SECOND MEETING OF THE COMMISSION ON MACROECONOMICS AND HEALTH

New Delhi 14-17 April 2000

CHAIRMAN'S SUMMARY

The activities in New Delhi were divided among three-and-one-half days. On Friday April 15, the members of the CMH and other attendees were treated to a day of intensive interaction and discussion with senior Indian policy makers, academics, and members of the pharmaceutical sector. The main conclusion, if I might risk an over-simplistic summary, is that while many positive and exciting things are happening in parts of Indian health care, the overall state of the public health system is in crisis for the poorest of the poor in Indian society. There is a very considerable amount of preventable morbidity and death that remains unattended because of meager public funding and a breakdown of administration and quality control at the primary health care level. The primary health system is so broken down and under-funded that five-sixths of health care costs are borne directly by households, mainly out of pocket. A considerable amount of that private spending is of very low quality, but the public health system is simply too unreliable and understaffed to make an adequate contribution. Tertiary care facilities are often excellent in terms of quality of staff, but are overwhelmed by patient demands, especially since a large number of patients use these facilities as a first or second resort, bypassing the ineffectual operations at the primary-health care level. There are vast differences in performance among Indian states, with the Southern states (especially Kerala, but also others), now outperforming the states in the North. There is much to be learned about the socio-economic, political, and perhaps even ecological bases of such differences in outcome.

On Saturday and Sunday, April 16-17, the CMH members, together with participants from the working groups and the donor agencies, discussed in detail the agenda of the CMH and the specific working groups. This was the occasion to debate various aspects of the broader agenda, such as the relative weights to be accorded systemic reform versus greater health-care funding in getting public health systems operating more effectively; or the relative weights to be accorded to categorical programs (such as immunization and HIV/AIDS control) versus broad systemic reforms (such as improved management and oversight of primary health facilities). Even though there are real and fascinating differences of opinion within the group, real discussion led to some real progress on these long-debated and contentious topics. For example, there is a general consensus that the issue is not really more money VERSUS system reform, but more money PLUS system reform, and that the CMH will emphasize that much greater funding for public health must go hand in hand with a breakthrough in health delivery systems. Similarly, the advocates of categorical programs acknowledged that even when effective technologies and interventions exist, we need to create new and innovative modes of delivery of such programs. Money and "will" is not enough to get HIV/AIDS programs in place, or TB/DOTS programs, or malaria control effectively in place. There must be new and

clever ways to deliver such services, drawing upon wider parts of society and institutions not strictly within the public health system (schools, enterprises, civic associations, the information technology industry, etc.).

On Monday morning, April 18, the group went on a series of site visits in Delhi. The first stop was a major tertiary care center. The basic message was that a superb staff faced profound problems of an ever-burgeoning patient population and therefore incredibly stretched resources. The basic referral system does not operate. We were told that around 80 percent of the patients showing up at the hospital each day arrive without a formal referral. The next stop was at a community-based NGO, in a "resettlement colony" in Delhi. The community was described as "lower middle class," poor but decidedly better off than slum dwellers. The NGO, Swaasthya, was dedicated mainly to the reproductive health and mother and child needs of the local community. The NGO helped to provide for a health clinic within the community a day or two per week (with a doctor visiting the community), as well as counseling of the local community to enable the mothers to obtain health care from public facilities outside of the immediate community (e.g. tertiary care facilities when needed). The very articulate head of the NGO explained to us how much time and effort was needed to "empower" the local women to seek the help that they needed, and to draw forth from them the "demands" for health services that otherwise would not be publicly expressed or acknowledged by the official health system. We heard once again about the incredibly low quality and service orientation of the primary health system.

I was fortunate to take a third stop that morning, though the rest of the group was not able to join. This stop was to a highly sophisticated tertiary heart institute in Delhi, the brainchild and creation of a brilliant and energetic Indian doctor who returned from the United States more than a decade ago to establish high-quality medical services in India. The institute is a privately funded set up, that uses much of its revenues to support ingenious and wide-reaching community-based activities. Together with Hewlett-Packard, they have equipped buses with high technology equipment to visit Indian villages to make diagnoses and treatments of heart conditions such as rheumatic heart disease, which has an incredible prevalence in India of around 6 per 1000 because of the high proportion of untreated strep infections that then progress to heart disease. The clinic is also experimenting and introducing many ingenious IT-based protocols (e.g. distance reading of EKGs from local communities) to multiply the reach of incredibly scarce medical resources in India.

It is very risky to summarize three-and-one-half very intensive days of meeting and discussion, but for the record, and especially for our colleagues that were not able to attend this meeting, let me do my best:

- There is an urgent need for improved primary health care in the poorest countries. Poor health, like its counterpart, poor education, is a critical barrier to successful economic development.

- Even with current technologies, the know-how exists to reduce the disease burden substantially. Cost-effective interventions are available for the major killers that account for a large proportion of excess mortality and morbidity in the poorest countries: diarrheal disease, HIV/AIDS prevention, malaria control, TB treatment, lower respiratory infections.

- Despite the cost-effectiveness of key interventions, a high proportion of impoverished populations lack suitable access to public health. This is the result of two forces: insufficient funding to make such services readily available, combined with a widespread breakdown of delivery mechanisms.

- Public health reform will therefore involve two major prongs: mobilization of much greater resources in support of public health, combined with deep reforms and innovations in the delivery of health care.

- The increased resource mobilization will itself have two major sources: domestic funding (both public and private) and foreign donor support.

- Domestic resources must rely on efficient use of both public (budget) and private funds. Public funding is vital in at least two areas: to support the poorest of the poor, and to support the provision of public goods (e.g. infection control, research, surveillance, etc.). Private funding, where affordable by households, should be allocated efficiently, meaning that there is a high premium on effective models of insurance, private-sector delivery of services, quality control assurance, etc. The appropriate boundaries between public and private funds are of course uncertain and subject to continuing debate.

- Donors will also have a very large role to play in the global provision of public health. This too if for two main reasons. First, the poorest of the poor in the world will not be able to afford even the rudimentary required level of health services. In a country with GNP of $300 per capita, even 5% of GDP devoted to public health makes available a mere $15 per person per year. Second, there are critical international public goods that cannot be provided by any individual government. This includes, for example, support for scientific research needed for future breakthroughs in HIV/AIDS, malaria, etc.

- The current international donor effort, something around $2.5 billion per year from all donors (individual governments plus multilateral institutions) is much too small, amounting to just 50 cents per person in the developing world (and about $2.50 per year per capita in the donor countries).

Our working groups are designed, of course, to address these issues (and to reach alternative conclusions were led by the evidence!). Working Group 1 focuses on the linkages from poor health to poor economic development (or from improved health to increased economic growth). Working Group 2 focuses on the supply of global public goods (increased R&D for diseases of the poor countries, cross-border control of

infectious disease, monitoring and diffusion of information and best practices). Working Group 3 deals with domestic resource mobilization and the organization of both public and private finances (e.g. public and private insurance). Working Group 4 addresses the issues of globalization: is internationalization good or bad for global health, and why? How are various aspects of the new trading system, especially the trade-related intellectual property rights (TRIPs) likely to affect the poorest of the poor? Working Group 5 deals with the critical issue of the effectiveness of interventions for key diseases, especially the killers like AIDS, malaria, TB, diarrheal disease, respiratory infection, etc. The main issues are the true costs of providing effective interventions, taking into account the full costs of running an effective health service (one that works in practice, not just on paper). Working Group 5 will also deal with the critical issues of new approaches to the design of key interventions: are there better ways to expand the DOTS program for TB? How can malaria control best be undertaken in Africa – bed nets, mosquito control, case management? Will AIDS interventions, such as condom distribution to sex workers, effectively slow the epidemic?

Working Group 6 closes the circle. Assuming that the case is made about the high social returns to improved public health (WG2); and that effective ways are available for intervention in the provision of public and private goods (WG2 and WG5); and that the domestic economy is doing its part to raise domestic resources to the extent possible (WG3), what should be the level and kind of support available from the international donor community? There is a strong presumption that much more assistance is needed than the roughly $2.5 billion per year, but how much more, and in what forms?