United Nations E/2009/88

Economic and Social Council

Distr.: General
1 June 2009

Original: English

Substantive session of 2009
Geneva, 6-31 July 2009
Item 2 (b) of the provisional agenda*
High-level segment: annual ministerial review

Note verbale dated 28 May 2009 from the Permanent Mission of Sri Lanka to the United Nations addressed to the President of the Economic and Social Council

The Permanent Mission of the Democratic Socialist Republic of Sri Lanka to the United Nations presents its compliments to the President of the Economic and Social Council and has the honour to request that the report of the South Asia regional preparatory meeting for the annual ministerial review of the Economic and Social Council, on the theme "Financing strategies for health care", held in Colombo from 16 to 18 March 2009 (see annex), be circulated as a document of the Council for consideration at its substantive session of 2009, under item 2 (b) of the provisional agenda.

At the regional preparatory meeting, key challenges that countries — particularly low-income countries — face in financing their health systems in order to achieve the internationally agreed goals on global public health were examined. Participants discussed how the international community can support countries as they move towards universal coverage, by (a) increasing funding for health; (b) making it more predictable; and (c) channelling funds to recipient countries in ways that strengthen national financing systems and local capacities and ensure better financing of health care in crisis situations. The meeting also provided an opportunity for the exchange of examples of best practices and new initiatives in financing for health care. The Government of Sri Lanka believes that the report will constitute a valuable contribution to the discussions on the theme at the annual ministerial review of 2009.

* E/2009/100.

09-35545 (E) 220609

Annex to the note verbale dated 28 May 2009 from the Permanent Mission of Sri Lanka to the United Nations addressed to the President of the Economic and Social Council

Report of the South Asia regional preparatory meeting on financing strategies for health care for the annual ministerial review of the Economic and Social Council

Summary

As part of the annual ministerial review process of the Economic and Social Council, a South Asia regional preparatory meeting on the theme "Financing strategies for health care" was held in Colombo from 16 to 18 March 2009. It was hosted by the Government of the Democratic Socialist Republic of Sri Lanka, in collaboration with the United Nations Department for Economic and Social Affairs and the World Health Organization. Organized as a multi-stakeholder event, with the participation of high-level representatives, the consultations consisted of plenary meetings and panel discussions, which were attended by 121 delegates.

The participants, including several ministers, examined key challenges that countries — particularly low-income countries — face in financing their health systems in order to achieve the internationally agreed goals on global public health. They discussed how the international community can support countries as they move towards universal coverage, by (a) increasing funding for health, (b) making it more predictable and (c) channelling funds to recipient countries in ways that strengthen national financing systems and ensure better financing of health in crisis situations. The meeting also provided an opportunity for the exchange of examples of best practices and new initiatives. The discussion took place against the backdrop of a worsening international economic and financial crisis.

Key policy messages

The following key messages emerged from the discussion:

Domestic sources of health care financing

- For universal coverage to be achieved, ways need to be found to increase domestic funding and to enhance efficiency in the use of resources;
- To ensure equitable access to health care, there is a need to move away from reliance on out-of-pocket payments towards a system of prepayment and pooling;
- As the proportion of total government expenditure allocated to health remains low in many Asian countries, with rising incomes, there is an opportunity to expand domestic health funding, even as countries see their growth rates reduced.

External sources of health care financing

- External funding needs to increase and become more predictable and better aligned with countries' national priorities and should be channelled to recipient countries in ways that strengthen national financing systems;
- Innovative sources of health financing should be welcomed, but they must be additional;
- The tendency of donors to focus on particular countries while neglecting others needs to be addressed.

Health care in conflict situations

- Improvement in health care is possible even when countries are facing crises;
- Keeping health systems — and especially primary health care — well funded enables countries to prevent secondary disasters such as epidemics and outbreaks in the case of a crisis;
- Compared to other areas, health remains underfunded during recovery and rehabilitation.

I. Introduction

At the 2005 World Summit, Heads of State and Government mandated the Economic and Social Council to hold annual ministerial-level substantive reviews as part of its high-level segment, in order to review progress made in the implementation of the outcomes of United Nations conferences and summits and to assess its impact on the achievement of the goals and targets of those conferences and summits. In 2009, the third annual ministerial review addresses the theme "Implementing the internationally agreed goals and commitments in regard to global public health".

On 16-18 March, the Government of the Democratic Socialist Republic of Sri Lanka, with the support of the United Nations Department for Economic and Social Affairs and the World Health Organization (WHO), hosted a South Asian regional preparatory meeting on the theme "Financing strategies for health care" to provide input to the 2009 review.[1]

The meeting provided an opportunity for Asian countries to contribute to the review, including by sharing best practices and lessons learned related to health care financing that could help in advancing and expanding activities to achieve the internationally agreed development goals (see enclosure).

The meeting brought together 121 delegates, including several Ministers, other senior representatives of Governments from Asia and other regions, and experts from the United Nations system and other international organizations, non-governmental organizations (NGOs), academia, and the private sector. Delegates examined emerging trends, challenges, and potential solutions in the areas of domestic and external funding for health care, challenges for health systems in countries in conflict or following crisis, best practices, and new initiatives to finance health care and the progress and challenges of the region in achieving the Millennium Development Goals (MDGs).

II. Proceedings of the regional preparatory meeting

A. Opening session and keynote address

The meeting was opened by Hon. Rohitha Bogollagama, Minister of Foreign Affairs, Democratic Socialist Republic of Sri Lanka. In his welcoming remarks, the Foreign Minister said that at a time of global financial, economic, food, energy, and environmental crisis, financing for health care, and the broader issue of achieving the MDGs, are even greater challenges. He stressed the importance of global partnership to achieve the MDGs, even for countries such as Sri Lanka, which are

[1] Please see http://www.un.org/ecosoc/newfunct/amrregional2009.shtml for the background note, programme, statements, presentations and list of participants.

on track to meet the MDG targets. He expressed his confidence that the meeting would allow the diverse and knowledgeable participants to engage in a valuable exchange of experiences.

The address by H.E. Nimal Siripala de Silva, Minister of Healthcare and Nutrition, Sri Lanka, highlighted the various ways in which the financial and economic crisis could adversely impact the health sector. He then identified actions that could help prevent or mitigate these negative impacts. He called for protection of the social sector to the greatest extent possible. He noted that Sri Lanka delivers health care without user fees with a budget second only to defence and education. While Sri Lanka has been greatly affected by the crisis, it has not compromised its expenditure on health, which it considers an investment in the future of the country. To reduce health costs, the Government is supporting disease prevention and health promotion. While a large part of Sri Lanka's health expenditure is covered by domestic resources, the Minister emphasized that leading global financial agencies, such as the World Bank, the International Monetary Fund, and the Asian Development Bank, have a shared responsibility to bridge the financial gaps caused by the global financial and economic crisis.

H.E. Ratnasiri Wickremanayake, Prime Minister of the Democratic Socialist Republic of Sri Lanka, recalled in his keynote address that, in Sri Lanka, public financing for health began more than two thousand years ago when Buddhist kings established public hospitals and maintained them with royal revenue. Even though Sri Lanka is by no means a rich country, its health care has been cited by international observers as among the best. This is despite the adverse impacts of terrorism and a natural disaster, the tsunami of 2004.

The Prime Minister noted that successive governments in Sri Lanka have been committed to health care for all. Though average growth rates have been moderate, Sri Lanka has systematically spent a fair portion of the national income on social welfare programmes aimed at reducing poverty and morbidity. The Prime Minister also noted that, though free health care and free education for all has always been a state policy, President Mahinda Rajapaksa has placed development issues, including poverty alleviation, at the centre of his policy agenda, known as "Mahinda Chintana". The vision of the Government is to target an annual growth rate of 7 to 8 per cent over the medium term, by adopting pro-poor and pro-growth strategies.

The Prime Minister said that Sri Lanka is proud of its achievements on the MDGs. He said that Sri Lanka appreciates the support of donor agencies, including the United Nations system, in achieving its development goals.

H.E. Ambassador Hamidon Ali, Vice President, Economic and Social Council, described the mandate and purpose of the annual ministerial review. He emphasized the link between the 2009 annual ministerial review theme of global public health

with the topic of the regional meeting and stated that it will help crystallize the challenges faced by the Asian region in respect to health care financing, especially at a time of global economic turmoil.

Ambassador Hamidon recalled that while Sri Lanka has made significant strides in the area of health, many countries are not on track to achieve the health-related MDGs, and are struggling to make ends meet at a time of shrinking health budgets. He warned that the financial crisis threatens to reverse recent accomplishments and could jeopardize progress, while at the same time noting that the economic crisis is also providing an opportunity to rethink the direction and nature of financing for health care. Simply cutting health budgets could not be the solution, as past experience has shown. Maintaining basic safety nets is essential in order to make progress on the MDGs, especially at a time of economic crisis.

In his statement, Mr. Thomas Stelzer, Assistant Secretary-General for Policy Coordination and Inter-Agency Affairs, Department of Economic and Social Affairs, said that the meeting was taking place at a time when the world was in the midst of its most severe financial crisis and economic downturn since the Great Depression of 1929. At the same time, the international community was in the midst of a historic venture to halve poverty, combat disease and improve the well-being of millions of people. In such circumstances, everybody needed to learn to do more with less.

He called attention to the progress in the achievement of the health-related MDGs, which had been facilitated by sustained economic growth, nearly a doubling of health aid from public and private sources between 2000 and 2006, and a strong personal commitment by world leaders and private philanthropists. But strong commitment and increased funding was not enough, he noted. He highlighted five key lessons which the international community had learned. These were the need for better health delivery systems; for making aid more effective by applying the principles of donor coordination and aid predictability; to focus greater attention on countries in crisis, given that 22 countries farthest from reaching the Goals are in or emerging from conflict; to give greater attention to newly emerging challenges such as the global health worker crisis and the rapid increase in non-communicable diseases; and, finally, the importance of the social determinants of health to meet the health and development goals. He recalled that the Economic and Social Council had a long tradition of bringing different constituencies and sectors to the same table. And this will also be the defining feature of the 2009 annual ministerial review on health.

Dr. Anarfi Asamoa-Baah, Deputy Director-General, World Health Organization (WHO), highlighted five themes on health care provision. First, the prevention of ill-health is a large, long-term investment, and the ageing of populations is only going to increase its costs. Second, relying on external financing for health care is

impossible, and solutions must be found within domestic financing. Third, there is no one-size-fits-all policy in health care financing, but a general lesson seems to be that it is important to avoid mistakes such as excessive reliance on out-of-pocket spending. Fourth, financing for health care has a twin agenda: increased funding, and enhanced efficiency through health sector reforms. The agenda for health financing is hence not only more money for health, but also more health for the money. The inefficiencies of the health sector must be dealt with, and a broader community of actors need to be engaged in the policy dialogue. Last, the financial crisis poses a great risk of undermining the progress made over the past years, but it is also an opportunity to reform health systems to make them more robust.

B. Session 1: Financing strategies for health care

Panel 1: Domestic financing for health care

Professor Weligamage D. Lakshman, Professor of Economics, University of Colombo, Sri Lanka, who moderated the panel, in his introductory remarks highlighted the special experience of Sri Lanka. He said that with its high levels of health and other social sector achievements, despite its relatively low level of income since the late 1970s, it was a statistical outlier. These achievements have been attributed in particular to state intervention and state expenditure within a social democratic framework. He noted that health financing in Sri Lanka, as elsewhere in the world, is coming from three sectors; the public sector, the private sector, and out-of-pocket expenditure. While public spending on health care has dramatically increased since 2004, he said that there are areas wherein Sri Lanka will still need to invest more, for example in the eastern and northern regions that have recently come out of armed conflict. Apart from increased resources to the health sector from the Government, the private sector, and possibly donor agencies and countries, to ensure fairness and equity, there is also a need to improve the efficiency in the use of available resources.

H.E. Tsolman Jadamba, Vice-Minister of Health, Mongolia, described the challenges which Mongolia is facing in finding a suitable model for financing its health care. She explained that before 1990, health services were financed from the budget and later through the social health system. Today health care is funded through a health insurance fund and out-of-pocket payments. There is an increasing involvement of the private sector. She said that Mongolia needed a health financing system which could provide the right incentives to ensure quality, equity, and transparency of health care.

Based on the experience of the 1997 Asian financial crisis, she said that there was a great concern that the health system is likely to be impacted by the financial crisis. No studies were made at the time to assess the impact of the financial crisis on children’s health status, however ten years later, medical checks made on young

men entering military services found that 29 per cent of youth were stunted. To prevent similar effects during the current crisis, Mongolia has taken steps to address the financial crisis by mobilizing domestic and external sources of health finance.

Dr. Rashid Jooma, Director General, Ministry of Health, Pakistan, reported on trends in financing health care in Pakistan. Dr. Jooma noted that health care spending at present is about $17 per capita, which constitutes only about a 15 per cent increase over the past 15 years after adjustments for inflation and population growth. Pakistan's key constraints in raising domestic funding are the limited revenue collection by provincial or district governments and the underutilization of allocated funds.

Dr. Jooma drew attention to the fact that health outcomes are not always well correlated with health spending. It is important to prioritize funding, design technically sound interventions, and monitor results to ensure that each unit (i.e. clinic, district) is accountable and responsible for their own budget. He emphasized that funding should be tied to results, and opportunities for raising funds, including taxation, user fees, earmarking, and external assistance, should be explored.

In terms of social protection, he noted that catastrophic health insurance is currently provided in Pakistan through the Rural Support Networks. The Government is also expanding coverage and payments for expensive health care such as hospitalization, based on household income and is offering conditional cash transfers to attract clients to prevention services.

Dr. David B. Evans, Director of the Department of Health Systems Financing, World Health Organization, recalled that the three core health financing functions are revenue collection, pooling, and purchasing. He emphasized that there are many other building blocks to health systems, such as service delivery, health workforce, medical products, vaccines, and technologies in order to provide efficient, equitable, quality coverage to the population.

He noted that there is concern that governments may face pressure to cut their health spending, especially among Asian countries. There is justification for opposing this, particularly since the world has learned from past crises that spending on health is imperative in an economic downturn to protect the poor and the most vulnerable groups.

To reduce reliance on out-of-pocket payments, it is important to push towards prepayment and pooling of funds as steps towards the achievement of universal health coverage. As countries are forced to do more with less, the crisis provides an opportunity to enhance efficiency of health care delivery by paying more attention to results-based financing. Dr. Evans said that recessions and crises offer a chance for bold thinking and we need to seize the opportunity. Enhancing social protection

by ensuring poor and vulnerable populations have access to required health services is particularly imperative during a financial and economic downturn. Health expenditure can be a valuable part of a stimulus package for countries in recession.

In closing, Professor Weligamage D. Lakshman noted that many countries have extremely limited resources available for health. Additionally, domestic resources are unlikely to be adequate in meeting the health needs of populations living in many of the world's poorest countries. At a time of economic uncertainty, it is critical to assess the challenges that domestic financing systems are facing so as to improve primary health care for all. Beyond increasing the volume of domestic funds, it was noted that there should also be a focus on enhancing the effectiveness of domestic spending. It was suggested that greater emphasis should be given to human skills, technical capacity-building, training, and management. Moreover, the public sector could learn from the private sector about revenue generation and resource management. Specific lessons which could be learned from the private sector include improving service delivery through efficient supply chains, distribution systems, and quality control and how to translate ideas into action with a focus on quick impact.

Panel 2: External financing for health care

The panel addressed the trends in South Asia regarding sources, quantity, and quality of external assistance for health; and governments' means of ensuring that external funds support the development of domestic financing systems and institutions. Furthermore, the impact of the current financial crisis on global funding for health care, and ways of addressing the crisis, were discussed.

Moderator Dr. David B. Evans, Director of Department of Health Systems Financing (HSF), World Health Organization (WHO), explained that trends in external support for countries have increased dramatically since 2000, particularly for health. While South Asian countries do not, in general, rely heavily on external financing for health, in some countries external resources comprise more than 30 per cent of national health expenditures.

Mr. Shinichi Asazuma, Senior Coordinator of Global Issues Cooperation Division, Ministry of Foreign Affairs of Japan, emphasized that a comprehensive approach to global health should be participatory and inclusive. In the midst of the current financial crisis, countries need to uphold their commitments to the health sector and continue exploring innovative financing mechanisms and work towards better allocation and use of inputs within developing countries. He informed participants that at the fourth Tokyo International Conference on African Development (TICAD IV), the "Yokohama Action Plan" was adopted and commitments were made to support global health issues.

The 2008 G8 Hokkaido Toyako Summit, hosted by Japan, endorsed the "Toyako Framework for Action on Global Health," and agreed to establish a follow-up mechanism to monitor progress. The framework envisages actions to be taken on health systems' strengthening; maternal, newborn, and child health; infectious diseases; adopting a cross-sectoral approach; and an increase of resources. Special attention was given to strengthening health systems by strengthening the health workforce, health financing, and health information by finding the right balance between vertical disease-oriented and horizontal health system interventions, and by promoting a participatory approach. In follow-up to the G8, Japan introduced a WHO resolution on Primary Health Care which will be submitted to the World Health Assembly and looks forward to policy actions on strengthening of health systems to be translated into action at the G8 La Maddalena, Italy, Summit and beyond.

Dr. Ravindra P. Rannan-Eliya, Director and Fellow of the Colombo Institute for Health Policy, focused on the Takemi Working Group Recommendations to the G8. Global health is an important issue for the G8 because of the slow progress on health MDGs and the implications for poverty and transnational risks, such as avian flu. Increased spending on global health has not translated fully into progress in achieving the health-related MDGs. High reliance on out-of-pocket payments continues to push more than 100 million people into poverty each year. While the global target of $30 per capita spending on health is unlikely to be met, Dr. Rannan-Eliya emphasized that even if aid falls short of current commitments, the MDGs and universal health coverage can be reached through improving health care efficiency. He pointed out that some of the poorer South Asian countries have met the health-related MDGs with less than $10 per capita of public spending.

Dr. Rannan-Eliya highlighted that to improve health outcomes, countries should ensure risk protection, access to services for the poor, and service efficiency. Based on a global survey, only public financing — including tax financing or social health insurance with tax financing — has been successful as a core means of health care funding. Within poor countries, only tax financing with public delivery has proven effective, while in middle- or high-income countries, social health insurance can be successful. He called upon G8 countries to increase their support to countries specifically with public health systems that aim to abolish user fees. In addition, they should support the policymaking and technical capacity development of developing countries. He saw the financial crisis as an opportunity to improve social protection and change the structure of public health delivery.

Ms. Ursula Schäfer-Preuss, Vice President of the Asian Development Bank, stated that South Asia has achieved remarkable health outcomes. Yet, even with recent sustained economic growth and expanding fiscal space, total expenditure for health is the lowest in the world, government expenditures are very low, and out-of-pocket spending for health is large. Due to these factors, health outcomes often lag for the

poor, and public health financing has not been sufficiently effective, efficient, or equitable. The future of health financing holds even greater challenges with population growth and ageing, and constrained budgets resulting from the global financial and economic crisis. During an economic downturn it is even more important to set health expenditure priorities high and aim for big strategic wins.

Ms. Schäfer-Preuss recommended four public health policies, especially for the South Asia region. The first is expenditure on essential health care that protects the poor and boosts national productivity, social inclusiveness, and social stability. Second is investing in effective measuring, monitoring, and evaluation of health expenditures and outcomes. Third is funding nutrition, given that 45 per cent of children under five in South Asia are still moderately or severely underweight, even though many interventions are both affordable and cost-effective. Furthermore, under Copenhagen Consensus, experts have identified micronutrient supplementation for children as the most cost-effective intervention to assist the poor. Fourth, taxing tobacco consumption and using the revenue to add to — not replace — existing public expenditure for health. She said that by investing in these four policies, countries could improve the effectiveness of their health care without dramatically increasing the costs.

Mr. Pablo Gottret, Lead Economist of the Human Development Sector Unit, South Asia Region, World Bank, observed that even though the share of donor funding in total health expenditures in South Asia is increasing, and is relevant for some governmental programmes, donor funding does not constitute a large share of health expenditure in the region. He also noted that a large part of the bilateral assistance for health is going to Sub-Saharan Africa and vertical programmes, mainly to combat HIV/AIDS. Additionally he pointed out that South Asian countries tend to have low levels of public spending in health, with many relying heavily on out-of-pocket payments. The fiscal space constraints suggest that additional resources would be pulled mainly from domestic revenue and spending efficiency.

According to Mr. Gottret, donor funding faces challenges in the region, especially in the midst of the current financial and economic crisis. The challenges include insufficient resources, volatility of funding, which makes financing of recurrent expenditures difficult, and fungibility of aid. Distortions generated by donor funding and sustainability of programmes, in the absence of sufficient domestic resource mobilization, remains a concern. The current financial and economic crisis will adversely impact the ability of governments to increase and sustain current levels of domestic expenditures in health at a time where remittances are also declining. Devaluation of the currency can also make imported medicine less affordable. In such an environment households may increase demand for publicly financed health services. Policymakers should focus on ensuring access to essential services, especially for those in the poorest quintiles whose health and nutrition status tend to be most affected, through well-targeted programmes. Protecting government health

expenditures should not be an objective in itself, however ensuring access to essential services must be.

Mr. Simon Wright, Project Manager in Action for Global Health (Action for Global Health is a cross-Europe network of NGOs and charities, calling for Europe to act to enable developing countries to achieve the health-related MDGs by 2015), described the commitments which Europe has made to the global health agenda. Against the backdrop of a rapidly worsening global financial and economic crisis, he called upon developed countries to act urgently on meeting ODA commitments for health, to improve the quality of ODA, and to invest in additional innovative health financing mechanisms. They should also consider the increase in sectoral budget support and use the International Health Partnership and Related Initiatives IHP+ as a vehicle to increase donor funding for health. Developing countries should involve citizens in order to prioritize health, reduce inequalities, and ensure universal access to health care.

Dr. Jorge Bermudez, Executive Secretary of UNITAID (UNITAID is an innovative mechanism for scaling up access to medicines and diagnostics for HIV/AIDS, tuberculosis and malaria), said UNITAID aims to make a difference by using the proceeds of a solidarity tax on airline tickets purchased in contributing countries to finance medicines and diagnostics for the benefiting countries. They also aim to build solid partnerships with implementing organizations such as WHO and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. Since 2006, membership of UNITAID has grown from five founding countries — Brazil, Chile, France, Norway and the United Kingdom — to 29, and the initiative has funded projects in 90 countries. Thus, UNITAID brings an added value by using its funds to reduce market prices; improve quality; use medicines adapted to patients' needs; and respond to urgent need of drug delivery.

The following discussion session addressed the questions of health care delivery through public administration or NGOs, as well as the issue of horizontal or vertical funding. Governmental representatives emphasized that external funding should be directed to strengthen the horizontal programmes, and should be allocated by the Ministry of Health. Multiple actors delivering health services, and vertical programmes concentrated on specific diseases instead of strengthening the health systems, were said to distort overall health outcomes. The sustainability of the donor-funded vertical programmes in light of the current financial crisis was also questioned. The NGO representatives particularly emphasized that some public administrations are less effective than others and in some countries, NGOs may deliver health services more effectively. NGOs may also be more flexible and innovative than national institutes, but they should work in partnership with national governments, within national plans. It was also suggested that governments could play a monitoring and advisory role to ensure that service delivery organizations

properly channel and utilize their funds. As a result, the question of channelling funds through governments or NGOs was seen to be greatly case-specific.

One participant drew attention to the problem of the diversity of health systems in the world. In order to channel money effectively, country-specific models are needed. To do so, the first step should be to develop normative guidelines about what public financing should look at; what the benchmarks for revenues should be; the opportunities for earmark taxing; and norms of pooling with reference to social health insurances. The second step is to develop country capacity to analyse what means fit them best. The third step is to actively support countries to improve existing opportunities and actively scale them up.

Dr. Evans summarized the discussion by saying that the global financial crisis will only amplify the ongoing crisis caused by the lack of access to health care and economic catastrophes due to out-of-pocket spending. The global community must ensure that external funding for health does not decrease. He also pointed out that while it is useful to hold the G8 accountable for their commitments, it is good to remember that ODA might still fall because the commitments are tied to decreasing GDPs. He also noted that the discussion suggested that developing countries, with the support of the international community, should take the lead in aid negotiations, question some of the proposed conditionalities, and ensure the accountability of aid to the people. The focus should remain on protecting people, not maintaining the quantity of the official development assistance.

C. Session 2: Health systems in crisis situations

Panel 3: Challenges for health systems in countries in or following a crisis

Dr. Poonam Singh, Deputy Regional Director, Regional Office for South-East Asia, WHO, moderated the third panel discussion by first acknowledging that today's crises, and the effects of climate change, will most affect the poor and vulnerable populations. These crises are an added negative impact to the affordability, accessibility, and quality of health services. Dr. Singh pointed out that the World Disaster Report shows that during the decade from 1996 to 2005, the Asia-Pacific region, home to 25 per cent of the world's population, had 44 per cent of the world's disasters and 58 per cent of the mortality related to disasters.

The panel focused on the different components of a health system that are likely to be affected during a crisis and the actions governments could take in order to prepare, respond, and recover. Furthermore, the effectiveness of emergency assistance in meeting health needs and supporting health systems, as well as the improvements that can be made while in the midst of a financial crisis, were addressed.

Focusing on health financing in Afghanistan, Dr. Ahmad Jan Naeem, Acting General Director, Policy and Planning Ministry of Health, Afghanistan, presented some key findings from a 2008 research study. The study identified difficulties in estimating total health expenditures since the principal source of financing in Afghanistan comes from out-of-pocket expenditures.

Though total public financing for the health sector in Afghanistan increased by 54 per cent since 2003, public health spending remains low when compared to other low income countries in the region. Total external funding is still estimated at above 90 per cent. A large share of this external assistance is allocated to primary health care and communicable diseases, in line with the burden of disease in Afghanistan. Conversely, the budget allocation towards drugs and medical supplies is largely inadequate, resulting in large household out-of-pocket expenditure which constitutes a significant financial barrier to access for the poor. Although the priority set to primary health care is considered to be pro-poor, the level of equity in health care financing is low. Distance from health care providers is another major barrier.

Dr. Ahmad Jan Naeem stressed that more information is needed to make informed decisions in order to improve the efficiency of service delivery, maximize the population's health, and achieve the Millennium Development Goals. To address this challenge, the Ministry is developing a health care financing strategy that will include four main components. The first is the establishment of health economics and financing capacity within the Ministry of Health, including cost-effectiveness research, public and private health service unit costing, aid coordination, and the establishment of Afghanistan National Health Accounts. The second component is to strengthen governance methods associated with health financing, including level programme budgeting, provincial planning and budgeting, and the management of NGO health service provision contracts. Thirdly, the strategy aims to strengthen health facility financial and resource management, including efficient use of health facilities, supporting public and private sector autonomy, and financial decision-making. The final component of the strategy is research and the establishment of suitable health care financing tools for managing and pooling risks among the population and for providing more equitable and sustainable health financing in Afghanistan.

Mr. Nicholas Rosellini, Deputy Regional Director of the United Nations Development Programme (UNDP), Bangkok, Thailand, pointed out that the Asia-Pacific region had to deal with three sets of challenges. These include frequent and severe natural disasters, some of the oldest and newest conflicts being in this region with sixteen countries dealing with internal and external conflict, in addition to global shocks, having to deal with financial, food, and oil crises, as well as being the epicentre of the avian flu.

Mr. Rosellini stressed that these multiple sets of crises have both direct and indirect impacts on the achievement of the MDGs. For example, the eradication of extreme poverty and hunger is difficult when damage to housing, service infrastructure, productive assets, and human losses reduce livelihood sustainability. Forced sale of productive assets by vulnerable households in the immediate aftermath of a crisis can push many into long-term poverty and result in increased inequality. Similarly, the important goal of combating HIV/AIDS, malaria, and other diseases is difficult to achieve when poor health and nutrition following disasters weakens immunity. Mr. Rosellini stated that two thirds of the global burden of HIV infection occurred in a complex crisis situation and thus should be addressed during the humanitarian response phase. Additionally, he says that it is crucial to build an HIV response in crisis management plans in order to generate recuperative methods for post-crisis recovery.

Mr. Rosellini said that in post-disaster and conflict contexts, fast, flexible, and predictable funding for early recovery planning and programmes is necessary. In addition, the early support to stabilization and inclusive access to services to pave a pragmatic path to peacebuilding is crucial. Yet, an analysis of early recovery financing showed that economic recovery and the infrastructure sector receive the greatest level of funding, 30 per cent of the total received, while health garnered 2 per cent and water and sanitation 4 per cent. Financing gaps render any talk of sustainable recovery impossible, noted the Deputy Regional Director of UNDP.

Mr. Chinnaswamy Kumar, Technical Support Coordinator — Micro Insurance, CARE India, focused on interventions in health for tsunami victims in India. CARE, one of the agencies to respond to the tsunami early on, designed the Tsunami Response Programme to identify the gaps in dealing with a crisis situation and to tackle them head on. Mr. Kumar explained that with its project design, CARE's aim is to link programmes of relief, recovery, and rehabilitation to measures for disaster preparedness and risk reduction.

He focused in particular on a microinsurance programme introduced by CARE in the aftermath of the tsunami as a risk-coping mechanism layered over livelihood rehabilitation initiatives to take care of repeated disasters of varying scale. The unique micro health insurance programme, which was piloted in one district as a community mutual with a private insurance company offering co-insurance support, is now being extended to other districts.

To ensure an effective health intervention response to a crisis, the intervention should map the needs and priorities of the community; be complementary to other initiatives; have standards and programming principles that should never be compromised; and even in a disaster context, it is important to institutionalize systems and processes, and build local capacities for sustainability, management,

and governance. The key message was that disasters can be turned into opportunities for communities.

Dr. Roderico Ofrin, Regional Adviser, Emergency Health Action, WHO Regional Office, Delhi, said that poverty and ill health are good friends, but that disaster and poverty are best friends. Disaster destroys health facilities and related infrastructure making it difficult to continue routine programmes such as TB treatment and vaccinations which can lead to the outbreak of diseases.

Comprehensive cross-sectoral programmes are needed for disaster risk reduction. Such strategies help ensure that health facilities are structurally and non-structurally fit to withstand hazards and can continually provide basic health care. They include concrete steps to make health locations disaster proof, ensure that facilities will know how to cooperate in the event of a disaster, and identify how to secure data.

In the ensuing discussion, it was noted that the 2005 humanitarian reform was aimed to address some of the concerns raised by participants, such as the lack of accountability and coordination and earmarked funds. Within the reform, humanitarian coordinators were meant to ensure effective leadership, the Central Emergency Response Fund (CERF) was introduced to improve funding for humanitarian emergencies, and the cluster approach was introduced to improve coordination among the different actors. When put to a test in Myanmar, the new structures proved helpful in ensuring an effective humanitarian response.

The steps taken helped to increase funding for humanitarian disasters, but had not succeeded in addressing the underfunding of disaster preparedness work. The urgency of disaster preparedness work should become apparent since today there are already 10 million ecological migrants due to climate change disasters and this number will likely increase.

The need to support community based approaches, to pursue participatory approaches, and to target the most vulnerable was underscored. Community work should build upon existing traditional health structures and indigenous coping systems as well as be respectful of traditional values. Participants highlighted that community preparedness is central to ensure an adequate response to disasters.

Moderator Dr. Poonam Singh added that most countries of the region consider the issue of preparedness chiefly a government responsibility. They have taken the tsunami crisis as an opportunity to develop initiatives and partnerships with other countries. Given that most of the casualties happen during the first hours of a disaster, when others are still rushing to help, it is thus essential to build the capacity of the community to respond to a situation.

D. Session 3: Progress and challenges in achieving the Millennium Development Goals

The panel on progress and challenges in achieving the Millennium Development Goals aimed to highlight the actions that governments have taken to promote the MDGs; the progress they have made; and impediments and challenges in achieving the goals. The panel acknowledged that while the South Asia region had made progress on the health-related MDGs, there was a need to step up efforts to meet the Goals by their 2015 target date, in particular for maternal health and malnutrition of children.

The moderator, Dr. Aminath Jameel, Minister of Health and Family, Maldives, encouraged participants to reflect on the progress that has been made in addition to the challenges that lie ahead, bearing in mind that only six years remain to meet the targets.

The first panellist, H.M. Mr. Gunasekera, Director of National Planning of the Ministry of Finance and Planning, reported on Sri Lanka's progress towards the MDGs. Sri Lanka has made immense improvements over the years and is on track, or has already achieved, the goals in poverty and hunger; universal education; child health; maternal health; and eradication of HIV/AIDS, malaria, and tuberculosis. The country is also making progress towards meeting the indicators of gender equality, but more efforts are needed in women's political participation.

With regard to other MDGs, Sri Lanka is advancing steadily. On environmental sustainability, the proportion of the land area covered by forests has decreased since the millennium, yet the country is on track with other environmental indicators. To meet MDG 7, the parliament is planning to protect forest resources by restricting wood-logging. He also said that Sri Lanka works closely with donors and other countries to achieve MDG 8, and has been successful in adopting information and communication technologies. Mr. Gunasekera identified interregional differences as the main challenge in achieving the MDGs. Sri Lanka addressed this issue in its Development Plan for 2008-2015, and believes that the country will be able to achieve all MDGs before the year 2015.

H.E. Mr. Abdalmahmood Abdalhaleem Mohamad, Permanent Representative of the Sudan to the United Nations and Chair of the Group of 77 and China, stated that progress towards achieving the MDGs has been uneven. Further efforts are needed to achieve universal primary education, especially for girls, and to halve the number of people who remain without access to safe drinking water and adequate sanitation. He also underscored that in order to reach the goals of environmental sustainability, it will be crucial to address climate change, taking into account the different responsibilities of developed and developing countries. In terms of the health-related MDGs, progress to reduce and eradicate diseases, such as HIV/AIDS, malaria and

tuberculosis, continues to be slow, especially in the least developed countries. He emphasized that more financial resources are needed to build stronger health care systems with adequate basic science and research capacity.

Ambassador Mohamad emphasized that the global financial crisis may delay the achievement of the MDGs for years. He warned that major wealth losses will have an enormous impact on domestic expenditure, especially in the social sector, and many of the least developed countries will become increasingly dependent on development aid. Currently, extreme poverty is already on the rise, especially among the poorest and most disadvantaged groups in least developed countries and in sub-Saharan Africa.

Ambassador Mohamad stated that this severe situation calls for effective monitoring of the implementation of the global partnership for development. He called upon the United Nations to assist in preparing a comprehensive matrix of MDG 8 commitments and to indicate specific targets and benchmarks for the goal. This would enable the creation of a supportive international environment, required to facilitate the implementation of the other internationally agreed development goals.

Mr. Bernard Savage, Head of the Delegation of the European Commission to Sri Lanka and Maldives, noted that economic growth alone does not correlate with poverty alleviation and progress towards the MDGs. In terms of health care, Ambassador Savage emphasized a strong correlation between levels of public funding for health and access to basic health care services, and sustained progress towards MDGs 4, 5 and 6. Under the Abuja Commitment, African Union member countries committed themselves to increase their spending on health to 15 per cent of their national budget, which could bring countries experiencing economic growth closer to the Commission on Macroeconomics and Health's minimum threshold of spending $50 per capita on health. The donor community could assist with the remaining gap by increasing and harmonizing funding for public health.

Ambassador Savage stated that an increased scale, greater predictability, and better alignment of EU aid could encourage sound policies and adequate financing, thus ensuring equitable access to basic services including health. He recommended direct budget support, allowing financing of the main components of the health sector, and linking development aid with health outcomes. Instead of concentrating on specific diseases, more attention should be given to human health resources, access to medicines, health financing, and decentralized participatory management. He noted that in line with these objectives, the European Community is committed under the EU-AU Africa action plan to support the elimination of user fees for basic health care. The EC also supports the International Health Partnership and encourages all development partners to join this process.

Ms. Purnima Mane, Deputy Executive Director, United Nations Population Fund (UNFPA), stressed that the least progress has been seen in MDG 5, improving maternal health. On current trends, two MDG 5 targets — to reduce maternal mortality by three fourths and to achieve universal access to reproductive health by 2015 — will be missed. Furthermore, maternal mortality rates may be a key indicator of the performance of a health system and its ability to respond to emergencies.

According to Ms. Mane, success in giving birth depends on broad development factors as well as a set of very carefully planned interventions. Currently, 99 per cent of maternal deaths occur in the developing world, with sub-Saharan Africa and South Asia the most affected regions. To improve reproductive health, three key interventions must be a priority: access to family planning, emergency obstetric care, and skilled attendance at birth. For example, by investing in midwives, Sri Lanka reduced its maternal mortality rate from more than 1,500 per 100,000 live births to about 30. To accelerate progress, governments and development partners must focus on strengthening health systems to have strong supply chains, well-equipped facilities, and an adequate number of skilled health workers. Thus, it is estimated that only $6 billion in additional funding would save half a million women and 8 million newborns annually.

E. Session 4: Best practices and new initiatives in health care financing

The session comprised eight presentations, and was chaired by Dr. Anarfi Asamoa-Baah, Deputy Director-General, WHO, and moderated by Dr. David Evans, Director, Department of Health Systems Financing (HSF), WHO. The session highlighted innovative financing initiatives for health, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria; Affordable Medicines Facility for Malaria (AMFm); and Heartfile's Health Equity Financing Pilot project in Pakistan. Country examples of best practices were drawn from experiences in Sri Lanka and Japan. Indonesia shared its lessons learned on the importance of managing the political context of health care reform. The Self Employed Women's Association (SEWA) spoke from a civil society perspective on its work with women and their role in health care. Pfizer gave concrete examples of how partnerships between the private and public sector had delivered major health care improvements. A summary of the individual presentations is provided in the annex to this summary.

III. Conclusions and recommendations

In his closing statement, Hon. Rohitha Bogollagama, Minister of Foreign Affairs, Democratic Socialist Republic of Sri Lanka, thanked the United Nations family, particularly the Department of Economic and Social Affairs, as well as WHO and ESCAP, which partnered in the effort, for their support.

He said that the meeting had shown that the ongoing crises, including the financial crisis, would have an adverse impact on the achievement of the MDGs. He also stressed that given the great diversity in the region, there is no “one-size-fits-all” solution. While the public sector has to take the lead, civil society and the private sector have a critical role to play, including through public private partnerships.

He identified four key messages which had emerged from the meeting. Firstly, health goals should be pursued through inclusive multi-sectoral approaches. Secondly, sufficient resources need to be allocated as domestic financing will remain the bedrock of health policies. Efforts need to be made to enhance the efficient use of funds. Thirdly, adequate and predictable funding is crucial for the poorest countries. Innovative ways of generating more financing should be pursued. Finally, countries in post-crisis situations should be provided with special assistance and should learn from each other’s experiences.

Mr. Thomas Stelzer, Assistant Secretary-General for Policy Coordination and Inter-Agency Affairs, Department of Economic and Social Affairs, thanked Sri Lanka for its gracious hospitality and the Governments of Italy and Japan for their generous support in the organization of the meeting. He said that the frank and candid discussion on health financing from many different angles had produced a wealth of information which will serve as an excellent basis for discussion at the Council’s annual session in July.

He said that a key message of the meeting was that the current crisis provides challenges but also opportunities: governments have an opportunity to re-examine their health systems in light of the new context in which they must function. This requires a multi-sectoral approach and multi-stakeholder engagement and there is a need to pursue context-specific solutions to health challenges, particularly in post-crisis situations. He underscored that after having agreed upon priority areas, it was only by moving from words to action that the meeting could make a difference. Therefore, he encouraged participants to consider how they could use the innovative ideas and practical solutions discussed to address their own domestic health challenges. Additionally he stressed the importance in remaining engaged with one another, and the Council, through other annual ministerial review regional meetings or by making an annual ministerial review national voluntary presentation.

Conclusions

A crisis in health has existed in many countries before this financial crisis started. High reliance on out-of-pocket payments is estimated to have pushed more than 100 million people into poverty each year, even before the onset of the current crisis. Vulnerable groups in low- and middle-income countries, and countries in or emerging from conflict, are among those particularly affected. Today, low- and middle-income countries represent 84 per cent of the world population with more

than 93 per cent of the disease burden, yet less than 11 per cent of the global health expenditure. In addition, the 22 countries farthest from reaching the MDGs are countries in or emerging from conflict.

The financial crisis makes it more challenging to address this pre-existing crisis. It threatens to reverse recent accomplishments and to jeopardize hard won progress on the MDGs. We need to harness the lessons learned from past crises and bear in mind that it is imperative, in an economic downturn, to maintain domestic support for the health sector to ensure the affordability, accessibility, and quality of health services to the poor and most vulnerable groups. At a time when developing countries will become increasingly dependent on development aid, donors need to uphold their commitments to the health sector. While the crisis poses many challenges, it should also be seen as an opportunity to reform health systems, and to rethink the direction and nature of financing for health care.

Domestic financing will remain the bedrock of health policies. The strong correlation between high levels of public funding for health and access to basic health care services, and sustained progress towards the health MDGs 4, 5 and 6, suggests that governments will need to continue to take the lead in health care financing — including through tax financing or social health insurance with tax financing. It was noted that within low-income countries, only tax financing with public delivery has proven effective, while in middle- or high-income countries, social health insurance can be successful. While the different experiences presented at the meeting illustrate that there is no one-size-fits-all policy on health care financing, a general lesson seems to be the importance of reducing reliance on out-of-pocket payments, and to move towards pre-payment and pooling of funds to avoid catastrophic health expenditure and as steps towards the achievement of universal health coverage.

Overall official development assistance (ODA) has more than doubled since the Millennium Declaration was signed and ODA for health has increased, not only in dollar values, but as a share of total ODA. Although external funds do not represent a high proportion of overall health expenditure in the Asian region as a whole, five countries receive more than 30 per cent of all health expenditure from external sources, and another eight receive more than 10 per cent. Particularly for these countries, it is a matter of urgency that aid levels are maintained, as they will need to expand their capacity to raise domestic revenues — e.g. expand their tax base. It was pointed out that honouring past commitments might not, however, be sufficient, given that ODA might still fall because the commitments are tied to decreasing GNI. The good news is, however, that in previous global financial crises, health ODA has not necessarily fallen. It is important to encourage donors to ensure this does not happen this time around. In this regard, the fact that the G8 has global health on its agenda — Germany, Japan, now Italy and its commitment to strengthen the health system as evidenced at Toyako — was seen as an encouraging sign.

In line with the Toyako Framework for Action on Global Health, participants emphasized the importance of finding the right balance between vertical disease oriented and horizontal health system interventions. Concern was expressed that vertical programmes, focusing on specific diseases instead of strengthening the health systems, would distort overall health outcomes and might not be sustainable in light of the current financial crisis. Lack of predictability and volatility, conditionality, a heavy focus on particular diseases, and at times bypassing governments, were cited as some of the key challenges. It was felt that recipient countries should take the lead and be more assertive in negotiating aid modalities, rejecting some of the proposed aid conditionalities.

Existing innovative health financing mechanisms, such as UNITAID, new innovative sources which could arise from the work of the High Level Task Force on Innovative Financing, increased sectoral budget support, and use of the International Health Partnership and related initiatives such as the International Health Partnership+, were cited as effective vehicles to increase donor funding for health. Overall, it was noted that the focus should remain on protecting people, not maintaining the quantity of official development assistance.

It was stressed that improving the allocation and use of funds is as important as increasing the amount of funds, given that health outcomes are not well correlated with health spending. Developing an agenda for health financing hence means not only more money for health, but also more health for the money. With this twin agenda of increased funding and enhanced efficiency, it was suggested that even if aid should fall short of the commitments and if the global target of $30 per capita spending on health should not be met, the MDGs and universal health coverage can still be achieved by improving health care efficiency. Making increased use of results-based financing and focusing greater attention to preventive care and health literacy, are some of the measures cited which could help save costs in the long term, with a rapidly ageing population and the shift in the epidemiological disease burden towards non-communicable diseases.

It was pointed out that crises have both direct and indirect impacts on the achievement of the MDGs. For example, reaching the eradication of extreme poverty and hunger is difficult when damage to housing, service infrastructure, productive assets, and human losses reduce livelihood sustainability. Strong primary health systems, especially primary health care, can help prevent secondary disasters such as epidemics and outbreaks. Extending primary health care is therefore both an effective measure to improve the accessibility, affordability, and quality services, as well as to improve the response during crises and to accelerate the recovery and rehabilitation processes.

With regard to health financing in post disaster and post conflict situations, it was emphasized that fast, flexible, and predictable funding for early recovery planning

and programmes is necessary. Yet, an analysis of the early recovery financing showed that economic recovery and the infrastructure sector receive the greatest level of funding, 30 per cent of the total received, while health garnered only 2 per cent, and water and sanitation received only 4 per cent.

It was highlighted that risk coping mechanisms, such as the introduction of community based microinsurance systems, layered over livelihoods rehabilitation initiatives, can help to take care of repeat disasters of a varying scale. Interventions should map the needs and priorities of the community and be complementary to other initiatives. Given that most of the deaths occur during the first hours after the disaster, it is essential to build the capacity of the community to respond to a critical situation.

Throughout the discussion, the importance of engaging a broader community of actors was stressed. Additionally, the value of ensuring that there is sufficient political support for health care reform was one of the lessons learned that was shared.

Recommendations

A number of recommendations were offered for consideration by the Economic and Social Council and actors within the region:

- **Recommit to the principle of universal access to health care, including the revitalization of primary health care, and reiterate the importance of health for all;**

- **Emphasize that donor governments must act much faster to meet their commitments to increase the quantity and quality of official development assistance, and that the current economic crisis, where people tend to rely more heavily on the public sector, is not a time to reduce the quantity of external funding while hoping for greater efficiency in the use of resources;**

- **Scale up the provision of public services in the social sector in general and health care in particular;**

- **Stress the need to ensure better and more equitable health outcomes, including through the promotion of risk-pooling and pro-poor social insurance schemes;**

- **Ensure the provision of external funding to the parts of Asia which will still require predictable external support for health for some time, while recognizing that donor assistance can never be the long-term solution and that assistance should hence be used to build capacity for national**

governments to both raise domestic resources and make more efficient use of existing resources;

- **Continue ongoing efforts to better integrate external resources for health care with national systems to enable governments to build health systems, reduce duplication, and to maximize synergies;**

- **Recognizing that although there is no "one-size-fits-all" policy, guidance as to how recipient countries could develop their own financing systems, and support to develop their capacity to negotiate with donors as equals, should be provided by the international community;**

- **Welcome efforts to promote the development of innovative methods of financing health systems, while stressing that innovative resources of health financing must be additional to ODA commitments and indigenous resources;**

- **Country ownership requires full participation of citizens in setting policy, as well as in monitoring and implementation; it is specifically crucial to include women and marginalized communities in these processes;**

- **NGOs and CSOs can play an important role in advocacy, influencing policy, and in the delivery of pilot and neglected services, which should be supported;**

- **Increase funding for preventive action and disaster risk-reduction. Prioritize investment in primary health care as an effective measure to improve both the accessibility, affordability, and quality of services, as well as to improve response during crises and accelerate recovery and rehabilitation processes;**

- **Address the relative underfunding of the health sector in emergency situations by providing more fast, flexible, and predictable funding for early recovery planning and programmes;**

- **Welcome the cluster approach as a useful platform to promote intersectoral collaboration, effective coordination across various development agencies, and different types of actors in support of government priorities;**

- **Strengthen the resilience of communities to emergencies and disasters as the main strategy for sustainability disaster risk reduction and disaster preparedness.**

Enclosure

Presentations of best practices and new initiatives to finance health care

1. Mr. Robert Filipp, Head Innovative Financing, Global Fund to Fight AIDS, Tuberculosis and Malaria, showcased the success story of the fund. Since its beginning in 2002, the Global Fund has grown to a large institution that has pledged $20 billion, finances one third of all multilateral HIV/AIDS funding, and provides two thirds of all malaria and tuberculosis funding. In addition, the Fund is active in prevention of these diseases, and has a number of additional fundraising initiatives, such as (RED) products. He explained that the Global Fund acts only as a financing agent, responding to country demands, while countries implement the programmes. According to Mr. Filipp, the programmes are country driven, transparent, inclusive, and based on a results and impacts model. He stressed that the fund also finances programmes for national health system strengthening and national health strategies. Even though the funding of the Global Fund remains strong, despite the global financial crisis, the challenge lies in keeping global public health at the top of the international agenda.

2. Dr. Sania Nishtar, President and CEO, Heartfile, showcased the Health Equity Financing Pilot project in Pakistan. Health costs are the most important contributor to poverty after illiteracy and unemployment. This is especially apparent in Asian and Pacific countries in which out-of-pocket spending constitutes the principal means for financing health care. She explained that the Health Equity Financing Pilot project in Pakistan aims to develop a sustainable and replicable health financing model, to protect the poor against catastrophic spending and to provide better transparency to donors in order to guarantee its sustainability. In this innovative model, the health care provider is paid through a fund to improve the poorest populations' access to health care.

3. Dr. Thomas Teuscher presented the Affordable Medicines Facility for Malaria (AMFm) initiative, to be launched in May 2009. He emphasized that malaria control contributes to achieving all of the MDGs and thus is the third most cost-effective health intervention. This new mechanism will increase access to essential treatments through the reduction of the price of medicines. The AMFm initiative will use the global co-payment provided by UNITAID, to ensure universal access to treatment in public and private sector with affordable prices. Furthermore, AMFm aims to make combination therapy available at no or low cost to the end-user through negotiation of terms for low-cost antimalarials, and setting of prices and terms for international distribution. As this mechanism will use international, disease-focused resources, it will not distort country systems and will reduce out of pocket spending.

4. Dr. Ravindra P. Rannan-Eliya, Director and Fellow, Institute for Health Policy, provided an overview of health care in Sri Lanka and presented the country as a

third health care model. Developing countries, allocating only 2-3 per cent of GDP into health care, cannot afford national health care systems but need to successfully mix public and private financing. In the case of Sri Lanka, public financing for health care accounts for only 48 per cent of total health expenditures, but this limited budget is used effectively. Sri Lanka directs public funding particularly to hospital financing and inpatient provision, and ensures that public health care services are accessible to the poor. It has made sure that the policies are targeted to the poor and that the efficiency of the health care system is constantly improved.

5. Prof. Hasbullah Thabrany, Director, Institute for Social Security, University of Indonesia, focused on the politics and lessons learned in the development of the new national health care insurance in Indonesia. The driving force of the health care reform was the national social security law, passed in 2004. The new health care model was planned to improve health outcomes and replace the fragmented health care system. The funding was designed to be mobilized through a social national insurance model, in which government would subsidize the poor's access. The model faced pressures from local governments, politicians, and external donors, and it was criticized due to its mandatory central government controlled system and fund management. He said that an important lesson learned from the Indonesian experience was that when changing the financing model for health care, political aspects should also be considered.

6. Dr. Kiyotaka Segami, Executive Board-Director, Welfare and Medical Service Agency (WAM), presented Japan's national policy on the prevention of Metabolic Syndrome. This syndrome, which substantially decreases the life expectancy of patients, is a lifestyle-related sickness characterized by a group of metabolic risk factors such as abdominal obesity, hypertension, and insulin resistance. Japan has implemented a number of strategies and engaged all stakeholders to control medical expenditures due to the increase of metabolic syndrome in its ageing population. The treatment emphasizes a holistic approach, of which the primary measures are prevention and control of risk factors, through the promotion and support of lifestyle changes, with drug treatment as a last resort. The success of this approach lies in the implementation of a consistent long-term plan in coordination with various stakeholders and policymakers.

7. Mr. Kewal Handa, Managing Director of Pfizer India, talked about the potential of global public-private partnerships. Examples such as Operation Sanjeevini, which provides an innovative rescue service for road accidents, the Arogya Raksha Yojana Health Micro-insurance Scheme (ARYMIS), a health insurance plan for economically weak urban and rural patients, the Narayana Hrundayalaya hospital network founded by Dr. Devi Shetty, which provides state of the art free and subsidized heart surgeries, the comprehensive leprosy care association set up by Novartis, which provides patients access to treatment and disability management show that public-private partnerships can make a major

contribution to effective health care delivery. Pfizer's own global public private partnership work, such as the Mobilize against Malaria programme, the Diflucan Partnership Programme, the Global Health Fellows Programme, the Pfizer-Grameen Partnership, and the Pfizer India Healthcare initiative are each inspired by an effort to treat (medicines and services), teach (education and outreach), build (infrastructure), and serve (social advocacy).

8. Ms. Rehana Riyauala, Coordinator, Self Employed Women's Association (SEWA), reported that SEWA was founded in 1972 in India and today has over a million members. It is an organization of poor women working in India's informal economy, and comprises three movements: trade union, labour, and women's movement. In order to achieve the twin goals of full employment and self-reliance, SEWA follows an integrated approach of capacity-building, social security, and capital formation. She explained that SEWA provides its members preventive and curative health care services, in addition to health education and training programmes. SEWA has also implemented a number of initiatives, including health care for the poor, particularly in rural areas, and the strengthening of occupational health and safety. She said that these elements, together, have proven successful in providing sustainability in women's lives in India.