



for by the state. The ministers of health of the region have already endorsed a programme of 'managed migration'. The CCHD recommends further research on the factors that influence trade in nursing services and permanent migration of nurses, as well as attention to expansion of training and cost recovery from workers that choose to work outside of the region.

- **Target poor and rural populations:** China has presented evidence towards promoting a greater Government role in the health sector in order to alleviate pockets of poverty. Per capita health expenditure in urban areas was 3.29 times that in rural areas in 1998, a difference which increased to 3.64 times in 2003. Childhood mortality rates in most western provinces are three to five times higher than in developed coastal areas.
- **Finance health for the poor:** The Mexico NCMH makes the case for a universal health insurance scheme as the most appropriate option to ensure equity and efficiency in the health system. More than half of the population of Mexico has no medical insurance, and more than 90% of private health expenditures are out-of-pocket payments.
- **Work with civil society organizations (CSOs) and the private sector:** In Cambodia, MEDiCAM, the Cambodian umbrella organization for CSOs in the health sector, has carried out an investigation into the role of CSOs in macroeconomics and health processes. The work in Cambodia emphasized the urgent need for better coordination of relevant ministries and CSOs, which deliver a large proportion of health services.

*Increase the effectiveness of development assistance for health.*

- **Increase funding to reach national targets:** The report of the Ghana Macroeconomics and Health Initiative will be used in discussions with donors on financing options for the investment plan. The GMHI findings are being used by the United Nations system to inform the assessment of the health component of the Millennium Project in Ghana and as a reference in preparing the proposal for the United States Millennium Challenge Account.
- **Align development assistance to national plans and budgets:** The Government of Yemen embarked on the MDGs needs

assessment process as promoted by the United Nations Millennium Project in August 2004. The resulting sectoral investment plans were then consolidated into a national plan with guidance from the Ministry of Planning and International Cooperation and technical assistance from the United Nations country team and specialized agencies.

- **Harmonize donor procedures:** In Rwanda, several development partner meetings highlighted the need for establishing mechanisms to coordinate interventions undertaken by the Government and its partners in order to increase efficiency, avoid duplication and strengthen the intersectoral approach to development. For this reason, several coordination entities have been created in which representatives of the Task Force on Macroeconomics and Health participate.

#### A POLICY AGENDA

Drawing on these country findings, the report proposes a policy agenda, highlighting areas where efforts to strengthen country capacity and partner coordination are urgently needed. These experiences will be integrated into the work of the WHO to enhance WHO's support to countries and to contribute to global health and development discussions.

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# TOUGH CHOICES:

investing in health for development

*Experiences from national follow-up to the Commission on Macroeconomics and Health*



**World Health Organization**



Accelerating progress towards health targets in developing countries requires a break with 'business as usual'. Despite modest improvements in some countries, vast numbers of poor people continue to lack access to quality basic care. Redressing this situation will mean tackling the fundamental factors that limit national capacity, resulting in suboptimal allocation of scarce resources for health.

*Tough choices: investing in health for development* presents country experiences establishing national commissions on macroeconomics and health (NCMH) (or similar bodies) to bolster efforts towards reaching health goals. The unique value of the NCMH is in strengthening the national processes involved in making choices that determine health outcomes, through building evidence, improving national planning and heightening advocacy. Drawing on the findings from country experiences, the report presents a policy agenda along which national analytical and planning efforts could be focused.

## BACKGROUND

The work described in the report, taken forward in approximately 40 countries, builds on previous initiatives and movements and complements ongoing health and development efforts. Catalysed by the World Health Organization, this work has grown out of the concepts put forth by the Commission on Macroeconomics and Health (CMH). The CMH was launched by WHO in 2000 with a mandate to examine the links between health and development.

The work in countries makes the most of the current favourable environment for health. Recent years have seen a global promise to augment resources for health, both from domestic and external sources, although the health financing gap remains. Total commitments to development assistance for health rose from US\$ 7 billion to US\$ 10.7 billion between 2000 and 2003. Moreover, development partners have intensified commitments to ensure increased aid effectiveness, but it continues to be an important concern for countries. This concurrence of factors represents an imperative to single out effective strategies for reallocating health investments in developing countries to more effective uses.

The report describes how since 2001 countries have shaped multisectoral processes towards developing a strategy for scaling up health investments, costing this strategy and using the outcomes to influence policy-makers and political leaders in health, financing, planning and other ministries. The 12 experiences highlighted in the report are those where the processes have most progressed and which provide good examples to illustrate the main issues of the work: Cambodia, the Caribbean Community, China, Ghana, India, Indonesia, Mexico, Nepal, Rwanda, Senegal, Sri Lanka and Yemen.

## KEY FINDINGS FROM COUNTRY WORK

### Country ownership and specificity.

Countries drove and defined the follow-up processes, enhancing their impact. The work emphasized the facilitation of national capacity to focus health and development efforts on the poorest segments of the population and to establish health targets appropriate to individual country priorities.

### Coordination among health and development initiatives.

In countries, a myriad of health and development initiatives are ongoing, often resulting in a fragmented national landscape, placing administrative burdens and distorting country priorities. A national coordinating mechanism, such as the NCMH, can contribute to synergizing processes so that they clearly reflect health objectives.

### Planning the best possible use of resources.

*Enhance political support for increased health investments and positioning of health in development processes.*

- **Present country-based evidence on health-development links:** The Caribbean Commission on Health and Development (CCHD) report presents initial findings on the aggregate returns for areas such as foreign direct investment (FDI), tourism and trade that can be expected from health investments. For example, the CCHD report shows that a 1% increase in health expenditure could lead to a 3% increase in FDI flows in Trinidad and Tobago.

- **Strengthen development processes through dialogue:** The intersectoral composition of the Ghana Macroeconomics and Health Initiative (GMHI) has ensured that it is consistent with other ongoing planning initiatives. The report of the GMHI is designed to input into the Ghana Poverty Reduction Strategy and the Ministry of Health Programme of Work for 2007-2011.

*Create comprehensive strategies and systems that better address the health of the poor.*

- **Set priorities for allocation of resources:** The India NCMH identified 17 major classes of health conditions that accounted for over 80% of the disease burden in India in 1998. Then, further criteria were established to decide the list of priority health interventions. Included in the analysis was attention to the emerging noncommunicable disease burden and an ageing population.

- **Choose and cost interventions:** Yemen formulated Millennium Development Goal (MDG)-based health strategies and finalized the costing process of these strategies as an input into long-term national policy (2006-2015) and the medium-term health sector plan (which will be integrated into the five-year development plan). Other costing estimates that were compiled are presented below.

### Estimating the costs of meeting health targets

- The Ghana Macroeconomics and Health Initiative: an additional US\$ 5 billion will be needed over 2002-2015 to achieve national health priorities, including the MDGs.
  - The India National Commission on Macroeconomics and Health: public health spending should be increased from the current level of approximately 1.2% to 3% of GDP to achieve the MDGs and national health targets.
  - A health and population working group directed by the Ministry of Public Health and Population of Yemen: about US\$ 14 billion, or US\$ 53 per person per year, will be needed over 2006-2015 to meet the health MDGs.
- **Ensure the optimal quantity and quality of the health workforce:** The Caribbean Commission on Health and Development quotes a 35% vacancy rate for nurses, with an estimated loss of government revenue of US\$ 16.7 million through migration of nurses whose basic training was paid