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**Sixth Meeting of the Commission on Macroeconomics and Health**  
**Geneva, 21 August 2001**

Jeff,  
Commissioners,  
Working Groups Co-Chairs and Members,  
Colleagues,

It is a great pleasure to see you all again. I am pleased to see the Commission's Report beginning to take shape.

Of course, the Draft Report we are about to review is essentially the outcome of the CMH Chair's excellent work, based on the deliberations of the Commissioners in their earlier meetings and the six CMH working groups. The working groups have produced in total 94 papers and extensive reports.

This work has been a solid basis for getting the process rolling and to stimulating a debate in a focused direction. I hope that over the next few days all Commissioners will articulate their views, and reach a consensus on key issues, so that within the next few weeks a further draft can be produced and serve as a basis of the final report reflecting the agreed position of the Commission as a whole.

The report, and the working group summaries, represent a great body of scholarship and judgement around the main propositions being addressed by the Commission. I look forward to the discussion on how this work will move forward over the coming days.

I would like to warmly congratulate the CMH Chair, Commissioners and Working Groups Co-Chairs who have steered the work of the Commission. This has not been an easy task.

As I said at the CMH meeting in Paris, and I will say it again, no doubt there will be differences of opinion as to what the main focus should be with difficult choices to be made.

This is the reason we are here today: to agree on the main thrust of the Report and to consolidate the key policy messages that we wish to emerge. Our aim, as I am sure you will agree, is to produce a Report with a *difference*. A Report that will provide well-reasoned arguments, facts and illustrations in a convincing manner so as to challenge the way decision makers around the world view and treat health.

I sense that the main points of the Commission's analysis, and the key conclusions, are now quite clear, though it is essential that they be well-substantiated in a robust fashion. It is inevitable that a broad range of well-informed individuals, and interested groups, will want to examine the conclusions, criticize the analysis and pass judgements. Some of these will be inexplicably hostile to development: many will be sceptical about development assistance, and there will be those who challenge the Commissioners' assertions about the key role of good health in promoting human development. As you enter the discussion on how to take the report towards completion, let me outline some important aspects that need to be taken into consideration.

The Report will need to provide clear evidence-based answers as to what extent investment in health is an effective tool to generate economic growth and poverty reduction. The current draft of the report states on page five that "investing in health not only spurs overall economic development, but directly reduces poverty." The CMH will be expected to explain why this is so.

The Commission must also explain its conclusion that the main barrier to better and more equitable health outcomes in poor countries is the lack of available financial resources for health. It describes an intention to stimulate an increased volume and quality of health of spending within developing countries. However, it is an economic reality that developing countries cannot rely on their own internal resources in order to overcome poverty and improve the health status of their population. This is where the key role of the donor community will come into force. Hopefully, the Report will provide an innovative financial architecture of future ODA flows for health needs.

The donor community faces challenges to spend more and catalyse better results in relation to a broad range of development areas - agricultural and industrial production, communications, financial and other services, security and governance, as well as the provision of services for education, social development and health. They will ask the question: What is the right balance of investment to reduce poverty? How does this vary from country to country? What kinds of assurance do the rich countries need if they are to take forward dramatically increased investments in poor people's health? And how best to take forward reform in health sectors to trigger such outcomes?

These issues will be discussed at an important meeting organized by DFID on 5 September. This meeting is convened to provide chief economists of aid agencies, not involved in the Commission to date, to give their initial reaction to the provisional findings of the CMH Report and working groups reports.

They also need to be the subject of the meeting over the next few days. There are a number of other questions you will have to grapple with. How can the donor community deliver more, better, faster? Can they deliver on all three levels?

The need to reach a position on the broader determinants of health, such as income, water, sanitation, education, and others, will also be studied, in conjunction with the massive public health crisis we are facing in a number of countries, and the need for health systems reform. How can the Report best convey the combined needs of securing both more money **and** improved health systems?

Looking at the scope of core interventions: is the list of interventions sufficient? It might be useful also to add an additional explanatory analysis of the health interventions needed in countries experiencing an epidemiological transition to noncommunicable diseases?

There is the issue of global public goods - who should provide and pay for them? How can the Commission get the research agenda moving in terms of global public goods especially R&D on diseases which affect predominantly the poor?

The issue of globalization has been covered by Working Group 4 and to some extent by Working Group 2 and by Jeff's personal work. The Commission could contribute to a valuable policy consensus in this area and attempt to show how globalization can be made to work to benefit the world's 2 billion poor.

The issue is of course complicated. Medical services are now traded, medical costs are rising in poor countries, access to essential medicines is impeded and trained medical personnel are being recruited from developing to developed countries. At the same time, one can argue that issues like differential pricing and growing commitments to tackle diseases associated with poverty which have led to the Global Fund for AIDS and Health, are themselves products of globalization.

Before I end, I would like to briefly update you on the status of the Global AIDS and Health Fund. Over \$1.3 billion have already been pledged, and both funding and potential recipient governments, together with NGOs and international agencies, are intensely involved in discussing how best to set it up. WHO is a member of the Transition Working Group chaired by Minister Kiyonga from Uganda, and we will be working closely with the Technical Support Secretariat that has been established for a

period of four months in Brussels. I anticipate that they will draw on experiences of Stop TB, GAVI, Roll Back Malaria and other partnerships. They will also look critically at the particular ways in which WHO, and other UN agencies, can best contribute to the working of the Fund.

The work of this Commission has already greatly inspired and influenced the thinking in Brussels and a number of other capitals. I am sure the publication of the CMH Report in December, a month before the Fund will become operational, will have an important effect in focusing attention on the issues of health and development and stimulate debate on how best to develop new ways of transferring resources to where they are most needed.

I wish you all a good and productive meeting.

Thank you.