

All for universal health coverage

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As the USA engages in what promises to be a vibrant debate over how the world's most costly health-care system can efficiently and equitably provide access to quality health services to all American people, controversies about universal health coverage are brought into high relief, not only in the USA, but also worldwide. Since the mid-20th century, most nations have signed many accords, establishing that provision of health is a fundamental human right;^{1–4} health for all should be not only an aspirational target but also an essential framework for the United Nations system;^{5,6} international donor mechanisms should include support for essential health systems and health-workforce development;^{7,8} poor population health contributes to social and economic instability and undermines development efforts;⁹ and specific targets for country achievements in health should be set, and funded, through international instruments.

The world community is at a crucial juncture in implementation of all these understandings and agreements, each of which underscores the need for, and utterly depends upon, extending universal health coverage. The nearly US\$25 billion yearly enterprise¹⁰ that is global health features a long list of bold, targeted programmes, from child vaccination efforts to appropriate treatment of tens of millions of people now living with HIV/AIDS. Yet, the full bill for health spending in the world may already surpass \$6 trillion or 10% of the global gross domestic product (GDP), and the financing challenges in low-income and middle-income countries will increasingly be domestic, just as they are in high-income countries.¹¹ There is increasing appreciation of the links between disease and population health and nations' security, foreign policy, economic, and general social wellbeing.^{12–14} Amid the unfolding H1N1A influenza pandemic, political leaders everywhere are appreciating the strong link between health systems in low-income and middle-income countries, and the ability of the global scientific community to acquire real-time assessments of epidemic spread and clinical effect. And new threats to health arising from climate disruption suggest the need for vast infrastructures of adaptation to population-scale health disasters resulting from rising global carbon dioxide concentrations: catastrophic weather events, drought, heatstroke and dehydration, new infectious diseases emergence, food and malnutrition crises, and human migrations.¹⁵

On an immediate basis, the global campaign to provide antiretroviral drugs to people with HIV living in low-income countries, coupled with the worldwide increase in cancer, cardiovascular disease, diabetes, and other long-term management ailments, have prompted a shift in thinking about global health. For decades, global health referred mainly to prevention of infectious

diseases and epidemic control. Campaigns nowadays increasingly address lifelong interventions that need permanent systems of medical assessment and treatment in addition to population approaches to health promotion. In the 20th century global health world, vaccination was a dominant approach, often administered in one-off campaigns. The 21st century exigencies for global health dawned in Durban, South Africa, at the International AIDS Conference, amid demand for universal access to antiretroviral drugs, and the lifelong disease management required to sustain the life-sparing effects of the drugs.

As WHO Director-General Margaret Chan has correctly pointed out, "I think we can now let a long-standing and divisive debate die down. This is the debate that pits single-disease initiatives against the agenda for strengthening health systems." Chan continued in her address in June, 2009, "As I have stated since taking office, the two approaches are not mutually exclusive. They are not in conflict. They do not represent a set of either-or options. It is the opposite. They can and should be mutually reinforcing. We need both."¹⁶

Debate has emerged, pitting—we believe, incorrectly—health-systems support against targeted health campaigns. In truth, development of systems capable of delivering health, generally, or specifically targeted campaigns and health initiatives, all rely on the existence of health financing mechanisms that offer universal access to health. The specific nature of such financing schemes and service delivery models will vary, dependent on nations' economic and cultural norms. To assume that universal health coverage necessarily requires a single-payer government mechanism would be a mistake, and adherents to that position doom the people of the poorest nations to generations of medical deficiency. In classic terms, debates may be framed as the Bismarck model versus the Beveridge model, but this dichotomy is increasingly viewed as being as false as that which seeks to pit vertical schemes of health against horizontal.¹⁷ Whether a nation chooses a mixed economy model of coverage, single-payer mode, donor-issued voucher mechanism, or other innovative models of universal financing is not the issue; provision of universal health coverage is the issue facing the entire global health construct. Sadly, for most of the world's populations universal health coverage remains a mirage, blurred further out of focus by the present world financial crisis.

In the USA, for example, where spending on health topped \$2.4 trillion in 2008, or 17% of GDP,¹⁸ an estimated 47 million citizens have no health coverage whatsoever, and another 25–45 million are covered by insurance that is so inadequate that major medical events may cause family bankruptcy (panel). Studies in the USA show that at least half of all bankruptcies filed by American families

in 2005 were eventuated by medical events and catastrophic health expenditures,^{27,28} and about a quarter of all home foreclosures filed in 2007 (before the world financial crisis) were the result of the inability to meet mortgage payments because of such costs.²⁹ The USA is projected to spend \$4.1 trillion by 2016, and 25% of GDP in 2025 on health.^{30,31} Health spending is also growing at alarming rates in other countries of the Organisation for Economic Cooperation and Development.³² But the dilemmas of health-care financing for rich countries are less of a global concern than are the tragic failures witnessed in poor and emerging market nations.

For many people living in low-income countries, health services are obtained through out-of-pocket expenditures. Globally, such costs account for 19% of expenditure on health.³³ For low-income countries such as Bangladesh, Cambodia, Ghana, India, Pakistan, or Vietnam, it accounts for more than 50% of the total health expenditures.³⁴ High out-of-pocket expenditure restricts long-time economic survival³⁵ and leads to further poverty and impoverishments. In a review of household expenditure surveys from 89 countries, Carrin and colleagues³⁶ noted that due to the various charges associated with accessing health-care services, 44 million people face severe financial hardships and another 25 million are pushed into poverty every year. High out-of-pocket expenditures also prompt parents to withdraw children from schooling, using education fees to cover medical costs as necessary.⁹

Governments have missed opportunities to create rational health financing with prepaid risk pools, whether public or private, as exist in most high-income countries. And donors have shown little inclination to support such schemes. Although overall global health spending soared from \$5.6 billion in 1990, to \$21.8 billion in 2007, general health-sector development assistance has essentially remained level during that period, and both public and private donors have shown little interest in health-care financing or infrastructure.³⁷ In the meantime, health spending is growing at unprecedented rates in countries of low and middle income, even as some governments try to restrict their health budgets. As a rule, public spending has lagged well behind private expenditures, and the poorest people worldwide pay the highest percentages of their wealth for health,³⁸ often through inefficient and regressive out-of-pocket payments. This perverse economic trend—in which the poorest people have the most costly care, as a percentage of personal income and without the benefits of health insurance or social protection—is a major contributor to maternal mortality and to parental decisions denying education to girls.³⁹ Conversely, introduction of universal health-financing schemes has profoundly improved performance in other social sectors, such as education, and lowered bankruptcy filings and family budgetary crises.⁴⁰

This cycle of illness, impoverishment, and further illness is best interrupted with prepayment of health

Panel: Difficulties with estimation of number of people in USA without health coverage

Estimates of the numbers of American people without health coverage, or grossly underinsured by present plans, vary widely and are subject to fluctuation based on unemployment rates and political debate. No published estimates reflect the effect of the 2008–09 economic downturn and high US unemployment rates. Families USA, a liberal advocacy group, undertook a poll which found that 86.7 million American people were without health insurance at some time during 2007 or 2008—most, for more than 6 months.³⁹ The US Census Bureau estimated that during 2007, before the financial downturn, 45.7 million American people were without coverage.^{40,41} An independent analysis reckons that there will be 52 million uninsured American people by the end of 2009.⁴² Estimates of the size of the underinsured population depend, partly, on the definition used in describing insufficient coverage. One study finds that between 2003 and 2007, there was a 60% increase in underinsurance, leaving 25 million Americans with excessive out-of-pocket payments, despite paying for insurance.⁴³ If underinsurance was defined as coverage that needed families to spend more than 10% of yearly household income on health (out-of-pocket costs) the total in 2003 was 48.8 million American people.⁴⁴ With a definition of underinsurance as a state in which the coverage fails to adequately cover the costs of doctor visits, treatments, and medicines, Consumer Reports estimates that 45.2 million American people are underinsured.⁴⁵ The share of bankruptcies attributable to medical problems (62.1%) rose by 50% between 2001 and 2007.⁴⁶

costs through universal health coverage. The 58th session of the World Health Assembly in May, 2005, endorsed a resolution urging its member countries to work towards sustainable health financing, defining universal health coverage as access for all to appropriate health services at an affordable cost. The World Health Assembly also urged countries to strive for achievement of universal health coverage by using, on the basis of their specific contexts, a mix of prepayment systems including tax-based financing and social health insurance.⁴⁷

A report (figure) published by the Social Security Department of the International Labor Organization listed its member countries according to formal total coverage by different types of health insurance, including those provided by the State; by social, mutual, and private health insurance; and by employers. On the basis of their definition, nearly 50 countries have attained near universal coverage. Yet few have done so in Africa, Asia, and the Middle East. Of the 32 countries in Sub-Saharan Africa for which data were available, 12 did not have any coverage, 11 had fewer than 10% coverage, and nine had more than 10%. In the countries with more than 10% coverage, Gambia had 99.9%, Gabon 55%, Kenya 25%,

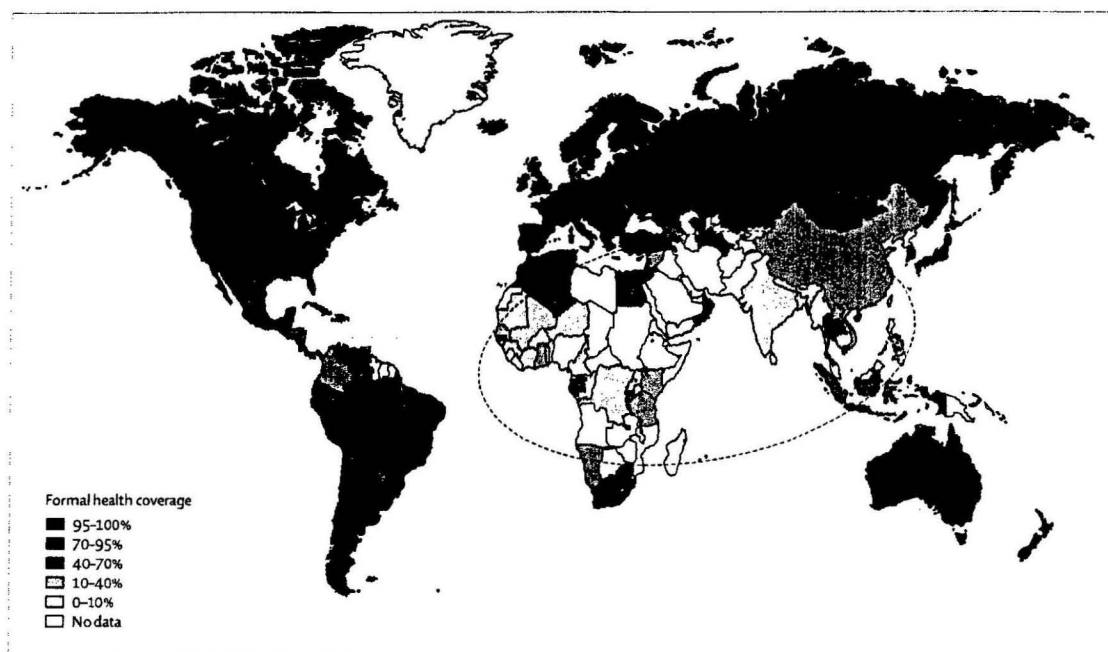


Figure: Extent of universal coverage worldwide

The encircled region has the poorest rate of health coverage in the world. International Labor Organization defined coverage as the population formally covered by social health protection (eg, under legislation, without reference being made to effective access to health services, quality of services, or other dimensions of coverage), explaining the depiction of the USA and South Africa. Source: data compiled by the International Labor Organization, 2008, from multiple sources; mapping by the Results for Development Institute (R4D).

Namibia 22.5%, and Rwanda 36.6% (although coverage for this country has recently improved through a national system of *Mutuelles*). Of the five south Asian countries listed, Bangladesh had 0.4%, India 5.7%, Nepal 0.1%, Pakistan 0%, and Sri Lanka 0.1%.³⁴

As the US example shows, vast wealth does not ensure health, and attaining universal coverage is a complicated affair. Moreover, direct links cannot be made between the amounts of monies spent by states (either per head, as a percentage of national GDP, or in absolute total sums) on health and outcomes achieved in the standards of population or individual health. Scrutiny of a dozen nations with highly divergent health systems (or lack thereof), and per head yearly spending ranging from US\$12 to \$4631 shows no discernable correlation between expenditures and health outcomes (table). In particular, the outcome similarities between Costa Rica, Cuba, and the USA, in view of their logarithmic spending differentials and disparate systems of delivery and financing, are striking. It is tempting to conclude that US outcomes, despite large expenditures, are similar to those in the two Latin American countries because the US has less than 75% population health coverage, versus universal coverage in Costa Rica and Cuba.

In low-income countries, the obstacles to universal health coverage begin with the obvious—money. The WHO Macroeconomic Commission³⁵ suggested that a minimum per head allocation of US\$34 is sufficient, but

the average per head expenditure for low-income countries is \$25, and can be as low as \$4 (Ethiopia) and \$12 (Bangladesh).³⁴

For decades, discussion of universal health coverage has been mired in larger political debates. To accept either simplistic praise or criticisms of universal health coverage would be a mistake. Data show a complex picture—eg, achievement of universal health coverage is not linked to country GDP. Many countries with low GDPs, such as Costa Rica, Cuba, Gambia, and Gabon, have attained impressive prepaid coverage compared with those with higher GDPs, such as China, India, and the USA. At issue are political commitment and health-systems design and management, particularly of its financing.

Further, attainment of high rates of population coverage might not necessarily lead to low out-of-pocket expenditures or improved health status. Tunisia, for example, has attained universal coverage, but its out-of-pocket expenditure is 45%.³⁶ This example indicates that there are bottom-line requirements for coverage, suggesting that even a package as inexpensive as \$34 per head per year has to include a range of medical delivery and health options to substantially affect population health outcomes, and avoid impoverishing individuals through high out-of-pocket expenditures.

In Vietnam, for example, nearly all poor people are covered by some form of health insurance or protection,

but the quality of care they receive in government health centres, or the range of medical exigencies covered by their financing plans, is inadequate.⁴⁴ Thailand, however, has achieved universal coverage with reasonable quality of care ensured, and improved health outcomes (table).

Successful health-financing schemes are an indicator of a gamut of political ideologies and philosophies; there is no one ideal system, and most feature a mix of public and private components. However, that attaining affordable universal health coverage, coupled with highly-ranked health outcomes, is linked to a common political process is striking. Most nations that have laudable success have at the highest levels of political power addressed three key questions. First, what are the role and responsibility of the State for the health of its people? Second, what are the responsibilities of the individual for his/her health? Last, what third-party players are acceptable, with which roles and responsibilities in health coverage for the nation's population?

The answers to the three questions vary widely, on the basis of the culture, political tendencies, and economics of a specific nation. There is no correct set of answers, but failure to formally address these questions guarantees both poor health coverage and achievements, often coupled with great financial inefficiency. Conversely, many low-income countries have confronted the three questions, and settled on innovative answers that have provided highly promising outcomes.

Rwanda, where the economy is mostly informal, focused on the third question about the role of non-governmental, and non-individual, players in the health of its people. A mutual insurance scheme known as *Mutuelles* seeks to bring all citizens under health insurance through a combination of government financing, and individual payments of US\$2 per year. For people unable to afford their yearly \$2 copayment, a third party—the Global Fund to Fight AIDS, Tuberculosis and Malaria—makes up the difference, paying premiums for 1.5 million Rwandan people.⁴⁵ In Bangladesh, the non-governmental organisation BRAC ensures the health care for more a million very poor people under its Challenging the Frontiers of Poverty Reduction programme.⁴⁶ Many countries have accepted third-party responsibility in the form of employer coverage for its workforce, including those engaged in the informal economy. In India, for example, an estimated 370 million workers are engaged in the informal economy; about 30 million are covered by community-based social protection schemes.⁴⁷

In 2000, the Mexican Government formally addressed all the three questions in an effort to diminish the impoverishing effect of catastrophic illness that bankrupted 3–4 million Mexican people every year and to provide access to care for 53 million uninsured citizens. In a process that culminated in 2003 legislative approval, Mexico increased federal expenditures on health (from 4.8% of GDP to 6.5% in 2006) and created innovative schemes to leverage taxation, employer contributions,

	Combined male/ female life expectancy (years [rank]*)	Maternal mortality per 100 000 births (rank†)	Per head spending (US\$ [rank]‡)	Estimated population with health coverage (%)	Population not surviving to 40 years of age (% [rank]§)
Bangladesh	63.21 (128)	350 (35)	12 (116)	<10%	21.4% (47)
Cambodia	61.7 (175)	440 (29)	17 (111)	..	24.4% (43)
Costa Rica	77.4 (53)	29 (98)	257 (41)	>95%	4% (108)
Cuba	77.2 (55)	33 (96)	NA	>95%	4.4% (104)
Ireland	78 (48)	6 (126)	1569 (20)	>95%	..
Jordan	78.7 (39)	41 (90)	139 (62)	..	7.9% (81)
Mexico	75.8 (72)	55 (81)	236 (45)	70–95%	..
South Africa	48.9 (206)	..	230 (46)	>95%	24.4% (44)
Sweden	80.74 (10)	5 (132)	2145 (11)	>95%	..
Thailand	72.8 (111)	44 (86)	112 (68)	>90%	9% (75)
USA	78.14 (48)	8 (121)	4631 (1)	76%	..
Vietnam	71.33 (128)	95 (65)	17 (110)	10–40%	12.8% (58)

NA=not available. ..=no data. *Rank of 225 countries. †Rank of 136 countries. ‡Rank of 133 countries. §Rank of 111 countries. Sources: World Bank, WHO, and International Labor Organization, based on most recently available data; years variable by country and indicator.

Table: Relations between key health indicators, spending, and access to health coverage

and individual payments, moving the country towards universal health coverage. Between 2003 and 2007, the number of Mexican people covered increased by 20%, use of health services soared, and the numbers of households facing impoverishment as a result of medical costs plummeted. Mexico is on track to achieve its goal of universal health coverage by 2010.⁴⁸

The entire Latin American continent is on track to achieve universal health coverage within the next decade. The achievement of Latin America offers hope to Africa, the Middle East, and Asia—but success looms only because of years of hard work and innovation across the continent.

History suggests that ensuring universal coverage takes some time; in the UK, nearly five decades of hard work and political debate were needed. South Korea did it faster, but still needed about two decades to attain universal coverage. There is no timetable attached to the WHO 2005 resolution for universal health coverage,⁴⁹ although a clearer path could emerge in a 2010 World Health Report dedicated to the topic. Daunting as the challenge of universal health coverage for the world's citizenry might seem, the global community committed to several equally impossible tasks: universal access to antiretroviral drugs for people living with HIV; the Millennium Development Goals; and poliomyelitis and measles eradication.

It is prudent for the world community to accelerate efforts aimed at ensuring health coverage for all, linking the goal with all donor, non-governmental organisation, and country health aspirations and targets related to health, rights, and poverty. This effort will need working on many fronts, starting with the political will of governments and civil societies. Countries are obliged to follow core obligations under the Universal

Declaration of Human Rights, including ensuring access to health facilities, goods, and services to everyone.⁴⁹ According to Article 12 of the International Covenant on Economic, Social, and Cultural Rights,⁵⁰ adoption of a national public health strategy and plan of action is a core obligation. Backman and colleagues⁵¹ at the Nordic School of Public Health in Sweden surveyed national plans for explicit commitments to universal access to health. Of 29 countries surveyed, only 15 had such explicit statements in their national plans.

Mexico's *Seguro Popular* shows the importance of phasing in coverage innovations, beginning with the most vulnerable populations in society. Under the 2003 scheme, the most dramatic efforts targeted unemployed Mexican people and those working in the informal economy or farming.

The introduction of universal health coverage through insurance schemes that initially target special groups, such as women and children, very poor people, and those with catastrophic illnesses, is a strategic approach that is gaining traction. For example, a new global campaign linked to the Millennium Development Goals promotes "Free quality services for women and children at the point of use and other access barriers removed".⁵² United Nations Secretary-General Ban Ki-moon in his address to the Global Health Forum in New York, USA, this year lent unequivocal support to the universal health coverage aspiration, and to near-term targeting of poor and vulnerable populations.

A strong advocacy drive is needed both nationally and globally. Further, the call for universal coverage should resonate well beyond the traditional boundaries of global health, bridging development and health programmes, non-governmental organisations, UN agencies, and donor agencies. This call is a health aspiration, offering antipoverty and pro-rights agendas.

Contributors

AP-M originated the idea. AMRC did the initial literature searches and wrote the first draft of the report. All subsequent research, drafts, and the final report were written by LG, with input and review from AP-M and AMRC.

Conflicts of interest

We declare that we have no conflicts of interest.

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misinterpretation during MRI.³ Radiologists with a background in fetal MRI or antenatal ultrasound might be the best placed to develop post-mortem MRI in the fetus, or a perinatal pathologist with a detailed understanding of development and pathological changes.

A new specialty in radiology seems to be emerging.³ In the future, specialists might work in a multidisciplinary team with pathologists to undertake the complete minimally invasive autopsy. Although a multidisciplinary team is expensive, it is probably necessary to reduce error and maintain skills in both specialties.

Whatever our personal thoughts are, minimally invasive autopsy is here to stay. The public have been made aware of the procedure through the media and television dramas, and therefore a relative requesting an MRI as an alternative is not unusual, especially when there are religious reasons for objection to an autopsy. Indeed, if the Coroners and Justice Bill completes its parliamentary passage, alternative options to the autopsy should be made available throughout the UK.¹⁰

Crucial to the future of the minimally invasive autopsy is the progress of the techniques and the development of specialist centres, allowing trained personnel to correctly use post-mortem imaging to ensure that the full diagnostic information is obtained. The specialist centres will involve bereavement counsellors, coroners,

and forensic medicine experts working alongside radiologists and pathologists. Until we have established how to select cases in which imaging can be part of a minimally invasive autopsy, the traditional autopsy with imaging as an adjunct should be encouraged.

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Call for global health-systems impact assessments



Despite unprecedented increases in global health funding in recent years, major challenges remain for reduction of global health disparities. Methods that anticipate the effect of targeted global health initiatives on health systems are needed and will improve health worldwide. Such methods—or health-systems impact assessments (HSIAs)—should be developed and used before global health initiatives are implemented (panel).^{1,2}

A growing body of evidence shows that although targeted global health initiatives have led to scaling up of some key health interventions, notably treatment of AIDS, they might also affect health systems—sometimes negatively.³⁻¹² At times, the capacity of people and institutions has been sacrificed for quick results. Some researchers and practitioners have recognised the need for HSIAs.³⁻¹⁴ Indeed, WHO's Maximizing Synergies Collaborative Group recently published an article

in *The Lancet* that highlighted the effects of global health initiatives on existing health systems, and called for "rigorous methods by which to assess" such interactions.¹² We agree with that need, and echo the call of Ronald Waldman that "A health systems 'impact statement' should be de rigueur for all disease-specific global initiatives and for local ones as well".¹³

WHO has identified six health-systems building blocks: service delivery; health workforces; health-information systems; medical products, vaccines, and technologies; health financing; and leadership and governance.¹⁵ Global health initiatives can affect all dimensions of these health systems—in positive and negative ways. For example, the health workforce is negatively affected when donors need external contractors instead of using local workforces, or when disease-specific programmes divert health workers from other comprehensive health responsibilities.

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Panel: Health-systems impact assessments (HSIAs)—call for action

Sign onto the call¹ at: <http://ghsia.wordpress.com/sign-onto-the-call-for-ghsias>

Those engaged in global health should hold governments and other affiliated organisations accountable for the effect of global health activities on existing health systems

WHO should:

- take the lead in development and dissemination of HSIAs that can be used by all groups associated with global health
- include prominent section for development and dissemination of HSIAs on their website

All donors, led by major donors such as the Bill & Melinda Gates Foundation, the US President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank should:

- require that all global health initiatives and programmes that they fund take into account the effect on the existing health systems
- fund activities to develop and implement effective evidence-based HSIAs

Government leaders and ministry of health personnel, particularly in developing countries, should assess and document effect of global health initiatives and programmes on their existing health system, irrespective of who funds the programme

Academic institutions and researchers should prioritise research for development of HSIAs that are evidence-based and take into account local realities

Non-governmental organisations and staff who participate in humanitarian work should:

- participate in development of and sign onto codes of conduct, such as the NGO Code of Conduct²
- take into account effect of their programmes on existing health system
- work with academic and other institutions to develop HSIAs that are appropriate to their specific situation

The Alliance for Health Policy and Systems Research, the Health Systems Action Network, the Countdown Working Group on Health Policy and Health Systems, the International Health Impact Assessment Consortium, the Institute for Health Metrics and Evaluation, and others involved in health systems advocacy and research should:

- support development of HSIAs and indicators that are evidence-based, easy to use, and appropriate to the implementing organisation's capacity and situation
- collaborate to establish a website where methods and expertise in the conduct of HSIAs are displayed

The methodological challenges that face those who attempt to predict the effect of programmes on health systems are complex. Noteworthy contributions have been made in recent years that will assist in development of an evidence-based approach. Some impact assessments already exist across social sectors—most notably environmental impact assessments. Health-impact assessments anticipate the health effects of proposals from sectors outside health,¹⁶ whereas health-system assessments review the various components of health systems. The health-system-assessment community has developed an approach that might be useful for development of indicators and methods for HSIAs, and WHO recently introduced the draft version of a toolkit to assist in monitoring health-systems strengthening.^{17,18}

We are aware of two published frameworks that anticipate the outcome of health programmes on health systems. In 2003, Bennett and co-workers¹⁹ predicted the possible effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria on the broader health system. According to recent reports,^{3,10–12} many of their predictions were correct. Atun and co-workers' toolkit¹⁴ to analyse the wider health-system context in disease-specific programmes has been used in various settings. These HSIA frameworks include or suggest indicators such as the diversion of health workers, strengthening of laboratory capacity, and financing arrangements. These and other indicators will need to be validated and updated as we learn more about the ways in which global health initiatives affect health systems.

This call brings with it the risk of too much analysis. Different degrees of depth and rigour in HSIAs are needed, depending on the project. Local participation should be solicited to ensure that assessments are relevant and effective. Indeed, the development of HSIAs should strengthen local health systems. Although HSIAs have not yet been developed rigorously as a widely accepted evidence-based method, global health organisations should not wait for their development before thinking about the effect of their activity on future health systems. Development and use of HSIAs should take place in tandem.

Use of HSIAs will often need a change in philosophy and approach. Every organisation that is planning a health intervention in a developing country will need to give thought to the long-term implications of its actions. Activities should be viewed in the context of improvement of health rather than being focused on short-term indicators or a few specific diseases. HSIAs should be used by all who participate in global health, including volunteers with small non-governmental organisations, researchers, and large donors.

Without HSIAs, initiatives targeted at specific diseases will probably, at best, continue to duplicate efforts within health systems and divert personnel and resources; or, at worst, erode long-term capacity. Although initiatives often focus on and publicise short-term goals, these interim markers should not obscure long-term objectives. The aim of WHO, ministries of health, clinicians, public health promoters, and others who are connected with global health is, simply, better health. The long-term improvements in health that we seek will be reached only

through the combined use of effective technologies and interventions (including addressing social determinants), with improved individual and institutional capacity. The time has come for the use of HSIsAs, an idea that will lead to worldwide sustainable improvements in health.

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Health and development financing in Africa

Improving performance and further advancing the G8's accountability in global health was part of the working-group themes for health experts at the 2009 G8 Summit.¹ As an example, what do we learn from the European Court of Auditors' (ECA) Special Report, entitled European Commission development assistance to health services in sub-Saharan Africa?²

The ECA warns that in general there is no clear correlation between the health situation of a country and the amount of health assistance received; in Mali and Ethiopia, AIDS receives greater attention regardless of whether the overall health situation is as bad or even worse than the HIV/AIDS situation. The same is also true in several sub-Saharan countries with low HIV prevalence and high maternal mortality. The independent evaluation of the World Bank's support for health, nutrition, and population states that excessive

earmarking of foreign aid for communicable diseases can reduce capacity in health systems.³

The 5-year evaluation of the Global Fund to Fight AIDS, Tuberculosis and Malaria says that "some countries received considerably more HIV per capita funding than others with similar epidemic and regional profiles".⁴ Tuberculosis and malaria funding, per person at risk, varies across countries.⁴ Are the most in need (ie, the most exposed) benefiting the most from external funding? Are poor people benefiting as they should according to the policies of development agencies? It seems not.^{2,4} Will the financial crisis encourage the donor community to ensure resource allocation (a public health evidence-based approach), help countries meet all health Millennium Development Goals, address chronic diseases, and be more equitable towards African populations in regions with different needs?