for other areas of health research?

Two ideas have been sketched out to stimulate the development of this tool at the level of methods and processes. In terms of methods, a five-step approach similar to the one suggested by the WHO Ad Hoc Committee on Health Research Relating to Future Intervention Options1 is conceivable.

Step 1: Calculate the attributable costs or the relative severity of specific health system problems e.g. inequitable resource allocation or the lack of financial protection.

Step 2: Identify the reasons for the persistence of health system problems and, on this basis, identify the kind of HPSR required to solve them:

- lack of knowledge ➔ analytical/strategic research
- lack of tools for resource allocation ➔ applied/developmental research
- inefficient use of existing tools ➔ operational research.

Step 3: Judge the adequacy of the current knowledge base for each problem.

Step 4: Assess the promise of possible research and development efforts.

Step 5: Assess the current resource flows for these efforts.

The major obstacle to applying such a framework to HPSR seems to lie in the first step. A consensus on the nature and situation of health system problems would first be necessary, similar to the consensus that now exists for the identification and measurement of specific diseases and risk factors. Furthermore, to enable the undertaking of steps 3-5, there is a need to agree on the classification of HPSR, a task currently being supported by the Alliance through the HPSR Thesaurus (published in its preliminary form in Newsletter No. 4: your comments would be very welcome).

Ensuring that priority-setting processes are acceptable is as important as developing the evidence base. For this purpose, the Accountability for Reasonableness framework, developed by Daniels and Sabin2, would seem appropriate. Priority-setting decisions, such as those of a research institute or a funding agency, may be considered legitimate and fair if they satisfy the following four conditions.

1. Publicity: limit-setting decisions (e.g. the funding available for a given area) and their rationales must be publicly accessible.

2. Relevance: these rationales must rest on evidence, reasons and principles that fair-minded parties (policy-makers, donors, researchers, community advocates) can agree are relevant to deciding how to meet specific needs in the face of resource constraints.

3. Appeals: there must be a mechanism to challenge decisions and for dispute resolution regarding limit-setting decisions, including the opportunity to revise decisions in light of further evidence or arguments (e.g. an essential national health research (ENHR) committee).

4. Enforcement: there must be either voluntary or public regulation of the process to ensure that the first three conditions are met (e.g. laws and statutes).

This framework makes reference to the efforts sponsored by COHRED to develop institutions and processes at country level — an enabling environment — where priority-setting can take place and the necessary evidence can be developed. The next step would be to focus on HPSR so that allocation of resources for research in this area leads more directly to improved health systems.

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CAPACITY-STRENGTHENING

Building and strengthening capacity for HPSR in developing countries: a new Alliance initiative

Health is now an important component of the agenda for development. Changes in health policies and systems must be based on the best available evidence, drawn from scientifically valid studies undertaken within developing countries themselves. However, the expertise for carrying out such studies is lacking, especially in the “research-poor” least-developed countries.

The Alliance is now seeking donor support to launch a major six-year initiative to strengthen capacity for health policy and systems research (HPSR), with a tentative budget of US$9.3 million. The initiative takes into account the experience in capacity-strengthening of various international research programmes over the last 25 years.

The goal of the initiative is to support policy-makers in improving health in poor and middle-income countries by developing the capabilities of broad-based coalitions of investigators, policy-makers, donors and community advocates. It aims to improve their ability to analyse and set priorities for health policy and systems research, undertake quality projects and facilitate the demand, supply and utilization of results for improved health policies.

Complementary capacity-strengthening approaches are proposed, in the form of five grant mechanisms, to be implemented with technical support. The initiative will be mainly directed at “research-poor”, least-developed countries, with the emphasis on the needs of the poor and marginalized population. Capacity-building grants are proposed for these countries, to enable research groups to undertake diverse activities of between three and five years’ duration. Capacity-building will mainly take the form of research and needs-based training, with technical and financial support provided by the Alliance for the 3-5-year period. At the same time, the Alliance will advocate the use of HPSR for policy-making in these countries, by stimulating demand and facilitating the research-to-policy process.

Selected institutions from other countries will also be eligible for capacity-strengthening grants and academic support, through grants for curricular development, young researchers and courses, seminars and workshops. It is expected that these grant mechanisms will be combined and adapted to suit specific institutions and developing-country situations, with significant technical support to be provided by the Alliance and its partners as well as by regional networks.

Partner support will be crucial in moving this initiative forward. In particular, we need information on capacity-strengthening needs now that we are approaching donors for funding (see Editorial). We will keep everyone informed on our progress in raising funds.

FORUM 5

Alliance partners contribute to Global Forum for Health Research annual meeting

Forum 5, the fifth annual meeting of the Global Forum for Health Research, was convened in Geneva, Switzerland on 9-10 October 2001 with the theme “The 10/90 gap in health research: assessing the progress”. Less than 10% of global spending on health is devoted to diseases or conditions that account for 90% of the global disease burden.

A total of 701 participants from 92 countries attended presentations and discussions during the three-and-a-half-day meeting. The Alliance held a partners’ meeting in parallel with Forum 5, with the participation of 30 institutional representatives, including those from HPSR networks in Africa (Health Economics and Policy Network in Africa HEPNet) and Asia (Asia Pacific Health Economics Network and the China Health Economics and Training Network).

The Alliance organized one each of the plenary, parallel and workshop sessions, and partners also had the opportunity to present posters. In the plenary session “Health policy research and the 10/90 gap” partners identified the areas of health policy development which could benefit from HPSR, analysed the financial

ALLIANCE SPEAKERS AT FORUM 5 PLENARY

“HEALTH POLICY RESEARCH AND THE 10/90 GAP”

Yu Dezhi, Deputy Director General, Ministry of Health, China: Strengthening health policy research, deepening health reforms and development in China.

Guillermo Soberon, Executive President, Mexican Health Foundation (FUNSALUD), Mexico: Research on health policies and systems: FUNSALUD’s interest in the matter.

Lola Dare, Chief Executive Officer, Centre for Health Sciences, Training, Research and Development, Nigeria: Research and its role in health policy making in Africa.
and institutional mechanisms involved in demand and discussed strategies to improve the demand for and utilization of HPSR in developing countries.

In the parallel session “Enhancing health policy and systems research performance”, innovative research management strategies were identified and their benefits, challenges and applicability analysed. The following institutions shared their experiences:

- Regional Centre for Health Development (CRESEDA), Benin (Eusebe Alihonou)
- confronting the role of research in policy development and implementation (Gcinile Buthelezi, Health Systems Trust, South Africa)
- the role of the Health Systems Research Institute of Thailand in health systems reform (Wiput Phoolcharoen)
- Colombian Health Association (ASSALUD): Its influence on policy formulation and implementation (Francisco Yepes).

In the workshop on “Improving the relevance, support and utilization of HPSR”, Alliance partners discussed the design and implementation of strategies to improve relevance, support and utilization of HPSR, using the case studies described above as a starting point. The workshop's main conclusions were:

- the case studies provided valuable examples of innovative HPSR management in developing countries
- crucial for the development of HPSR was the creation of a mechanism for priority-setting and an environment that promotes dialogue between researchers and policy-makers
- perpetuating an evidence-based culture in health policy formulation requires the development of institutions that can undertake appropriate, needs-based HPSR.

The Commission for Macroeconomics and Health was launched by WHO in January 2000 to investigate the impact of health on development and recommend a plan of action to promote growth and reduce poverty through better health. The Commission focused on low-income countries and lower income countries within the middle-income group. Professor Jeffery Sachs (Harvard University) chaired the Commission which consisted of six Working Groups, each dealing with a specific health sector issue – Professor Anne Mills, Chair of the Alliance, was Co-Chair for the Working Group on Improving Health Outcomes for the Poor. Following are the main findings and recommendations of the Commission as consolidated in its December 2001 report Macroeconomics and Health: Investing in Health for Economic Development.

The relationship between health, poverty and economic development has thus far been examined largely in terms of growth and its impact on health with inadequate emphases on causality in the other direction. (See figure below). The Commission argues that improvements in health can in fact bring about sustained and substantial improvements in both social and economic well-being. The social and economic ramification of HIV/AIDS, suffered already by the next generation in Sub-Saharan Africa, attests to this.

Significantly, in spite of the existence of tested, cost-effective interventions to eliminate preventable conditions – communicable disease and maternal and perinatal ill-health – these remain the main cause of the high levels of mortality and morbidity in developing countries: under-5 mortality alone is still as high as 160 per 1000 live births in least developed countries; as a group, low-income countries account for over 75 per cent of global mortality in this category. The Commission further points out that, equally importantly, investments in health need to be matched with appropriate attention to population control to effectively initiate the virtuous circle of reduced fertility, better health and education of children and lower population growth.

The crucial resource necessary to meet the health needs of low-income countries is finance. The Commission estimates that essential inter-

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**REVIEW**

**Macroeconomics and Health: Investing in Health for Economic Development**

Report of the Commission on Macroeconomics and Health

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**FORUM 6**

Forum 6 will be held in Arusha, Tanzania, 12-15 November 2002. For more information visit: [www.globalforumhealth.org](http://www.globalforumhealth.org) or visit our Web site for grants to Alliance participants.
ventions to combat the poor health status in these countries would require an annual expenditure of between $30-40 per capita, with the bulk being public sector rather than private investment. For least developed countries, this would imply a five-fold annual budgetary increase per capita and for other low-income countries, an increase of about two and half times current expenditure (present per capita annual public spending being $7 and $13 respectively). Domestic options for raising the required resource are limited, and even middle-income countries with high level of HIV/AIDS will be hard pressed to increase efficiency and/or raise additional revenues to redress the financial gap.

Clearly then, there needs to be a large financial commitment from donors. Based on the per capita annual requirement of $30-40, the Commission estimates that the necessary levels of domestic and international resource mobilisation are:

<table>
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<tr>
<th>Year</th>
<th>2000</th>
<th>2007</th>
<th>2015</th>
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<tbody>
<tr>
<td>Increase in domestic mobilization in low income countries (as per cent of GDP)</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>International commitment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country-level programmes</td>
<td>$22m</td>
<td>$31m</td>
<td></td>
</tr>
<tr>
<td>R&amp;D for diseases of the poor</td>
<td>$3m</td>
<td>$4m</td>
<td></td>
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<tr>
<td>Provision of other Global Public Goods</td>
<td>$2m</td>
<td>$3m</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>$6m</td>
<td>$27m</td>
<td>$38m</td>
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For successful implementation of its ‘action agenda for investing in health for economic development’, the Commission envisages a partnership between WHO, the World Bank, donors and recipients that would coordinate and mobilize resources and build and strengthen requisite political, administrative and managerial capacity and accountability in developing countries. Specifically the Commission recommends:

(i) the need to establish evidence-based, outcome-oriented programmes for sustainable scaling up of essential health interventions within the framework of poverty reduction strategies and incorporating long-term donor financing.

As a starting point, to assess individual country needs, the suggestion is to set up National Commissions for Macroeconomics and Health assisted by WHO and the World Bank;

(ii) as the most effective mechanism to address the health needs of poor in low-income countries, a service delivery system at the grass-roots (close-to-client) supported by broader disease-specific national programmes according to specific country epidemiological profiles;

(iii) substantial investment in global public goods – evidence, surveillance and research and development – relevant to low income countries; and

(iv) an action plan for access to essential drugs, especially for tropical vector-borne diseases, coordinated by the pharmaceutical industry, governments and international agencies.

The full text of the Report as well as Working Papers of each Working Groups are available on the WHO Web-site: www.who.org