



EXECUTIVE BOARD MEMBERS' RETREAT
Accra, Ghana
19-20 November 2003

EB/Retreat/03/Discussion Paper 1

11 November 2003

MILLENNIUM DEVELOPMENT GOALS AND HEALTH TARGETS

Introduction

The Millennium Development Goals were endorsed by all United Nations Member States at the 2000 Millennium Summit, and provide an ambitious targets for reducing poverty. Health is at the core of the MDGs. Three of the eight Development Goals, eight of the 18 targets, and 18 of the 48 indicators are health related¹. (Annex 1). The MDGs do not provide a comprehensive list of health targets (for example, lacking indicators for reproductive health, reduction in non communicable disease, and HIV treatment). However, they are an important milestone in progress towards health for all.

Too many low income countries are not on track to achieve the health related MDGs. Recent assessments from the World Bank and UNDP based on national reports conclude that several goals will not be met by 2015 at current rates of progress, particularly child health and maternal mortality.

The World Health Assembly (WHA) and the UNGASS on HIV/AIDS have set several health related targets for 2005 that are closely linked to the MDGs and to some extent act as interim measures of progress. These include targets for HIV, tuberculosis, malaria. The WHA has also set targets to be reached by 2005 for other diseases that are not included as indicators in the MDGs, but are important measures of disease control. These include polio, leprosy, measles and tetanus. Health targets for 2005 are all for communicable diseases, and categorised in two groups; reduction in the burden of endemic disease, and elimination or eradication of disease. (Annex 2).

Value of targets

Time limited targets are valuable in facilitating coordinated action, mobilising resources, and promoting a sense of urgency. Failure to reach health targets means the economic, social and epidemiological burden of disease continues to exert a profoundly negative influence on communities and countries, and may lead to scepticism and fatalism in policy makers, donors and health workers. Targets tend to be more useful in promoting a change in action if they are challenging but feasible, and not to distant in the future.

¹ Document A56/11

Catalytic impact of '3 by 5' and other health targets

Given the inadequate progress towards achieving several of the health-related MDGs, an urgent change is required to meet the challenges of introducing and scaling up effective public health interventions, and overcoming inequity in access and health outcomes. However, from this perspective, the MDGs are too distant to provide the impetus currently needed. Other more proximal health targets provide an opportunity to transform approaches to public health and augment the power of the MDGs.

The social and economic burden of HIV is the greatest health disaster for several centuries. The recent target recognised by the WHA to get 3 million people with HIV in developing countries onto ARV treatment by 2005 is catalysing changes in the way WHO works, and in public health more broadly. The target is ambitious but feasible, if adequate resources are raised, and health system develop and adapt to meet this challenge. Achieving the '3 by 5' target is essential to build confidence in the capacity of the global community to reach the MDGs by 2015.

The primary requirement for accelerated progress is adequate resources. Human and financial resources are the pillars of a health system, and lack of them is the main obstacle to progress. Health care budgets remain inadequate in most developing countries, and the financial burden on the poor is unacceptably high. Many skilled workers are leaving the public health services in search of better career prospects. Social sector spending ceilings have restricted the capacity of some Ministries of Health to mobilise and utilise recent increases in ODA for health. A realistic assessment of the resource needs for reaching '3 by 5' and other health targets demonstrates the actual short term needs.

The secondary requirement is development of health systems. Focussing on specific targets does not require a return to vertical approaches to disease control. However, inadequate investment in health and inappropriate implementation of health sector reform processes can have a detrimental effect on health systems. Planning for reaching health targets can assist in identifying health system needs.

- (a) **Efficiency.** There are less than 26 months remaining to the end of 2005. Experience in health emergencies, and with the SARS epidemic, has demonstrated that the global community can respond effectively and urgently to meet a health crisis. These important lessons can be applied more widely to accelerate progress towards health related targets, and improve the efficiency and quality of public health interventions.
- (b) **Health measurement and monitoring.** The primary measures of success of an effective health system are improved health outcomes for the poor. Improvement of tools and systems for measurement is needed, with increased use of these measures for management. A Health Metrics Network, made up of countries and partner organizations, is in development, hosted by WHO, and facilitate this process.
- (c) **Integration.** Primary, secondary and tertiary care are frequently viewed as competing approaches for improving the health of populations, and are often competing for resources. It has been argued that spending money on ARV treatment will reduce investments in prevention. This argument fails to recognise how availability of

treatment increases uptake of counselling and testing services, and therefore strengthens prevention strategies.

- (d) Coordination.** Many new players are making a contribution to primary health care, including non government organisations, academic institutions, civil society organisations, and the private sector. Governments will continue to provide leadership in coordinating initiatives to meet health targets.

* * *

Annex 1: Millennium Development Goals and Indicators
Goals, targets and indicators in the Millennium Development Goals directly related to health²

| | | |
|-------------------------------|--|---|
| GOAL 1: | ERADICATE EXTREME POVERTY AND HUNGER | |
| Target 1: | Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day | |
| Target 2: | Halve, between 1990 and 2015, the proportion of people who suffer from hunger | 4. Prevalence of underweight children (under five years of age) 5. Proportion of population below minimum level of dietary energy consumption |
| GOAL 2: | ACHIEVE UNIVERSAL PRIMARY EDUCATION | |
| Target 3: | Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling | |
| GOAL 3: | PROMOTE GENDER EQUALITY AND EMPOWER WOMEN | |
| Target 4: | Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015 | |
| GOAL 4: | REDUCE CHILD MORTALITY | |
| Target 5: | Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate | 13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of 1-year-old children immunized against measles |
| GOAL 5: | IMPROVE MATERNAL HEALTH | |
| Target 6: | Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio | 16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel |
| GOAL 6: | COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES | |
| Target 7: | Have halted by 2015, and begun to reverse, the spread of HIV/AIDS | 18. HIV prevalence among 15-to-24-year-old pregnant women 19. Condom use rate of the contraceptive prevalence rate 20. Number of children orphaned by HIV/AIDS |
| Target 8: | Have halted by 2015, and begun to reverse the incidence of malaria and other major diseases | 21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures 23. Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under directly observed treatment short course |
| GOAL 7: | ENSURE ENVIRONMENTAL SUSTAINABILITY | |
| Target 9: | Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources | 29. Proportion of population using solid fuels |
| Target 10^a: | Have, by 2015, the proportion of people without sustainable access to safe drinking water | 30. Proportion of population with sustainable access to an improved water source, urban and rural |
| Target 11: | By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers | 31. Proportion of urban population with access to improved sanitation |
| GOAL 8: | DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT | |
| Target 12: | Develop further an open, rule-based, predictable, non-discriminatory trading and financial system | |
| Target 13: | Address the special needs of the least developed countries | |
| Target 14: | Address the special needs of landlocked countries and small island developing States | |
| Target 15: | Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term | |
| Target 16: | In cooperation with developing countries, develop and implement strategies for decent and productive work for youth | |
| Target 17: | In cooperation with pharmaceutical companies provide access to affordable, essential drugs in developing countries | 46. Proportion of population with access to affordable essential drugs on a sustainable basis |
| Target 18: | In cooperation with the private sector, make available the benefits of new technologies, especially information and communications | |

^a At the World Summit on Sustainable Development, Member States adopted an equivalent target for sanitation: "to halve, by the year 2015, the proportion of people who do not have access to basic sanitation."

Note: For WHO's operational activities in monitoring and reporting, Development Goal health indicators representing more than one measure (i.e. for tuberculosis and malaria) have been broken down into their single measures. Additionally, HIV-related indicators have been reformulated to incorporate the corresponding footnotes of the initial indicator list.

Sources: Implementation of the United Nations Millennium Declaration, Report of the Secretary-General, document A/57/270 (31 July 2002). First annual report based on the "Road map towards the implementation of the United Nations Millennium Declaration", document A/56/326 (6 September 2001); World Summit on Sustainable Development: Plan of Implementation, September 2002.

= = =

² Document A/56/11

Annex 2: Health Targets for 2005**1. Targets to Reduce the Burden of Endemic Disease**

| Disease | Target |
|---------------------|---|
| HIV/AIDS | <p>Expand access to antiretroviral drugs to three million HIV-positive people in developing countries</p> <p>60% of countries have adequate surveillance of HIV/AIDS, sexually transmitted infections and related behaviours</p> <p>The proportion of infants with HIV will be reduced by 20%</p> <p>80% of reproductive health services will provide and promote the use of condoms</p> <p>90% of young people have access to the information, education and services they need to protect themselves and others from infection</p> <p>60% of people have access to HIV/AIDS testing and counselling services</p> <p>All injectable medicines and vaccines will be supplied with single use injection equipment</p> <p>All blood supplies will be screened for HIV</p> |
| Tuberculosis | 70% of people with infectious TB will be diagnosed, and 85% cured |
| Malaria | <p>At least 60% of those suffering from malaria should be able to access and use correct, affordable and appropriate treatment within 24 hours of the onset of symptoms</p> <p>At least 60% of those at risk of malaria, particularly pregnant women and children under five, should benefit from suitable personal and community protective measures such as insecticide-treated mosquito nets</p> <p>At least 60% of all pregnant women who are at risk of malaria, especially those in their first pregnancies, should receive intermittent preventive treatment</p> |
| Measles | Reduce the number of measles deaths worldwide by half |

2. Targets to Eliminate or Eradicate Disease

| Disease | Target |
|--------------------------------------|---|
| Poliomyelitis | Interruption of transmission of poliomyelitis (by end 2004) |
| Leprosy | Eliminate leprosy as a public health problem in all countries, ie, prevalence below one case per 10,000 population in each country |
| Maternal and neonatal tetanus | Elimination of maternal and neonatal tetanus as a public health problem (ie, to arrive at a rate of neonatal tetanus below 1 per 1000 live births per year at the district level) |
| Dracunculiasis (Guinea Worm) | Eradication (as soon as possible) |

= = =

English | Español | Français

Search

OK

[Home](#)[Countries](#)[Health topics](#)[Publications](#)[Research tools](#)[WHO sites](#)[MDG Home](#)[Goals, Targets & Indicators](#)[Achieving Goals](#)[Links](#)

Millennium Development Goals

Location: [WHO](#) > [WHO sites](#) > MDG Home**Millennium Development Goals (MDGs)**

The Millennium Development Goals (MDGs), adopted at the Millennium Summit of the United Nations in September 2000, call for a dramatic reduction in poverty and marked improvements in the health of the poor. Meeting these goals is feasible but far from assured. Success in achieving the MDGs will require a seriousness of purpose, a political resolve in countries, and an adequate flow of resources from high-income to low-income countries on a sustained and well-targeted basis.

The importance of the MDGs in health is, in one sense, self-evident. Improving the health and longevity of the poor is an end in itself, a fundamental goal of economic development. But it is also a means to achieving the other development goals relating to poverty reduction. The linkages of health to poverty reduction and to long-term economic growth are powerful, much stronger than is generally understood. The burden of disease in some low-income regions, especially sub-Saharan Africa, stands as a stark barrier to economic growth and therefore must be addressed frontally and centrally in any comprehensive development strategy. The AIDS pandemic represents a unique challenge of unprecedented urgency and intensity. This single epidemic can undermine Africa's development over the next generation, and may cause tens of millions of deaths in India, China, and other developing countries unless addressed by greatly increased efforts.

The feasibility of meeting the MDGs in the low-income countries is widely misjudged. On the one side of the debate are those who believe that the health goals will take care of themselves, as a fairly automatic by-product of economic growth. With the mortality rates of children under 5 in the least-developed countries standing at 159 per 1,000 births, compared with 6 per 1,000 births in the high-income countries. They take the view that it's just a matter of time before the mortality rates in the low-income world will converge with those of the rich countries. This is false for two reasons.

First, the disease burden itself will slow the economic growth that is presumed to solve the health problems; second, economic growth is indeed important, but is very far from enough. Health indicators vary widely for the same income level. The evidence suggests that 73 countries are far behind in meeting the MDGs for infant mortality, and 66 are far behind for meeting the MDGs for child mortality. The disease burden can be brought down in line with the MDGs only if there is a concerted, global strategy of increasing the access of the poorest that 73 countries are far behind in meeting the MDGs for infant mortality, and 66 are far behind for meeting the MDGs for child mortality. The disease burden can be brought down in line with the MDGs only if there is a concerted, global strategy of increasing the access of the world's poor to essential health services.

INFORMATION SOURCES

- [Report of the Commission on Macroeconomics and Health](#)
- [Macroeconomics and Health web site](#)
- [Consultation on increasing investments in health outcomes for the poor](#)

HIV/AIDS

[3 by 5 Initiative](#)
WHO's drive to
HIV/AIDS tre
three million
the end of 20
[3 by 5 Initiative](#)

DISEASE OUTBREAKS

[Avian influenza \(H5N1\) - update](#)
[Full text](#)

[Avian influenza \(H5N1\) - update](#)
[Full text](#)

[Disease outbreaks](#)

[Avian influenza](#)
[Latest information](#)

[Severe acute respiratory \(SARS\)](#)
[Latest information](#)

EMERGENCIES

[Iran crisis](#)
[Latest information](#)

[Liberia crisis](#)
[Latest information](#)

[Health action](#)

TOBACCO

[The WHO Framework Convention Tobacco Control](#)
[List of signatories](#)

GENERAL WEBSITES

[INFORMATIO](#)

[Media centre](#)
Press release
statements, f
photographs
and video linl

[Director-Gen](#)
Biography of
Director-Gen
all major spe
biographies c
Directors-Gen

[Governance](#)
WHO Constiti
documentatic
Executive Bo
World Health
Resolutions a

[About WHO](#)
Contact, perr
licensing info
and employr
opportunities

[Travellers' he](#)
Vaccination
requirements
risks and pre
accidents anc
diseases.

[About WHO](#) | [Employment](#) | [Other UN Sites](#) | [Search](#) | [Site Map](#) | [Suggestions](#)
© Copyright 2003 World Health Organization

EXECUTIVE SUMMARY OF THE REPORT

Technology and politics have thrust the world more closely together than ever before. The benefits of globalization are potentially enormous, as a result of the increased sharing of ideas, cultures, life-saving technologies, and efficient production processes. Yet globalization is under trial, partly because these benefits are not yet reaching hundreds of millions of the world's poor, and partly because globalization introduces new kinds of international challenges as turmoil in one part of the world can spread rapidly to others, through terrorism, armed conflict, environmental degradation, or disease, as demonstrated by the dramatic spread of AIDS around the globe in a single generation.

The world's political leaders have recognized this global interdependence in solemn commitments to improve the lives of the world's poor by the year 2015. The Millennium Development Goals (MDGs), adopted at the Millennium Summit of the United Nations in September 2000, call for a dramatic reduction in poverty and marked improvements in the health of the poor. Meeting these goals is feasible but far from automatic. Indeed, on our current trajectory, those goals will not be met for a significant proportion of the world's poor. Success in achieving the MDGs will require a seriousness of purpose, a political resolve, and an adequate flow of resources from high-income to low-income countries on a sustained and well-targeted basis.

The importance of the MDGs in health is, in one sense, self-evident. Improving the health and longevity of the poor is an end in itself, a fundamental goal of economic development. But it is also a *means* to achieving the other development goals relating to poverty reduction. The linkages of health to poverty reduction and to long-term economic growth are powerful, much stronger than is generally understood. The burden of disease in some low-income regions, especially sub-Saharan Africa, stands as a stark barrier to economic growth and therefore must be addressed frontally and centrally in any comprehensive development strategy. The AIDS pandemic represents a unique challenge of unprecedented urgency and intensity. This single epidemic can undermine Africa's development over the next generation, and may cause tens of millions of deaths in

Table 1. LIFE EXPECTANCY AND MORTALITY RATES, BY COUNTRY DEVELOPMENT CATEGORY, (1995–2000)

| Development Category | Population (1999 millions) | Annual Average Income (US dollars) | Life Expectancy at Birth (years) | Infant Mortality (deaths before age 1 per 1,000 live births) | Under Five Mortality (deaths before age 5 per 1,000 live births) |
|-------------------------------|----------------------------|------------------------------------|----------------------------------|--|--|
| Least-Developed Countries | 643 | 296 | 51 | 100 | 159 |
| Other Low-Income Countries | 1,777 | 538 | 59 | 80 | 120 |
| Lower-Middle-Income Countries | 2,094 | 1,200 | 70 | 35 | 39 |
| Upper-Middle-Income Countries | 573 | 4,900 | 71 | 26 | 35 |
| High-Income Countries | 891 | 25,730 | 78 | 6 | 6 |
| Memo: sub-Saharan Africa | 642 | 500 | 51 | 92 | 151 |

Source: *Human Development Report 2001*, Table 8, and CMH calculations using *World Development Indicators of the World Bank, 2001*.

India, China, and other developing countries unless addressed by greatly increased efforts.

Our Report focuses mainly on the low-income countries and on the poor in middle-income countries.¹ The low-income countries, with 2.5 billion people—and especially the countries in sub-Saharan Africa, with 650 million people—have far lower life expectancies and far higher age-adjusted mortality rates than the rest of the world, as shown in the accompanying Table 1. The same is true for the poor in middle-income countries, such as China. To reduce these staggeringly high mortality rates, the control of communicable diseases and improved maternal and child health remain the highest public health priorities. The main causes of avoidable deaths in the low-income countries are HIV/AIDS, malaria, tuberculosis (TB), childhood infectious diseases, maternal and perinatal conditions, micronutrient deficiencies, and tobacco-related illnesses. If these conditions were controlled in conjunction with enhanced programs of family planning, impoverished families could not only enjoy lives that are longer, healthier, and more productive, but they would also choose to have fewer children, secure in the knowledge that their children would survive, and could thereby invest more in the education and health of each child. Given

the special burdens of some of these conditions on women, the well-being of women would especially be improved. The improvements in health would translate into higher incomes, higher economic growth, and reduced population growth.

Even though we focus mainly on communicable diseases and maternal and perinatal health, noncommunicable diseases (NCDs) are also of great significance for all developing countries; for many middle-income countries the mortality from communicable diseases has already been significantly reduced so that the NCDs tend to be the highest priority. Many of the noncommunicable diseases, including cardiovascular disease, diabetes, mental illnesses, and cancers, can be effectively addressed by relatively low-cost interventions, especially using preventative actions relating to diet, smoking, and lifestyle.² Our global perspective on priorities needs to be complemented by each country analyzing its own health priorities based on detailed and continually updated epidemiological evidence. Our argument for outcome-oriented health systems also implies substantial capacity to deal with a range of conditions not detailed here, such as low-cost case-management of mental illness, diabetes and heart attacks. The evidence also suggests that approaches required to scale up the health system to provide interventions for communicable diseases and reproductive health will also improve care for the NCDs.³

The feasibility of meeting the MDGs in the low-income countries is widely misjudged. On the one side of the debate are those optimists who believe that the health goals will take care of themselves, as a fairly automatic byproduct of economic growth. With the mortality rates of children under 5 in the least-developed countries standing at 159 per 1,000 births, compared with 6 per 1,000 births in the high-income countries,⁴ these blithe optimists assume that it's just a matter of time before the mortality rates in the low-income world will converge with those of the rich countries. This is false for two reasons. First, the disease burden itself will slow the economic growth that is presumed to solve the health problems; second, economic growth is indeed important, but is very far from enough. Health indicators vary widely for the same income level. The evidence suggests that 73 countries are far behind in meeting the MDGs for infant mortality, and 66 are far behind for meeting the MDGs for child mortality.⁵ The disease burden can be brought down in line with the MDGs only if there is a concerted, global strategy of increasing the access of the world's poor to essential health services.

On the other side of the debate are the pessimists, who underestimate the considerable progress that has been made in health (with the notable exception of HIV/AIDS) by most low-income countries and believe that their remaining high disease burden is a byproduct of corrupt and broken health systems beyond repair in poorly governed low-income countries. This alternative view is also filled with misunderstanding and exaggeration. The epidemiological evidence conveys a crucial message: the vast majority of the excess disease burden is the result of a relatively small number of identifiable conditions, each with a set of existing health interventions that can dramatically improve health and reduce the deaths associated with these conditions. The problem is that these interventions don't reach the world's poor. Some of the reasons for this are corruption, mismanagement, and a weak public sector, but in the vast majority of countries, there is a more basic and remediable problem. The poor lack the financial resources to obtain coverage of these essential interventions, as do their governments. In many cases, public health programs have not been modified to focus on the conditions and interventions emphasized here.

The key recommendation of the Commission is that the world's low- and middle-income countries, in partnership with high-income countries, should scale up the access of the world's poor to essential health services, including a focus on specific interventions. The low- and middle-income countries would commit additional domestic financial resources, political leadership, transparency, and systems for community involvement and accountability, to ensure that adequately financed health systems can operate effectively and are dedicated to the key health problems. The high-income countries would simultaneously commit vastly increased financial assistance, in the form of grants, especially to the countries that need help most urgently, which are concentrated in sub-Saharan Africa. ***They would resolve that lack of donor funds should not be the factor that limits the capacity to provide health services to the world's poorest peoples.***

The partnership would need to proceed step by step, with actions in the low-income countries creating the conditions for donor financing, while ample donor financing creates the financial reality for a greatly scaled-up, more effective health system, with the shared program subject to frequent review, evaluation, verification, and mid-course corrections. The chicken-and-egg problem of deciding whether reform or donor financing must come first would be put aside with both donors and recipients frankly acknowledging that both finance and reform are needed at

each stage, and that both must be sustained by an intensive partnership. For lower-middle-income countries with large concentrations of poor, a prime task of national governments would be to mobilize additional resources to finance priority interventions that assure coverage of the poor within those societies.

The commitment of massive additional financial resources for health, domestic and international, may be a necessary condition for scaling up health interventions, but the Commission recognizes that such a commitment will not be sufficient. Past experience shows compellingly that political and administrative commitments on the part of both donors and countries are key to success. Building health systems that are responsive to client needs, particularly for poor and hard-to-reach populations, requires politically difficult and administratively demanding choices. Some issues, such as relative commitments to the health needs of rich and poor, relate to the health sector. Others, such as whether the public sector budget and procurement systems work or whether there is effective supervision and local accountability of public service delivery, are public management issues. Underlying these issues are broader questions of governance, conflict, and the relative importance of development and poverty reduction in national priorities.

The Commission recognizes the importance of these and other constraints and treats them in depth in several places in this Report. Success will require strong political leadership and commitment on the part of countries that can afford to contribute resources as well as from developing countries—in the private and public sectors and in civil society as well. It requires the evolution of an atmosphere of honesty, trust, and respect in donor-recipient interactions. Success requires special efforts precisely in those settings in which health conditions are most troubling and where public sectors are weak. Donor support should be readily forthcoming to help overcome these constraints. Where countries are not willing to make a serious effort, though, or where funding is misused, prudence and credibility require that large-scale funding should not be provided. Even here, though, the record shows that donor assistance can do much to help, by building local capacity and through the involvement of civil society and NGOs. This is a daunting challenge, yet one that is more than ever a strategically relevant objective. Governments and leaders who help stimulate and nurture these actions will be providing a specific antidote to the despair and hatred that poverty can breed.

The Commission worked hard to examine whether the low-income countries could afford to fund the health systems out of their own resources if they were to eliminate existing wasteful spending in health and other areas. Our findings are clear: *poverty itself imposes a basic financial constraint, though waste does exist and needs to be addressed.* The poor countries should certainly improve health-sector management, review the current balance among health-sector programs, and raise domestic resources for health within their limited means. We believe that it is feasible, on average, for low- and middle-income countries to increase budgetary outlays for health by 1 percent of GNP by 2007 and 2 percent of GNP by 2015 compared with current levels, though this may be optimistic given intense competing demands for scarce public resources. Low- and middle-income countries could also do more to make the current spending, public and private, more equitable and effective. Public spending should be better targeted to the poor, with priorities set on the basis of epidemiological and economic evidence. There is scope for private out-of-pocket spending in some cases being replaced with prepaid community financing schemes. Yet for the low-income countries, we still find a gap between financial means and financial needs, which can be filled only by the donor world if there is to be any hope of success in meeting the MDGs.

In most middle-income countries, average health spending per person is already adequate to ensure universal coverage for essential interventions. Yet such coverage does not reach many of the poor. Exclusion is often concentrated by region (e.g., rural western China and rural north-east Brazil), or among ethnic and racial minorities. For whatever reason, public-sector spending on health does not attend sufficiently to the needs of the poor. Moreover, since many middle-income countries provide inadequate financial protection for large portions of their population, catastrophic medical expenses impoverish many households. In view of the adverse consequences of ill health on overall economic development and poverty reduction, we strongly urge the middle-income countries to undertake fiscal and organizational reforms to ensure universal coverage for priority health interventions.⁶ We also believe that the World Bank and the regional development banks, through nonconcessional financing, can help these countries to make a multi-year transition to universal coverage for essential health services.

The Commission examined the evidence relating to organizational requirements for scaling up and some of the key constraints that will have to be overcome. Fortunately, the essential interventions highlighted here

are generally not technically exacting. Few require hospitals. Most can be delivered at health centers, at smaller facilities that we refer to as health posts, or through outreach services from these facilities. We call these collectively the *close-to-client (CTC)* system, and this system should be given priority to make these interventions widely accessible. Producing an effective CTC system is no small task. National leadership, coupled with capacity and accountability at the local level, is vital. This will require new political commitments, increased organizational and supervisory capacity at both local and higher levels, and greater transparency in public services and budgeting—all backed by more funding. These, in turn, must be built on a foundation of strong community-level oversight and action, in order to be responsive to the poor, in order to build accountability of local services, and in order to help ensure that families take full advantage of the services provided.

Some recent global initiatives for disease control, including those for TB, leprosy, guinea-worm disease, and Chagas disease, have proved highly successful in delivering quality interventions and, in some cases, changing attitudes and behaviors in some very difficult situations over large geographical areas. An important feature of these initiatives is the inclusion of rigorous systems of monitoring, evaluation, reporting, and financial control as mechanisms for ensuring that objectives are met, problems are detected and corrected, and resources are fully accountable. The result is a growing body of evidence concerning both the degree of progress achieved and the operational and managerial strategies that contribute to success. Lessons from these experiences can provide useful operational guidance, especially for the delivery of interventions at the close-to-client level.

In most countries, the CTC system would involve a mix of state and nonstate health service providers, with financing guaranteed by the state. The government may directly own and operate service units, or may contract for services with for-profit and not-for-profit providers. Since public health systems in poor countries have been so weak and underfinanced in recent years, a considerable nongovernmental health sector has arisen that is built upon private practice, religiously affiliated providers, and nongovernmental organizations. This variety of providers is useful in order to provide competition and a safety valve in case of failure of the public system. It is also a *fait accompli* in almost all poor countries.

A sound global strategy for health will also invest in new knowledge. One critical area of knowledge investment is operational research regard-

ing treatment protocols in low-income countries.⁷ There is still much to be learned about what actually works, and why or why not, in many low-income settings, especially where interventions have not been used or documented to date. Even when the basic technologies of disease control are clear and universally applicable, each local setting poses special problems of logistics, adherence, dosage, delivery, and drug formulation that must be uncovered through operational research at the local level. We recommend that as a normal matter, country-specific projects should allocate at least 5 percent of all resources to project-related operational research in order to examine efficacy, the optimization of treatment protocols, the economics of alternative interventions, and delivery modes and population/patient preferences.

There is also an urgent need for investments in new and improved technologies to fight the killer diseases. Recent advances in genomics, for example, bring us much closer to the long-sought vaccines for malaria and HIV/AIDS, and lifetime protection against TB. The science remains complex, however, and the outcomes unsure. The evidence suggests high social returns to investments in research that are far beyond current levels. Whether or not effective vaccines are produced, new drugs will certainly be needed, given the relentless increase of drug-resistant strains of disease agents. The Commission therefore calls for a significant scaling up of financing for global R&D on the heavy disease burdens of the poor. We draw particular attention to the diseases overwhelmingly concentrated in poor countries. For these diseases, the rich-country markets offer little incentive for R&D to cover the relatively few cases that occur in these rich countries.⁸ We also stress the need for research into reproductive health—for example, new microbicides that could block the transmission of HIV/AIDS and improved management of life-threatening obstetric conditions.

We need increased investments in other areas of knowledge as well. Basic and applied scientific research in the biomedical and health sciences in the low-income countries needs to be augmented, in conjunction with increased R&D aimed at specific diseases. The state of epidemiological knowledge—who suffers and dies and of which diseases—must be greatly enhanced, through improved surveillance and reporting systems.⁹ In public health, such knowledge is among the most important tools available to successful disease control. Surveillance is also critically needed in the case of many NCDs, including mental health, the impact of violence and accidents, and the rapid rise of tobacco and diet/nutrition-related diseases.

Finally, we need a greatly enhanced system of advising and training throughout the low-income countries, so that the lessons of experience in one country can be mobilized elsewhere. The international diffusion of new knowledge and “best practices” is one of the key forces of scaling up, a central responsibility of organizations such as the World Health Organization and the World Bank, and a goal now more readily achieved through low-cost methods available through the internet.

A war against disease requires not only financial resources, sufficient technology, and political commitment, but also a strategy, operational lines of responsibility, and the capacity to learn along the way. The Commission therefore devoted substantial effort to analyzing the organizational practicalities of a massive, donor-supported scaling up of health interventions in the low-income world. We started by noting the changes that will be needed on the ground within the countries themselves. After all, essential health interventions are delivered in the communities where poor people live. Scaling up must therefore start with the organization of the CTC delivery system at the local level. The role of community involvement, and more generally of mobilization of a broad partnership of public and private sectors and civil society, is crucial here. The CTC system should also be supported by nationwide programs for some major diseases, such as malaria, HIV/AIDS, and TB. Such focused programs have important advantages when properly integrated with community health delivery, by mobilizing communities of expertise not available at the community level, public attention and financing, political energies, and public accountability for specified results.

Since scaling up will require a significant increase in international financing, an effective partnership of donors and recipient countries, based on mutual trust and performance, is essential. In this context, the mechanisms of donor financing must change, a point that has been recognized in the international system in the past 3 years by the creative introduction of a new framework for poverty reduction, often termed the *Poverty Reduction Strategy Paper (PRSP) framework*.¹⁰ The early results of the PRSP process to date are promising, and the Commission endorses this new process.¹¹ A concerted attack on disease along the lines that we recommend will help to ensure success of this emerging approach to donor-recipient relations. The strengths of the PRSP include: (1) deeper debt cancellation, (2) country leadership in the preparation of the national strategy, (3) explicit incorporation of civil society at each step of the process, (4) a comprehensive approach to poverty reduction, and (5) more

donor coordination in support of country goals. All of these are applicable—indeed vital—to the success of the health initiative proposed here. To achieve the potential benefits of the PRSP framework, donor and recipient countries must specify a sustainable financing scheme and investment plan for the health sector as an integral part of the PRSP scheme for health.

Though we advocate a greatly increased investment in the health sector itself, we stress the need for complementary additional investments in areas with an important impact on poverty alleviation (including effects on health). These include education, water and sanitation, and agricultural improvement. For example, education is a key determinant of health status, as health is of education status. Investments in these various sectors work best when made in combination, a point highlighted by the PRSP process. We did not, however, make cost estimates outside of the health sector.¹²

Within the context of the PRSP, the Commission recommends that each developing country establish a temporary National Commission on Macroeconomics and Health (NCMH), or its equivalent, chaired jointly by the Ministers of Health and Finance and incorporating key representatives of civil society, to organize and lead the task of scaling up.¹³ Each NCMH would assess national health priorities, establish a multi-year strategy to extend coverage of essential health services, take account of synergies with other key health producing sectors, and ensure consistency with a sound macroeconomic policy framework. The plan would be predicated upon greatly expanded international grant assistance. The National Commissions would work together with the WHO and World Bank to prepare an epidemiological baseline, quantified operational targets, and a medium-term financing plan. Each Commission should complete its work within two years, by the end of 2003.

We recommend that each country will need to define an overall program of “essential interventions” to be guaranteed universal coverage through public (plus donor) financing. We suggest four main criteria in choosing these essential interventions: (1) they should be technically efficacious and can be delivered successfully; (2) the targeted diseases should impose a heavy burden on society, taking into account individual illness as well as social spillovers (such as epidemics and adverse economic effects); (3) social benefits should exceed costs of the interventions (with benefits including life-years saved and spillovers such as fewer orphans or faster economic growth); and (4) the needs of the poor should be stressed.

We estimate that by 2010 around 8 million lives *per year*, in principle, could be saved—mainly in the low-income countries—by the essential interventions against infectious diseases and nutritional deficiencies recommended here.¹⁴ The CMH estimated the costs of this expanded coverage,¹⁵ including related general costs of system expansion and supervision, for all countries with 1999 GNP per capita below \$1,200, plus the remaining handful of countries in sub-Saharan Africa with incomes above \$1,200 (see Table A2.B for the list of countries).¹⁶ Total annual health outlays for this group of countries would rise by \$57 billion by 2007 and by \$94 billion by 2015 (Table A2.3). The countries in the aggregate would commit an additional \$35 billion per year by 2007 and \$63 billion per year by 2015.¹⁷ The donors, on their part, would contribute grant financing of an additional \$22 billion per year by 2007 and \$31 billion per year by 2015 (Table A2.6).¹⁸ Current official development assistance (ODA) is on the order of \$6 billion.¹⁹ Total donor spending, including both country-level programs and the supply of global public goods, would be \$27 billion in 2007 and \$38 billion in 2015. The increased donor financing for health would be additional to overall current aid flows, since aid should be increased in many areas outside of the health sector as well.

Most of the donor assistance would be directed at the least-developed countries, which need the most grant assistance to extend the coverage of health services. For those countries, total annual health outlays would rise by \$17 billion by 2007 and \$29 billion by 2015, above the level of 2002. Given the extremely low incomes in these countries, domestic resource mobilization would fall far short of need, however, rising by \$4 billion by 2007 and \$9 billion by 2015. The gap would be filled by donors, with grant assistance equal to \$14 billion per year in 2007 and \$21 billion per year in 2015. We also note that, on a regional basis, Africa would receive the largest proportion of donor assistance, a reflection both of Africa's poverty and its high disease prevalence. AIDS prevention and care would account for around half of the total cost of scaling up.²⁰

To understand these sums, it is instructive to consider the costs of the health interventions on a per capita basis. We find that, on average, the set of essential interventions costs around \$34 per person per year, a very modest sum indeed, especially compared with average per capita health spending in the high-income countries of more than \$2,000 per year. The least developed countries can mobilize around \$15 per person per year by 2007 (almost 5 percent of per capita income). The gap is therefore \$19 per person per year. With 750 million people in the least-developed countries

in 2007, that comes to around \$14 billion. The other low-income countries can mobilize around \$32 per person on average (again roughly 5 percent of per capita income). Some of these countries will need donor aid to reach the \$34 per person requirement, and others will not. The other low-income countries will have a combined population of around 2 billion in 2007, and when calculated on a country-by-country basis will need roughly \$3 per capita on average to close the financing gap, therefore requiring a total level of donor aid of approximately \$6 billion. The low-middle-income countries will need an additional \$1.5 billion, mainly to cover the high costs of AIDS.

It is important to put the total donor assistance into perspective. Although the required assistance is large relative to current donor assistance in health, it would be only around 0.1 percent of donor GNP, and would leave ample room for significant increases in other areas of donor assistance as needed. We stress that the increased aid for health must be additional to current aid flows, since indeed increased aid will be needed not only in health but also in education, sanitation, water supply, and other areas. Also, although the donor flows look large in relation to current health spending, particularly in the poorest countries, this reflects how little they spend, which in turn reflects their low incomes. This expansion of aid to the health sector needs to be phased over time to ensure that resources are used effectively and honestly, which led us to the time path of increasing coverage shown in Table 7, which shows the basis of our costing. Note that the donor assistance will be required for a sustained period of time, perhaps 20 years, but will eventually phase out as countries achieve higher per capita incomes and are thereby increasingly able to cover essential health services out of their own resources.

This program would yield economic benefits vastly greater than its costs. Eight million lives saved from infectious diseases and nutritional deficiencies would translate into a far larger number of *years* of life saved for those affected, as well as a higher quality of life. Economists talk of disability-adjusted life years (DALYs) saved,²¹ which add together the increased years of life and the reduced years of living with disabilities. We estimate that approximately 330 million DALYs would be saved for each 8 million deaths prevented. Assuming, conservatively, that each DALY saved gives an economic benefit of 1 year's per capita income of a projected \$563 in 2015, the direct economic benefit of saving 330 million DALYs would be \$186 billion per year, and plausibly several times that.²² Economic growth would also accelerate, and thereby the saved