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Supplementary webappendix

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WEB APPENDIX for World Report

What impact has the Commission's report had?

Kelley Lee, Director of Global Health, Simon Fraser University, Canada: "I believe that the Commission's Report was significant because it reframed health economics, from an obsession by neo-liberalism with crude market-based problems and solutions, to a focus on poverty and equity. Critics like to tar all economics, and all economists, with the same brush but this would be quite unfair. The Report showed that economics is a large tool box, rather than one big sledgehammer, that governments could use to foster health development. The importance given to economic tools reflected the dominant political climate of the 1990s, namely that there were no "free lunches" in this world and that everyone had to pay their way. Simply stating that we need to redistribute the world's wealth so that everyone can have good health just didn't have political traction. The Commission's aim was to promote globalization with a human face, but it was recognised that the argument needed to be politically convincing. The Commission's Report tried to achieve this by arguing that health is, not simply a drain on a society's resources, but an essential sector worthy of substantial investment if a country was to economically develop. Such utilitarian language might not be palatable to all, but one cannot deny that the Commission changed the way we debate health development policy.

Howard Waitzkin, Distinguished Professor Emeritus, Clinical Professor of Medicine, University of Mexico: "No, not really. In my opinion (and many others'), its impact has been mainly ideological, to support corporatized, private sector interventions. The financial contributions requested by the CMH from rich countries have not materialized, and the Report diverted attention from other options much more likely to address public health needs in less developed countries successfully - such as horizontally organized public health systems, a Tobin tax on international financial transactions to generate income for those countries, and country-determined rather than donor-determined program development."

Sania Nishtar Founder and President of Heartfile, Pakistan: "It is often better to have just one powerful message emerging from an analysis rather than a plethora of messages as the former creates more traction and has higher likelihood of being factored into policymakers' realm of decision making. To be fair, it was the resonance created by that one idea which echoed loudly with the time-bound outcome-based stipulations of the Millennium Declaration. Although the latter's contribution towards mobilizing international support for health post-2000, was more salient, the former also lent impetus."

Howard Stein, professor at the Department of AfroAamerican and African Studies, University of Michigan, MI, USA: "The report has been widely read and cited. There is little doubt that it has helped to mobilize resources in support of health needs in developing countries. The Report provided a strong endorsement of the Global Fund to Fight AIDS, Tuberculosis, and Malaria just prior to its establishment in 2002. They anticipated a budget of \$8 billion in 2007. However, by 2007 GFFATM had already received nearly \$10 billion dollars and nearly \$16 billion by the end of 2009. There is little doubt that funding through GFFATM and Pefpar have played a vital role in increasing the accessibility of many of the world's poor to ARVs. At the end of 2010, they were financing ARVs for around 4.7 million people and helped push the coverage in Africa from 17% in 2005 to 37% at the end of 2009. The report also came out against user fees for health services at a moment when there was a preponderance of evidence of its deleterious effect on the accessibility of the poor to essential services. However, the alternative they proposed was prepayments for community based health services which could still affect those that could not afford to buy into the plan.

“In many other ways the Commission’s report simply supported the status quo with all of its consequences to the health and welfare of people in developing countries. There is little in this report on the causes of poverty and poor health, including the gross inequities of the global economy and the abysmal failure of decades of neoliberalism. This should not be surprising given that the many of the commissioners had worked at the World Bank, IMF or multilateral agencies (even including the DG designate of the WTO). There are worries about the affordability of drugs but continued support for the WTO protection of property rights with a hope that problems can be avoided through corporate flexibility and goodwill. The report provided a strong endorsement of HIPC and PRSPs although they perpetuated a continuation of the same Washington consensus policy conditionality in place since the early 1980s. The report encouraged many of the same neoliberal health policies developed and promoted by the World Bank including a move toward privatizing health services, decentralizing state health institutions, a focus on state rather private sector inefficiencies, using the very problematic DALYs as a guide to health care priorities and relying on local resources to assist in funding health care despite the inequities that can arise in this system. The issue of health as a basic human right is mentioned only once and there is no reference to the Alma Ata Declaration with its global commitment more than 30 years ago to universal primary health. In contrast the emphasis on health care is instrumental and focused on its potential role in increasing economic growth. This is very much in line with the orthodoxies continuing to come from the donors and the Bretton Woods institutions.”

Tony McMichael, Prof of Population Health, The Australian National University, Canberra:

“My concern with the work of the Commission is that it primarily construed human population health as a resource, worth investing in because improved health would then enhance economic productivity and national development. This utilitarian view, while legitimate, harks back to Edwin Chadwick's agenda in mid-19th century England. He recognised that the blight of endemic disease and incapacitation in London's labour force was an impediment to work and progress.

On its own, that view distorts our perceptions of population health. Even more important in this environmentally stressed world is the recognition that population health is an outcome, a sentinel measure of whether societies are on a sustainable path. Individual good health is, reasonably, a right and a social expectation. The good health of a population is a key, integrative, measure of how well a society is managing its biophysical and social environments.

I think the Commission's view has helped perpetuate a narrow, utilitarian, perspective on population health. This perspective is constraining the ability of public and policy-maker to recognise that the great 'global environmental changes' (including climate change) that we have caused will play out to the great detriment of population health. This is slowing progress on the national and international policy fronts.”

Lincoln Chen: President of US China Medical Board: “Positive was the report's high political visibility, outreach to economic policy-makers, and it may claim some success in increasing health ODA (one of the purposes of the Commission). Jeff Sachs was remarkably bold in arguing for \$billions for health, and he deserves credit for changing mind sets -- ultimately leading to \$billion enterprises like Global Fund.”

Rick Rowden author of The Deadly Ideas of Neoliberalism: How the IMF has undermined public health and the fight against AIDS: “I regret to say that I fear the report was relatively useless and did not have

any discernible impact on improving global health or donor aid for health. It was plagued from the beginning by three considerable constraints. First was contextual, at the time of the study it was the height of the political ascendancy of neoclassical free trade type policies and the IMF's monetarist fiscal discipline and tight monetary policies, which went largely unquestioned when the study was undertaken in 2001. So the entire scope of the report reflects this political environment of the time by completely ducking the crucial criticisms about the IMF & World Bank macroeconomic policies then impacting on national budgets (and thus on health expenditures).

“The second major constraint is that the report in particular neglected to critique the two main macroeconomic policies impacting most heavily on national budgets generally, and thus on health budgets -- the fiscal deficit-reduction targets and the inflation-reduction targets as determined by the IMF programs. These two policies are based on extremely conservative policy approaches and the fact is that IMF & WB ruled out perfectly valid other more expansionary policies from consideration -- with devastating consequences for national budgets and health budgets. These policies both kept the governments from spending more on recurrent health and from making further long-term public investments in the underlying health system infrastructure. These policies also blocked the domestic companies, including many nascent manufacturing firms, from expanding production and employment (because in order to drive inflation [unnecessarily] low to please IMF, interest rates must be raised, which then makes the commercial credit needed by companies out of reach), and further companies were wiped out by rapid and premature trade liberalization. So economic diversification, employment and a larger national tax base were all sacrificed. This should have been the central point of the CHM report - that there are problems with the macro policies and development model, and this is screwing up health budgets. Of course, it was not.

“The third constraint was the confines of the perspective used in the CMH report. Like many health and health financing advocates, the frame of the report was to stay entirely within the health sector silo and take the only view of the health sector's immediate and long-term needs...A more meaningful and comprehensive approach would have inverted the sector silo approach, starting outward and looking inward to see how larger national economic policies of the rest of the economy are impacting on the national budget, and thus on the health budget, as was done later by the WHO's 2008 Commission on the Social Determinants of Health.”

Eduardo Pisani, Director General, International Federation of Pharmaceutical Manufacturers and Associations (IFPMA): “The Commission on Macroeconomics and Health (CMH) placed health at the center of the global development agenda, strengthened the links between health and economic activity, and raised the imperative of investing in health to a higher level than previously attained on the global political agenda. The positive impact of the CMH on stimulating new sources of funding and generating unprecedented levels of health investment is an outcome IFPMA fully supports and applauds. Over the decade since the CMH was established, the R&D-based pharmaceutical industry has positively embraced and fully committed to multi-stakeholder engagement, its donation programmes have continued unabated, as has its involvement in technology transfer¹. In addition, it has also directed considerable financial resources toward R&D for the diseases of the developing world (DDW)². The next ten years will require even greater resolve in the health sector in developing countries and emerging markets at a

¹ See “Technology Transfer: a collaborative approach to improve global health”, IFPMA, 2011, <http://www.ifpma.org/global-health/access/technology-transfer.html>

² See 2011 IFPMA Status Report

time when many developed countries face an uncertain economic outlook. Hans Hogerzeil, former WHO Director for Essential Medicines and Pharmaceutical Policies.”

Ilona Kickbusch, Director of the Global Health Programme at the Graduate Institute of International and Development Studies, Geneva : “I think it is clearly the role of the WHO to embark on such high level intellectual efforts that bring together some of the best thinkers world-wide. The way we position health within government and society and the rationale we give for investing in health need to be well thought through and constructed – we need clear conceptual reference points, otherwise data is meaningless. Only the two together provide us with evidence.”

David Bloom, Clarence James Gamble Professor of Economics and Demography, Harvard School of Public Health, Boston, USA: “I think that the particularly significant core outcome of CMH was the dissemination of the idea that population health can spur economic growth and development. Economists and others had long recognized that wealth could lead to health, but the reverse linkage had been severely neglected at the macro level. Although this conclusion is intuitive for most people and not surprising, it was news to most macroeconomic policymakers.

In this respect, CMH was a huge breakthrough, because this finding stimulated a substantial amount of thinking about the relationship between macroeconomics and health in various parts of the world. That thinking and related research have led to dialogue and discourse about these issues among academics and practitioners, including economic policymakers. Having the academic grounding for these new ideas has given health and economic policymakers (among others) stronger grounds for advocating for greater emphasis on population health in countries’ development plans.

The CMH Report has led to a decade of efforts aimed at understanding the underlying mechanisms by which health affects economic well-being. This research has, in turn, promoted further understanding, but much more remains to be investigated.

Looking back, it is clear that CMH provided a boost to academic research on the relationship between health and economic development and gave this area legitimacy at a level that it did not previously have. In part, CMH did this by engaging policymakers in ministries of finance and ministries of planning – an action that ensured that the research done and conclusions reached would be relevant to those specific policymakers. It also did this by drawing in outstanding and extremely well-known economists like Jeffrey Sachs to work on and to write and speak about these issues.

CMH’s ability to give a major boost to this research and to make it useful to policymakers must be attributed in no small measure to Gro Harlem Brundtland’s convening power. Because she had been a head of state, she was able to bring leading economic policymakers to the table and leverage their participation to give prominence and reach to the CMH report.

Still, more remains to be done to inculcate this idea all the more firmly into the minds of policymakers, but the ideas developed thus far have already had real policy applications.

Amanda Glassman, director of global health policy, Center for Global Development, USA: “I think the CMH included a very important discussion of global public goods in health that played an important role in motivating the creation of the Global Fund and GAVI, but was not adequately reflected in the later fundraising and resource allocation strategies of these agencies. On fundraising, these bodies used an ad

hoc approach, saw themselves as transitional and are only now realizing the more permanent role that is needed...The CMH also failed to help the WHO place itself as a GPG -- as a standard-setting agency, with a unique and essential role in dealing with transnational health issues. The current crisis at WHO is a testament to that failure.”

Carol Medlin Senior Program Officer, Bill & Melinda Gates Foundation: “The CMH report raised the profile of global health on the international agenda, and underscored the critical impact that health investments have on achieving development goals such as economic growth, prosperity and well-being.

Derek Yach, Senior Vice President of Global Health and Agriculture Policy, PepsiCo: “on balance, global health has benefited substantially from the work of the CMH. It unified like never before, the work of finance ministries, development agencies and health departments. For a few years it provided a solid authoritative voice about the economic value of investing in health. Without such sustained “voice” in recent years, there has been a return to seeing health as an expenditure item to be cut like other costs on the budget!”

What did it achieve (politically, technically, practically)?

Sania Nishtar Founder and President of Heartfile, Pakistan: “By and large some countries were able to establish the institutional frameworks CMH called for—this action can be attributable directly to CMH’s advocacy. Most of these countries can be classed as Emerging Market Countries where fiscal space, institutional capacity and policy consistency created the space and environment for such changes. However, other changes in the landscape of global health and development, which were aligned with CMH’s recommendations, were also influenced by other overarching factors. 2000 onwards, up until the financial crisis, was a period marked by unprecedented support for health—evidenced, in absolute terms by aggregate increases in ODA for health by over 200%. This was the result of the fortuitous but fortunate coexistence of three shaping overarching factors: first, a global economic boom, which created the fiscal space in the OECD countries; secondly, a global agreement on a set of targets enshrined in the Millennium Declaration, which served as a rallying point for the development community; thirdly, evidence of the links between investments in health and broader development gains. The latter was a contribution of the CMH, which in addition also stipulated a clear internationally recommended standard of annual financial commitments. Although the latter was not reached by most OECD donors, it created a target, nevertheless. It is within this broader context that I would like to view CMH’s positive contributions.”

Prabhat Jha, University of Toronto Chair in Disease Control, Director, Centre for Global Health Research, LKSKI/KRC, St. Michael's Hospital, Toronto, Canada:

1. Re emphasized (after the World Bank’s WDR 1993) that health investments can yield economic growth. Obvious to us health nuts, but not outside (eg Larry Summers once wrote that wealthier is healthier).
2. Emphasized that the scale of investment needed for big health outcomes is in the billions and not in the millions.

3. Spurred global funds (GFATM)
4. Spurred some countries to mobilize more domestic finance for health (eg India, and South Africa, lesser extent China)

Carol Medlin, Senior Program Officer, Bill & Melinda Gates Foundation: “The CMH report ushered in a decade of unprecedented spending on global health and remarkable progress in terms of reduced death and sickness. However, while gains have been made, much more remains to be done. We cannot afford to divert our attention from these priorities.”

Ilona Kickbusch, Director of the Global Health Programme at the Graduate Institute of International and Development Studies, Geneva : “It influenced the debate by reinforcing the argument that health lies at the basis of development. It is important to remember that this was done in a period of neoliberal heyday – the accepted premise in many influential quarters was that economic development and growth creates health, so let’s not deal with health now. The argument probably had more impact on the poverty and MDG debate and implementation than within the WHO. And in the fight against poverty the influence of the report and of course Jeffrey Sachs himself was extensive. Also it helped establish the focus of many of the new vertical health initiatives – linked to the “health MDGs” - and the work of major foundations in health. It did stay within the accepted “growth” model.”

Derek Yach, Senior Vice President of Global Health and Agriculture Policy, PepsiCo: “It drew heavily on economists, finance ministries, the World Bank and the IMF in building the arguments; and maintained their support for at least 4 or 5 years after publication. It was during that period (2001-2006) that the recommendations started to take hold in many countries. Progress in China, Ghana and others were reported in what was its final report of 2006 (see link below). By then, some countries had established planning commissions to cost interventions in their countries and started to increase domestic funding for health.

It drew attention to the need to invest large sums of money if the MDGs were to be achieved. Funding that had to come from a mix of domestic and international donors sources. Most of the funding targets were however not met and are today in danger of falling further behind as cuts are imposed on development aid by many countries. The rationale for these investments remains valid today and there is no doubt that cutbacks will translate into increased deaths and lower economic output in effected countries. Greater effort needs to be given to maintaining the gains during deficit reduction exercises.

The report supported “innovative financing” mechanisms that were embedded into the way the Global Fund and GAVI evolved. Work on related mechanisms continues spurred on by the Commission’s work. UNITAID being one response. Work in this area needs to be expanded.”

In terms of what has happened as a result of the CMH report, I would place increased awareness and advocacy at the top. The CMH was instrumental in placing evidence of the links between health and development, center stage of global development deliberations. However, the quantum of changes it recommended were fairly significant, which is why its impact has to be viewed in context.

What have been the disappointments/failures?

Hans Hogerzeil, former WHO Director for Essential Medicines and Pharmaceutical Policies, Professor of Global Health at Groningen University (Netherlands): “Governments and donors have focused on MDG 4, 5 and 6 and have generally ignored the needs for other essential medicines. Public funding for other essential medicines has generally dried up.

The international donor community has basically refused to accept the prevention and treatment of NCDs in LIC/MICs as an issue for development collaboration.

Governments and donors have also failed to see the extent to which the whole area of NCDs is infected with vested interests and conflicts of interest, especially in the pharmaceutical industry but also widely extended into the scientific community, the professional associations and even most patient organizations.

I would have liked to see that the pharmaceutical industry (both research-based and generic, both in rich and in middle income countries, and with very few positive exceptions such as GSK) had better read the signs of the times: that the research pipeline is drying up; that there is a huge need for better access to generic medicines, especially for middle-income people in middle-income countries who can afford their own medicines provided they are not overpriced and which can be served by low-cost quality generics (even if expensive brands remain on the same market for the rich); that they adapt themselves to the situation that by far the largest proportion of essential diseases can be treated with generic medicines; and that another business model is needed, which is more a commodity-based model with large volumes and smaller margins, competing on quality and price in transparent markets, not based on expensive commercial marketing efforts and corruption of the prescribers.

I would have liked to see that more governments recognize the genuine health care needs of their population, and especially of the poor and disadvantaged; and that they would have recognized that any health care system that is not actively managed by government stewardship will automatically drift towards depersonalized, fragmented, commercialized and hospital-based care – which is exactly what the patients do NOT want. In other words, that the governments would have recognized and taken up their essential role of good governance.”

Kelley Lee, Director of Global Health, Simon Fraser University, Canada: “Has the Commission's idea to harness economics to benefit the health of the poor worked? The Occupy Wall Street movement would clearly argue that it has not. While there was initial promise that the ideas of the Commission were permeating beyond the health development community, championed by Jeffrey Sachs in the hallowed halls of power, it did not fundamentally change the way fiscal policy is made. This was what was needed to make a real difference. And since 2001 the framing of health development (and indeed foreign policy) has shifted to a focus on security. During the past ten years, huge swathes of public wealth have evaporated to fight overseas conflicts, build 'homeland security' and contain financial contagion. Health has been recast as a "new security risk" and the task has become preventing "disease threats" to a globalised (read industrialised) world. With the benefit of hindsight, we can see now that

far greater prudence was needed in how we spent our public and private resources. Rather than chasing paper wealth, the Commission would argue that people represent the real wealth in any society. Amid today's economic crisis, therefore, there is a real opportunity for the Commission to renew its core ideas and refocus governments on what really matters in societies."

Sania Nishtar Founder and President of Heartfile, Pakistan: "There is also the share of disappointments tagged to the CMH and what it recommended. Its total neglect of non-communicable diseases, which we now know, lead to massive economic losses at the national, global, individual and household levels is one of them. Secondly, its emphasis on universal health coverage could have been better positioned with a clear message about the need for health reform to achieve that end-point. Additionally, CMHs emphasis on diseases of the poor was inferred as an endorsement of the vertical approach to disease-domain funding, which is limited in its ability to address systemic constraints that are an impediment to achieving disease specific outcomes."

Lincoln Chen, President of US China Medical Board: "Negative were the very weak, almost made up, data and numbers to justify the conclusions which were by no means validated by evidence. The report seemed detached from the commissioned micro-studies. The report was essentially a set of made up numbers with pre-derived conclusions."

Most worrisome amongst some of us was the fact that the Commission had the ethics and moral thinking reversed. Arguing to invest in health to grow the economy makes health "instrumental" to economic growth rather than making health "intrinsically-valued" not justified as a means rather than an end. The social determinants commissioned conceived by a later WHO (led by Tim Evans) reversed that ethical lapse.

We have had enough experience in the past decade to recognize that some health crises such as SARS can be economically catastrophic. And we also know that much of the macro-economy has nothing to do with health care per se (e.g. Greece and Italy today)."

Ilona Kickbusch, Director of the Global Health Programme at the Graduate Institute of International and Development Studies, Geneva : Because of the changes in the leadership of the WHO the report of the Commission was not really "owned" by the organization, and there were no strong champions after the leadership change. Many public health advocates also remained skeptical of economic premise and arguments – they had not been sufficiently involved in the work of the Commission. The health NGOs did not really pick it up and there was no continuous debate – it read more like a World Bank Report. Maybe it was also too focused on the chair

Prabhat Jha, University of Toronto Chair in Disease Control, Director, Centre for Global Health Research, LKSKI/KRC, St. Michael's Hospital, Toronto, Canada: "1. Insufficient attention to chronic diseases. The analyses of the CMH below done at the time suggested that of the estimated 160 M or so lives that could be saved from the CMH recommendations, over 30 M would result just from higher tobacco taxes (the Economist picked this up also in the coverage of the CMH). As a whole the CMH was way too light on tobacco taxes as a core strategy for better global health."

2. Should have prepared better for bad times and not just good times (when incomes were rising and the world could think of more cash and foreign aid for health). The CMH should, in retrospect, have done more to make the case that in economic downturns (like that after 2008) governments should use stimulus spending to build health and health systems. That is, most of the G-20 gathered in London around 2008 (except perhaps for Gordon Brown) did not think that big stimulus funds should do anything except “shovel ready” ideas like bridges etc. But the case could be made that using fiscal stimulus to bring people more under Canadian/British/universal health systems would have a big impact on poverty, free up money that the poor currently are saving for health disasters, and let them spend on goods and services which would create more jobs for others (versus saving for catastrophic health expenditures). It might get you fired from US jobs (eg Don Berwick praising the UK NHS was enough for US Senators to do him in!), but the big picture would counsel countries not to be American when it comes to organizing health finance!

Plus I could make the case that some health investments are “shovel ready”- examples- vaccinate every kid in the world with the same antigens that your kids and mine get, or worldwide low cost treatment with the polypill for those with existing vascular disease, or worldwide ACT treatment for kids and adults for malaria/fever deaths.

3. Insufficient attention to the importance not just of more money but also restructuring foreign aid to deliver new knowledge. Specifically, (a) child mortality investments and research over the last 40 years along with public attention mean that the costs of saving a child are dropping, but in contrast saving an adult life is becoming more expensive; (b) foreign aid, should arguably, try to get countries to hike their own spending on health (ie public spending) while trying to get new innovations financed by bilaterals, World Bank etc (as governments don't have much of an appetite for experimenting in areas they don't already work in). I think we missed the boat on this basic point.

4. CMH was a little too focused on Africa, in retrospect.

Bernard Pécoul, Executive Director, Drugs for Neglected Diseases initiative (DNDi): “While there has been improvement, access to essential medicines in developing countries remains a major problem. Neglected diseases continue to cause significant morbidity and mortality in these countries for lack of adequate health tools. The need for new, field-adapted treatments remains urgent and largely unmet.

There has been substantial involvement of the WHO through the Commission on Intellectual Property Rights, Innovation and Public Health (CIPRH), followed by the adoption of a Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property by all WHO member States, and more recently through the work of the Consultative Expert Working Group on R&D financing & coordination (CEWG). However, the goals of the WHO Global Strategy will not be met unless adequate technical and financial resources are secured on a long-term basis.

Several issues still need to be addressed, and these should be formulated in a new set of recommendations, more in line with the current landscape. The main issue today is that of sustainability.

For neglected diseases, product development partnerships (PDPs) can offer innovative solutions in response to patient needs. The R&D drug pipeline for these diseases has been replenished. But three challenges remain:

The first is that even though new health tools have been made available in recent years, major implementation and access issues have prevented them from reaching patients in neglected disease-endemic countries. WHO, in collaboration other international organizations, should provide further capacity strengthening for the production, registration, and delivery of affordable quality medicines in developing countries – not only for HIV, TB, and malaria.

The second is that adequate and sustainable financing is critically needed to ensure the further progression of promising new tools that are in pre-clinical or early clinical phases. Innovative financing mechanisms such as a financial transaction tax could play a critical role in securing such sustainable funding, and offer the predictability required for R&D activities.

The third is that a global framework is needed for determining funding allocation according to public health priorities, coordination of R&D projects, and overcoming regulatory and intellectual property barriers.

While there has been an increase in licensing by some pharmaceutical companies, this has not been done on a uniform scale. More licensing agreements for R&D and manufacture of affordably priced quality medicines in developing countries, including through more engagements with PDPs and, for example, initiatives such as the Medicines Patent Pool, are vital. Open innovation will make the difference in neglected disease R&D. Differential pricing provided a much needed boost in terms of access, but 10 years down the road we now see that this remains a short-term solution. We need to look at sustainable solutions.

Derek Yach, Senior Vice President of Global Health and Agriculture Policy, PepsiCo: “The report called for the creation of a Global Health Research Fund to address market failures and a massive gap in research capability that exists between developed and developing countries. This call never gained traction yet remains a real need.

Two major contributors to burden were underplayed in the CMH: nutrition and NCDs.

The Commission mentions the importance of malnutrition in several places but without the focused attention it gives to selected infectious diseases. This despite that fact the under and over nutrition along with micronutrient deficiencies represent the largest single contributor to the burden of disease. CMH thus missed the chance to start addressing food insecurity and its links to economic and political stability; the relationship between food systems, food policies, obesity and the environment. Issues now receiving the attention of the UN through the Scale-Up Nutrition initiative; and through the World Economic Forum’s New Vision for Agriculture.

The Commission focused sharply on MDG health goals and with the exception of tobacco, ignored the clear evidence a decade ago that NCDs were then and would increasingly become the major causes of

the burden of disease exerting massive economic costs on societies. This evidence has got stronger over the last decade and was the basis for the UN High Level meeting addressing NCDs in September this year. The economic impact was clearly outlined in a joint WHO/WEF report and in the spirit of the CMH, a list of cost-effective best-buys formed the basis for policy recommendations. CMH methods and logic were therefore applied to NCDs. Unlike the early years of the century, the economic crises now mean that no extra funds are likely from international funds to meet some of the needs well described and rather, domestic investments and a greater reliance on private-public partnerships will be needed to tackle NCDs.”

How relevant is the Commission in today’s climate? In Today’s climate, what would a new Commission look like/focus on?

Carol Medlin Senior Program Officer, Bill & Melinda Gates Foundation: “The main messages of the CMH report relating to the importance of health investments on development and economic growth remain relevant even in today’s economic climate. Even in the face of the global financial crisis and other important issues emerging on the development agenda – including agriculture and food security – improving the health of millions of the world’s poorest is one of the most effective investments we can make to improve lives and help communities on the road to self sufficiency. This makes it necessary to maintain our focus on critical global health priorities.”

Gorik Ooms, researcher at the Department of Public Health at the Institute of Tropical Medicine, Antwerp, Belgium: “CMH report has been a game changer – international assistance from peanuts to real money. But 10 years later we need another game changer – a farewell to conventional ‘development’ assistance, aiming to be temporary and encouraging self-reliance through economic development; a welcome to some kind of global mutual social support. As paradoxical as it may sound, by abandoning the idea of national self-reliance, assistance to the poorest countries can greatly increase and become more reliable, and these countries’ economies can grow much faster. (This is not really a paradox, in fact. Creating national mutual social support schemes, high income countries abandoned the aim of individual self-reliance, which greatly contributed to the emancipation of the underprivileged.)”

Prabhat Jha, University of Toronto Chair in Disease Control, Director, Centre for Global Health Research, LKSKI/KRC, St. Michael's Hospital, Toronto, Canada: 1. A CMH focused on chronic diseases is a must, and would have the tough job of not only defining how to spend more money, but also how to save money from health systems, aging etc. But I think the conclusions of such a new CMH would be similar to the big lessons on how the world has reduced child mortality:

- a. Invest in R&D to get much better tools relevant at low cost and everywhere.
- b. Invest in monitoring/epidemiology/activities like the Million Death Study in India to monitor progress and to raise public understanding of the big diseases and what can be done about them.
- c. Re jig foreign aid so it pushes governments to do the stuff they know how to do (ie write cheques for outcomes on MCH, etc), while paying for stuff that may well flop (eg novel strategies to reduce NCD).

- d. Engage the Bric countries a lot more, including as sources of new knowledge.

Howard Waitzkin, Distinguished Professor Emeritus, Clinical Professor of Medicine, University of Mexico: “Unfortunately, faith in market-based reform persists, though less so now that world capitalism is failing and empire as we have known it is ending. The almost complete lack of scientific evidence supporting the arguments and proposals of the CMH confirms the arguments of Bourdieu and many others that these concepts derive more from quasi-religious faith in the market than from verifiable scientific principles.

Yes, indeed we should be proposing a new agenda - an agenda based on a strengthened public sector; an end to neoliberal policies of public sector cutbacks, privatization, and exploitative public-private "partnerships"; the development of strong public-sector infrastructures for public health; and support for the popular movements struggling to achieve alternative programs like those we have seen especially in Latin America. By the way, I provide more details about this agenda in my recent book (<http://endofempire.net/>).”

Ilona Kickbusch, Director of the Global Health Programme at the Graduate Institute of International and Development Studies, Geneva : “Messages that change the world tend to be simplistic. This Commission Report said: invest in health and you will get development. It focused mainly on poverty and was still committed to a model of economic growth. Ten years later the Commission Report on Social Determinants and Health said: Social Injustice kills. It focuses on gradients and is committed to a model of economic redistribution. We now have a report on economic determinants, one on social determinants – we still lack a report on political determinants of health. Today we need thinking that – along the lines of the Stiglitz/Sen/Fitoussy Commission on the Measurement of Economic Performance and Social Progress – questions some of the economic models of what constitutes progress of societies and links that debate to the role of health and wellbeing in 21st century societies.

Such Commissions do make a difference if the mechanism is used wisely and not too frequently. Every ten years or so seems appropriate at the rate the world changes and intellectual models change. Chairs and members need to be chosen carefully and the many stakeholders in global health, in particular civil society, need to be part of the debate. The process is as important as the outcome. They need a good balance between full intellectual independence and support from the WHO – because in the end it is the WHO that ensures their continuity. “

Kelley Lee, Director of Global Health, Simon Fraser University, Canada: “Rather than chasing paper wealth, the Commission would argue that people represent the real wealth in any society. Amid today's economic crisis, therefore, there is a real opportunity for the Commission to renew its core ideas and refocus governments on what really matters in societies.”

Derek Yach, Senior Vice President of Global Health and Agriculture Policy, PepsiCo: “Yes. It’s main conclusion that investing in health benefits economic development remains true today yet is being increasingly contested and ignored in an era of austerity in OECD countries; and has yet to be fully acted upon in emerging economies.

Its follow-up work though should have been funded for at least 10-15 years, not 5 years. Further, Lee’s decision to establish the Commission on Social Inequalities in Health (which after an expensive series of meetings concluded that they exist!) confused decision makers and impeded the progress that was underway by then. The lesson for WHO is also clear-stick with programs for longer to allow them to become embedded in country work.”

Sania Nishtar Founder and President of Heartfile, Pakistan: A commission of this nature today would have to be conceptualized in a very different context. The world is in the midst of an economic crisis, which is not likely to remain confined to one region because of global economic inter-dependencies. Determinants of the economic downturn and resulting constraints, underscore the need to accord higher attention to transparency and accountability. Also, we now know more clearly that without attention to overcoming systemic systems barriers, sustainable progress towards health improvements are not possible, which is why the health community is now rallying behind the “whole of government approach” with a realization that the levers to improve health are often in the control of actors outside of the health sector.

There is a corresponding shift in thinking towards international commitments where sustainability, inclusive of environmental sustainability and human security are assuming preeminence—hence the likely shift from the Millennium Development Goals to the Sustainable Development Goals, post 2015.

Hans Hogerzeil, former WHO Director for Essential Medicines and Pharmaceutical Policies, Professor of Global Health at Groningen University (Netherlands): “I think the report was and is highly relevant. If all recommendations would have been followed by all stakeholders, the world would have been a better place.

But now the report should be updated and strengthened on the basis of the large amount of new data from low- and middle income countries that have become available over the last few years (WHO/HAI surveys on price, availability and affordability of essential medicines in LIC/MICs, ATM Index on company behaviour, and newly available data on medicine markets in MICs from commercial sources such as IMS Health).

These data will support even stronger evidence-based recommendations on the need for generic policies, reducing taxes, regulating commercial margins; and especially on the legitimate and essential role of good governance in making policies, regulating the market, assuring the quality of generic medicines, preventing conflicts of interest and corruption, and caring for the poor and disadvantaged.

I would also like to see that the new report be much more explicit about access to essential health services and products as part of the right to health, as committed to by over 160 countries in the International Covenant on Economic, Social and Cultural Rights and further explained in General Comment 14.”

Bernard Pécoul, Executive Director, Drugs for Neglected Diseases initiative (DNDi): “We need a stronger focus on the barriers to implementation and access, and the hindrances to sustainable solutions. With leadership from WHO, we need a global framework – the seeds of which were planted in the Global Strategy – but which still requires international coordination and political leadership for implementation. The Global Strategy needs to be activated.”

Eduardo Pisani, Director General, International Federation of Pharmaceutical Manufacturers and Associations (IFPMA): “Looking at the future, prioritizing investments in multi-stakeholder approaches for both R&D and access for in the area of DDW is crucial. Continued work on new innovative financing

mechanisms which adequately reward providers of R&D is also fundamental. Several funding models currently exist from which we need to extract the major strengths and advantages and develop a new model for sustainable, predictable funding. Increased overall funding level will also help address current drug development challenges in the area of DDW as most of the R&D projects are in relatively early stages. As more projects progress into later development, more strain will be placed on the clinical trials and regulatory infrastructure in developing countries—where trials will take place and where medicine approval will occur. To address this gap, it may be worth focusing some attention and resources on strengthening regulatory capacity, for example via harmonization of regulatory requirements at regional levels.

Access to medicines is a complex challenge that requires collaboration among all health actors. Besides continued commitment of the R&D-based pharmaceutical industry, political willingness from governments can play a significant role in enabling adequate environments for innovation and access, and committing human, financial and infrastructural resources. Generic pharmaceutical companies should also carry out a complementary yet critical role through targeted access programs modelled on those initiated and supported by innovative firms.”

In the years to come countries throughout the world are expected to lose significant amounts of national income as a result of non communicable disease’s negative impact on labor supplies and a reduction in GDP. While effective first-line NCD medicines exist and are now available in generic form, there are too many instances, where these medicines are still failing to reach many people living in the developing world. This underscores the importance of partnership to understand what the most significant problems are and to work together to solve them.”