



# G8 and strengthening of health systems: follow-up to the Toyako summit

Michael R Reich, Keizo Takemi

The 2008 G8 summit in Toyako, Japan, produced a strong commitment for collective action to strengthen health systems in developing countries, indicating Japan's leadership on, and the G8's increasing engagement with, global health policy. This paper describes the context for the G8's role in global health architecture and analyses three key components—financing, information, and the health workforce—that affect the performance of health systems. We propose recommendations for actions by G8 leaders to strengthen health systems by making the most effective use of existing resources and increasing available resources. We recommend increased attention by G8 leaders to country capacity and country ownership in policy making and implementation. The G8 should also implement a yearly review for actions in this area, so that changes in health-system performance can be monitored and better understood.

## Introduction

The declaration of the G8 Toyako summit, held in Japan in July, 2008, covered global health issues under the topic of development and Africa. The official summary stated:<sup>1</sup>

“The G8 leaders welcomed the Report of the G8 Health Experts Group, presented along with its attached matrices showing G8 implementation of past commitments, and set forth the Toyako Framework for Action, which includes the principles for action on health.”

The leaders confirmed the G8 commitment to provide US\$60 billion over 5 years, as agreed at last year's G8 Heiligendamm Summit, and also decided to provide 100 million mosquito nets for malaria prevention by the end of 2010. The Report of the G8 Health Experts Group was prepared by government officials in health and foreign policy from the G8 countries, with leadership from Japan, and covered several crucial issues in global health.<sup>2</sup> The report was an indicator of growing policy attention to health-system strengthening by Japan and the global health community more broadly.<sup>3</sup> At the summit's conclusion, the Japanese Government decided to undertake follow-up activities by working with an external experts committee, which Keizo Takemi chaired. These efforts were designed to identify action-oriented policy recommendations for the G8 to strengthen health systems and maintain momentum and continuity to future G8 summits, especially the 2009 meeting to be hosted by Italy.

This paper provides an overview of Japan's follow-up activities on global health to the Toyako summit and presents the context for three policy papers with recommendations for G8 action. We review the emerging focus on health-system strengthening and discuss the unique role of the G8 in global health governance and architecture. We then discuss the three policy papers and conclude with a discussion of future directions.

## A growing focus on health systems

The global health agenda is shifting from an emphasis on disease-specific approaches to a focus on strengthening of health systems. These two approaches are often called the

vertical and horizontal approaches to health improvement. Some have argued for a third compromise strategy that would combine the two into a so-called diagonal approach,<sup>4,5</sup> whereas others have called for this debate to “rest (in peace).”<sup>6</sup> We believe that a better balance needs to be struck between the two approaches, so that efforts at fighting specific diseases and strengthening health systems can support each other effectively. But balance is difficult to define precisely when the knowledge base is thin and conflicting about how vertical programmes may affect horizontal efforts. There is little reliable evidence available to suggest that improving one approach necessarily affects the other negatively. Yet clearly the disease-focused programmes are concerned about shifts in global resources to health systems.

The growing attention to health systems can be attributed to several factors. First, the development of disease-specific approaches over the past decade has created various unintended results.<sup>7</sup> These approaches have contributed greatly to health improvement, especially since existing multilateral and national health agencies could not deal with the devastating effects of diseases such as HIV/AIDS in many developing countries. However, now recipient countries are faced with a fragmented array of uncoordinated disease-control programmes that are promoted by multiple donors. The opportunity costs of servicing the disease-specific programmes have been recognised as reducing the effectiveness of health ministries in some situations.<sup>7</sup> Furthermore, the disease-specific programmes attract financial and human resources away from government agencies, and might be contributing to a weakness of health systems. Two of the major disease-specific programmes—the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), and the GAVI Alliance (a consortium of organisations to promote immunisation and vaccination)—have launched major efforts to strengthen health systems in recipient countries. Although these programmes have encountered problems in implementation, they nonetheless indicate recognition of the need to develop both disease-specific approaches and those for strengthening of health systems.<sup>8</sup>

Published Online  
January 15, 2009  
DOI:10.1016/S0140-6736(08)61899-1

See Online/Comment  
DOI:10.1016/S0140-6736(09)60002-7  
DOI:10.1016/S0140-6736(09)60003-9  
DOI:10.1016/S0140-6736(09)60004-0

Department of Global Health and Population, Harvard School of Public Health, Boston, MA, USA (Prof M R Reich PhD); and Research Institute of Science and Technology, Tokai University, Tokyo, Japan (Prof K Takemi MA)

Correspondence to: Prof Michael R Reich, Department of Global Health and Population, Harvard School of Public Health, 677 Huntington Avenue, Boston, MA 02115, USA  
michael\_reich@harvard.edu

**Panel 1: Opportunities for overcoming the health-workforce crisis (Masamine Jimba, Meghan K Reidy)**

The health workforce—the people who actually deliver clinical and public health services—is a fundamental element of any functioning health system. Although human resources for health has been neglected by donor agencies and global health initiatives for decades in favour of easier, more targeted areas, human resources for health has now gained growing attention from various stakeholders.

The Joint Learning Initiative (JLI) helped to create this momentum, publishing a monumental work, *Human resources for health: overcoming the crisis*, which identified the shortage of health workforce as a crisis.<sup>27</sup> The *World Health Report* in 2006 then estimated that more than 4 million health workers will be needed to meet the shortfall, including 2.4 million physicians, nurses, and midwives.<sup>28</sup> The Global Health Workforce Alliance (GHWA) was established in the same year. In 2008, the first global forum on human resources for health was held in Uganda and issued the *Kampala Declaration and Agenda for Global Action*.<sup>29</sup> The Toyako G8 summit supported the Declaration and drew attention to the health workforce, stressing its importance over the other five building blocks of the WHO health-system framework.<sup>2</sup>

Effective use of health workforce can produce both improved health-system performance and improved health outcomes. Improvement of health outcomes needs more than meeting the numbers of the right types of health workers; it requires improvements in how the health system creates and supports health workers, and the political context to achieve and implement reforms.<sup>30</sup>

To respond to these requirements, we have to overcome several key challenges: inappropriate quantity and quality of existing health workforce caused by shortages, lack of skills, and poorly functioning payment and supervision systems; macroeconomic policy constraints; lack of country capacity to undertake key tasks such as engaging leaders and stakeholders, planning human investments, managing for performance, developing enabling policies, and learning for improvement;<sup>27</sup> international migration of human resources; and lack of donor coordination.

To overcome these challenges, we need to use the growing workforce investments more effectively. New resources are becoming available through several global health initiatives, along with recommendations and guidelines from different health organisations, pioneering interventions in low-income countries, and financial and political commitments from donor countries, particularly G8 countries. Although these opportunities are available, few sub-Saharan countries are adequately using them. As a result, these countries have shown little progress in achieving the health-related Millennium Development Goals.

(Continues on next page)

A third factor is growing recognition about the difficulties that weaknesses in health systems present in achieving the Millennium Development Goals (MDGs).<sup>12</sup> Difficulties with health-system performance are considered major causes for the delays in achieving key targets of the health-related MDGs—ie, those related to child mortality (MDG 4); maternal mortality (MDG 5); and the prevention of HIV/AIDS, malaria, and other diseases (MDG 6). These delays are especially pronounced in countries in sub-Saharan Africa.

Fourth, the growing demand for aid effectiveness and donor harmonisation within countries, on the basis of the principles of the Paris Declaration on Aid Effectiveness, indicates concerns about system-wide effects of global health initiatives. The increase in resources devoted to health worldwide, however, has focused more on inputs (especially human and financial resources) rather than outputs or health effects (such as effective coverage and health outcomes). Yet little evidence exists to show that previous attempts to achieve strong donor coordination (through strategies to reduce poverty and sector-wide approaches) have helped to improve health-system performance.

Advocates of single-disease control programmes are concerned that the renewed emphasis on health systems could move resources away from their programmes and undermine progress achieved so far. The risk of letting infectious diseases increase should be carefully monitored as efforts develop to strengthen health systems. A community-based approach, with attention to collective quality of life, could help avoid undesired consequences of a focus on health systems.

### Strengthening of health systems

No consensus exists for the operational definition of health-system strengthening. Several competing approaches are popular in the global health community, and are promoted by different agencies.<sup>13</sup> We briefly present several of the main approaches.

WHO's *World Health Report 2000* raised a broad international debate about issues related to health systems.<sup>14</sup> The report defines a health system as including "all the activities whose primary purpose is to promote, restore or maintain health".<sup>14</sup> The main focus of the report and the ensuing debate, however, was on how to measure different aspects of health systems rather than how to strengthen health-system performance.

WHO presents its updated approach to health-system strengthening in a report entitled *Everybody's Business*.<sup>15</sup> However, this report does not provide a clear definition or boundary for a health system. Indeed, the report states "There is no single set of best practices" for health-system strengthening because "health systems are highly context-specific."<sup>15</sup> Additionally, the report's framework is not easy to apply in practice. The report identifies six so-called building blocks for a health system: service delivery, health workforce, information, medical technologies, financing, and leadership or governance. But how they fit together,

For the Paris Declaration on Aid Effectiveness see <http://www.oecd.org/dataoecd/11/41/34428351.pdf>

A second factor contributing to the focus on health systems is recent efforts by WHO to restore policies for primary health care. The approach for primary health care was officially launched worldwide through the Alma Ata Declaration of 1978.<sup>9</sup> Implementation of primary health care within countries, however, has been confronted by many challenges in low-income settings. WHO is now seeking to resurrect the primary health-care approach with the *World Health Report 2008*, which was issued in October on the 30th anniversary of the Alma Ata Conference,<sup>10</sup> and with a renewed emphasis on the principles of universal coverage, people-centred approaches, and effective delivery of primary care.<sup>11</sup>

how they relate to one another, and how a health system can be built with the blocks is not clear.

The World Bank describes its approach to health-system strengthening in its 2007 strategy document on healthy development.<sup>16</sup> The document recognises that the World Bank needs a “collaborative division of labor with global partners”,<sup>16</sup> including WHO, the UN Children’s Fund (UNICEF), and the UN Population Fund (UNFPA), which are viewed as providing technical expertise in disease control, human resource training, and service delivery. The World Bank considers its comparative advantages as broader systemic issues, especially health financing and health economics, as well as public–private partnerships, public-sector reform and governance, intersectoral collaboration for health, and macro-economics and health. A major challenge for the World Bank is implementation of its strategy, at a time when the Bank’s own financing is becoming a smaller proportion of global health funds, when the substantive challenges encompass more than the Bank’s areas of comparative advantage, and when the previous Bank strategy of 1997 has not been effectively assessed.<sup>16</sup>

With the growth of interest in strengthening of health systems, the world now confronts a proliferation of models, strategies, and approaches. Efforts by WHO and the World Bank represent just two approaches; other frameworks also exist. How do we assess these different conceptual models and select an appropriate one? Unfortunately, no one method exists for strengthening health systems that can be applied to all countries. Improvement in the performance of health systems is a process that has to be adapted to the situation of each country—its political and economic circumstances, its social values, and its national leadership.

From a policy-maker’s perspective, a strategic framework for health-system strengthening should help decide what to do, how to do it, and what results to expect. Furthermore, the framework should relate to appropriate theories while it helps to produce practical results. Additionally, it should provide guidance about how to implement the ideas in real-world political situations and how to relate the objectives to different ethical perspectives. We believe that one approach to strengthening of health systems takes important steps in meeting these criteria<sup>17</sup> and can help sort through the diverse ideas that are promoted by different agencies.

### Global health architecture and the G8 G8’s role in global health

The global health architecture is undergoing fundamental structural changes. As noted in the World Bank’s strategy document,<sup>16</sup> the global health organisations who were once dominant are increasingly marginal and less influential. This tenet is true for both the World Bank’s previous financial dominance and WHO’s previous normative dominance. Policy making in global health has become a multistakeholder process, but without an

(Continued from previous page)

To take advantage of these opportunities, the G8 should take the following actions.

Strengthen the capacity of countries to plan, implement, and assess health workforce programmes, so that they can more effectively use the existing health workforce and G8 commitments:

- Develop assessment mechanisms for health workforce progress within countries
- Identify ways to change macroeconomic policies to reduce constraints on expanding the health workforce
- Strengthen international networks of higher education institutions to provide access to health and medical education in areas with few resources

Address the demand-side causes of international health-worker migration:

- Clean their own houses and increase the number of health workers in their own countries with their own resources
- Support the WHO code of practice to address migration issues
- Seek practical solutions that protect both the right of individuals to seek employment through migration and the right to health for all people

Undertake a yearly review of actions by G8 countries to improve the health workforce:

- Assess what the G8 countries are doing, what has worked, and evidence to support this, with use of a standard set of common measures
- Use this review to assess how health systems are doing, to identify gaps in financing and information, to develop evidence-based best practices, and to increase knowledge about how to improve health-system performance through strengthening human resources, as well as to see how well G8 countries are carrying through on what they have pledged to do

explicit institutional process and with competition and confusion both globally and nationally. The proliferation of overlapping yet opposing frameworks for health-system strengthening is an indicator of this disorganisation. We believe that the G8 can play a major part in catalysing efforts to reframe the global health architecture in a more coherent direction.

The rise of the G8 coincides with rapid changes in global health governance in the 21st century, especially the decreasing role of WHO as the sole international health agency. In the past decade, new stakeholders have entered the decision-making arena of global health, including the Bill & Melinda Gates Foundation, the Global Fund, and GAVI. Public–private collaboration has become a maxim of health policy both globally and nationally.

One traditional strength of WHO has been its constitutional mandate to represent member states through the World Health Assembly. In the new era of global health, however, WHO is limited by its legal framework in its interactions with the private sector and non-governmental organisations. Another major strength and constraint of WHO is its nature as an agency that mainly offers information and technical advice, but cannot substantively affect how national governments allocate financial and human resources to strengthen health systems.

Calls to reform WHO have a long history. Every new Director-General has pursued change at the organisation; yet implementation of new ideas remains a challenge.<sup>18</sup> Recent calls for the reform of WHO reflect broader attempts to reform the UN, and these appeals have

### Panel 2: Strengthening health financing in partner developing countries (Ravi P Rannan-Eliya)

Health expenses impoverish millions of households and seriously undermine efforts to reduce poverty in many countries, providing a policy linkage between health and social protection agendas. Additionally, inadequate funding for crucial public health functions in developing countries impairs human security in an interconnected world,<sup>39</sup> as shown by recent global crises involving avian influenza and melamine.

The 2002 Monterrey summit led to substantial increases in financing for health in developing countries, including a doubling of external assistance and increases even in Africa in government budgets.<sup>40</sup> Despite this investment, trend rates of progress toward Millennium Development Goals 4 and 5 have not improved substantially in most regions, and Africa and South Asia remain significantly off track. More money has not always translated into better performance. Continued increases in investment are needed, but increases in funding need to be complemented by efforts to improve how money is spent. The global financial crisis only reinforces the need to improve the returns on health spending.

Financing and payment policies make the crucial difference in improving the effectiveness of health spending. There is now broad consensus among technical experts that out-of-pocket payments for health care are unfair for poor people and can result in illness leading to financial difficulties and poverty for millions.<sup>41</sup> Furthermore, mechanisms such as community-based health insurance, private insurance, and user fees have not proved viable pathways to scaling up coverage and social-health protection. As a result, implementation of an incremental shift to public financing that substitutes for out-of-pocket financing, especially for poor and vulnerable groups in society, is crucial. Yet questions remain about how to effectively implement the shift to public financing from private out-of-pocket sources.

The G8 can be an effective mechanism to ease better health financing policies in partner developing countries. Aid is more effective when appropriate policies are in place, which depends on country commitment and ownership. G8 nations have recognised these necessary conditions with their commitments to support new initiatives such as International Health Partnership and Providing for Health,<sup>42</sup> which both promise to increase alignment with countries and support policies for public financing.

The present global economic crisis provides an ideal opportunity to bolster global commitments to health financing, even though this approach might seem counterintuitive. As the International Monetary Fund has urged,<sup>43</sup> both G8 nations and developing countries will need substantial fiscal investments in the medium term to stimulate consumption and global demand. Public spending to expand health-care coverage represents for many countries one of the most efficient means to do so. At the same time, contractions in global trade and increases in unemployment will leave millions of people without adequate health-care coverage and undermine support for an open global trading system that benefits both G8 nations and developing country partners. This crisis, with the increased awareness that it brings of market failures that need government action, could in fact be the best time to invest in expanding health-care coverage through better financing policies.

The commitment to policies for public financing should translate into support by the G8 for countries that decide to abolish user fees in their public sectors for maternal and child-health services, HIV/AIDS, tuberculosis, and malaria. The G8 should provide clear directions to their own aid organisations and multilateral development agencies to forge a coherent approach to the question of public financing for health, especially for the choice between taxation and financing for social health insurance, which should depend on country circumstances.

The G8 should respond with three actions:

- Complement its efforts on increasing money for health with efforts to improve the value of health spending through support for better country-led health financing and systems policies
- Build on the existing consensus among technical experts with an explicit G8 commitment to prioritise support for country health financing policies that place public financing for health, in the form of tax financing or social health insurance, as the core of efforts to expand coverage for poor people and vulnerable groups in society
- Invest in the ability of developing country partners to improve financing policies. This approach will need increased investments in building national capacity for assessment of health-systems policy and in the mechanisms to understand and share the lessons of best practice countries

gained increasing persuasiveness and priority on the global health agenda.<sup>19</sup> It is imperative for the WHO, as the world's principal agency for global health policy making, to clarify and strengthen its core functions and improve its technical and organisational competencies.

Into this increasingly crowded area of global health has emerged a new informal and self-appointed entity known as the Health 8 or H8—comprised of WHO, the World Bank, GAVI, the Global Fund, UNICEF, UNFPA, UNAIDS, and the Bill & Melinda Gates Foundation. This meeting of global health leaders resembles that of global political leaders, providing a setting for discussion with restricted organisational capacity. At their inaugural meeting on July 19, 2007, the H8 leaders stated they “met informally” with the objective of “strengthening their collaboration in global health in order to achieve better health outcomes in

developing countries”.<sup>20</sup> Among the five themes discussed was the renewed interest in health systems.

The H8 leaders agreed that strengthening of health-system performance should be judged by its ability to deliver health outcomes, and they urged WHO and the World Bank “to fast-track the completion of the normative framework for health systems strengthening”.<sup>20</sup> The H8 thus creates an opportunity for enhanced communication, collaboration, and consensus-building for global health policy, including interactions with the G8.

The G8 has discussed global health issues at every meeting since 1996, according to a systematic analysis of the G8 and governance of global health.<sup>21</sup> The study found that the G8 has emerged as an “effective, high-performing centre of global health governance across the board”.<sup>21</sup> Japanese and Italian leadership have been important in

pushing the G8 to address global health issues, as exemplified by the Japanese initiative at the 2000 Kyushu-Okinawa to propose the Global Fund, which was then endorsed by G8 leaders at the 2001 Genoa summit under Italian leadership.

The nature of the G8 provides a highly personal, visible, and flexible mechanism for addressing global health policy making. The yearly meeting of national leaders allows for focused discussions with key stakeholders from outside the G8. For example, the G8 has included four core African partners at several meetings to discuss crucial issues of development and health. The emergence of the G8 in the governance of global health indicates the need for a more flexible mechanism than the existing multilateral health institutions to tackle emerging global health threats that need collective action. The G8 can think and act outside the existing global health bureaucracies and stakeholders. Thus it is uniquely positioned, through its power and vision, to help shift the global health agenda and priorities. At the same time, however, the G8 does not have its own implementation capacity and therefore has to depend on existing organisations or new entities for action.

The rise of the G8 and H8 in global health indicates a power shift in global politics. The globalisation of health issues means that common agendas are nationally set, so individual states cannot focus solely on their own geopolitical issues. Nation states with the ability to deal with challenges across nations will consequently greatly affect international politics. The G8 process encourages the eight political leaders to engage in global issues while providing incentives for stakeholders outside the G8—in the private sector, non-governmental organisations, and international agencies—to find ways in which to affect what happens inside the G8. This power shift is restructuring the architecture of global health policy making. H8 members are seeking to define their own roles in the new architecture. But where this restructuring will lead remains uncertain.

The emergence of global health as foreign policy has contributed to the rising interest of the G8. In March, 2007, foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand issued the Oslo Ministerial Declaration on the “urgent need to broaden the scope of foreign policy” to include global health.<sup>22</sup> They declared, “Together, we face a number of pressing challenges that require concerted responses and collaborative efforts. We must encourage new ideas, seek and develop new partnerships and mechanisms, and create new paradigms of cooperation.”<sup>22</sup> Foreign ministers’ initiative on global health calls for new forms of global governance to address health challenges and asserts a set of common values, including, “Every country needs a robust and responsive health system.”<sup>22</sup> The UK and Japanese Governments have embraced the strategy of global health as foreign policy with particular enthusiasm.<sup>23,24</sup>

### Panel 3: Towards collective action in health information (Kenji Shibuya)

Global interest in health information—and its metrics and assessment—is exemplified by the Millennium Development Goals (MDGs) and performance-based financing. This unprecedented interest has increased the pressure on countries and agencies to generate high-quality and timely data.<sup>31</sup> Without sound measurements to benchmark achievements and the efficiency of resource use, debates on priorities for health and what does or does not work tend to be based more on ideology than on evidence.

At the Toyako G8 Summit, the *Report of the G8 Health Experts Group* recognised the need for action to create appropriate monitoring and assessment of health systems so that policy makers could base their decisions on accurate health information.<sup>2</sup>

Health agencies and countries are actually generating increasing amounts of data.<sup>31</sup> Such data, however, do not necessarily provide comprehensive information for users, nor do they answer crucial questions posed by the global health community. We do not know whether well intentioned programmes do more good than harm until sound evidence is provided. The lack of effective and efficient health monitoring and assessment can be attributed to the following six factors.

First, the quantity and quality of data relevant for monitoring progress and assessing health systems is poor and has had substantial underinvestment in the past decade.<sup>31,32</sup> Second, the efforts for correcting the scarcity of data have led to proliferation of indicators, inconsistent frameworks, and fragmented activities among stakeholders.<sup>33</sup> Third, work is duplicated across agencies, and these agencies compete to fill the same gaps rather than maximising their comparative advantages.<sup>33,34</sup> Fourth, progress towards making data openly accessible remains slow.<sup>35</sup> Fifth, an obvious trade-off exists between country ownership, as a core component of the Paris Declaration,<sup>36</sup> and independent assessments. Despite a growing trend for performance-based disbursement, agencies are still vulnerable to political pressure from recipient countries.<sup>37</sup> Finally, many countries lack both the incentives and capacity to collect, share, analyse, and interpret better quality data.<sup>35</sup>

(Continues on next page)

### Global health and human security

The agenda for global health thus encompasses more than just population health; it now intersects with foreign policy, economic development, and human rights and human dignity. Countries ignore these broader dimensions at their own risk. Such people-centred approaches have converged into the notion of human security over the past decade. Human security complements the traditional idea of national security and has been defined as protection of “the vital core of all human lives in ways that enhance human freedoms and human fulfillment”,<sup>25</sup> with particular attention to freedom from want and from fear. Human security is achieved through two types of strategies: those that shield people from crucial and pervasive threats (protection strategies) and those that enable people to develop the capacity to cope with difficult situations (empowerment strategies). This approach has particular relevance for health-system strengthening because human security focuses on individuals and communities, represents a demand-driven process, and seeks to promote a comprehensive view of how to improve overall wellbeing.

Japan is one of the strongest advocates for human security. This approach provides a context for reframing

(Continued from previous page)

The correction of such inefficiencies across the agencies, institutions, and countries will make global health metrics more useful and reliable, and leverage the comparative advantage of every stakeholder. Such efforts should focus on local capacity building through regional and global collective action since the ultimate goal of the global health metrics community is to establish a sustainable scheme to develop local capacity to collect high-quality data, monitor and assess health programmes and systems, and inform policy. Some conditionality on the use of pooled resources would be necessary to give incentives and improve capacities to collect better data within countries.<sup>38</sup>

In view of the G8's unique role in global health, together with its commitment to accountability and the increasingly prominent role of health metrics and assessment in global health,<sup>32</sup> we recommend that, through a collective and multistakeholder approach, the G8 should focus on correcting the major inefficiencies in the current field of health metrics.

Implement a G8 yearly review to assess the G8's commitments to health systems and programmes:

- Define a standard set of metrics and measurement strategies for monitoring and assessment of aid effectiveness, health programmes, and systems
- Plan and assess future health-related activities by the G8 and partners with use of a common framework and metrics

Establish a digital commons with a network of global and regional centres of excellence to improve access to—and the quality of—datasets and analyses within countries and globally:

- Promote the principles of open access and data sharing in the public domain
- Develop a global databank for common indicators (starting with MDG targets, human resources, and resource tracking) and a data exchange and quality assurance mechanism
- Establish a Cochrane-type process for global health monitoring to generate empirical evidence for health policy

Pool resources for health metrics within countries and globally to create a global health metrics challenge:

- Develop capacity and create an incentive structure for countries and data producers to collect, share, analyse, and interpret better quality data
- Make health funding contingent upon third-party assessment that is compliant with agreed principles, including standard measurement strategy, data in the public domain, strengthening local capacity, and appropriate use of information technologies

See Online for webappendices 1–3

Japan's pacifism after World War 2, which is reaching a turning point under a new generation of leaders. Human security provides a conceptual foundation for a renewed Japanese pacifism and a new form of global citizenship. For the past decade, the Japanese Government has used global health as a starting point for its policy on human security and has given global health high priority on its foreign policy agenda.<sup>24</sup> Within the framework of human security, the global health agenda offers the opportunity to develop concrete strategies that can be implemented through both bilateral and multilateral agencies and through G8 processes.<sup>26</sup> The dual strategies embedded in human security—protection and empowerment within communities—are consistent with WHO's renewed commitment to primary health care and with Japan's efforts after World War 2 to strengthen its own national health system.

## Policy papers for the Toyako follow-up

To continue the momentum on health-system strengthening that was created by the Toyako summit, the Japanese Government asked that follow-up activities be pursued by the Working Group on Challenges in Global Health and Japan's Contributions (Takemi Working Group), and the Japan Center for International Exchange. The project prepared three policy papers on themes that were emphasised in the Toyako Framework for Action on Global Health: health workforce, health finance, and health information. The project has been undertaken outside the formal channels of government agencies (also known as a Track-2 diplomatic effort) but with the informal participation of Japan's ministries of health, finance, and foreign affairs plus representatives from H8 agencies, G8 governments, and civil society organisations. This Track-2 strategy provides flexibility in consideration of ideas and experts outside the conventional approach, while assuring collaboration with key stakeholders. The strategy is designed to identify innovative means to strengthen health systems that can gain acceptance by the G8 and relevant implementing agencies.

The policy papers address three necessary components to strengthen the performance of health systems. They cover topics that are important inputs to health systems: managers and policy makers need people, money, and data to make decisions about what a health system does. At the same time, health information also includes outputs, as assessments of different health-system activities (how money and people are used and what they produce in terms of health outputs and health outcomes). The three components are also related to each other: money is needed to hire people; these people work in the health system in which they collect, analyse, and interpret health information; and the data are used by people to decide how to spend more money. Panels 1–3 show the main findings and specific recommendations for G8 action from the three papers. The full papers are available as webappendices 1–3.

At an international conference held in Tokyo in early November, 2008, Margaret Chan, Director General of WHO, and Julio Frenk, the former Minister of Health for Mexico, presented their views for the proposals for G8 action to strengthen health systems. Summaries of their keynote talks are published as Comments along with this article.<sup>44,45</sup> The meeting was attended by the director of UNAIDS, with representatives from the World Bank, UNFPA, UNICEF, Global Fund, GAVI, many non-governmental organisations, and G8 health experts and academic specialists from around the world. The discussion provided input to revise the three policy papers and this overview.

## Discussion

The three papers on health workforce, health financing, and health information express several common themes

on global health policy. Although these three components (people, money, and data) do not constitute a complete model of health-system performance, they do represent areas that are high on the global health agenda and are important elements of any model. Here we draw attention to common themes and recommendations in the three policy papers.

First, all three papers stress the need for the G8 to address the quality of resource use and the quantity of resource provision. The papers agree on the need to make more effective use of existing resources in addition to the need for more resources from external and domestic sources. The G8, for example, could promote efforts to identify best practices and the conditions under which existing resources are most effectively used to improve the performance of health systems.

Second, all three papers call on the G8 to enhance country capacity and ownership to strengthen health systems. The G8 can help ensure that countries have adequate human and financial resources to collect, analyse, and interpret data and assess the performance of their own health system. The G8 can help countries build their capacity to know how to use their health-system resources most effectively.

Third, all three papers agree that the G8 should implement a yearly review for global health commitments, with a standard set of common measures to assess how resources are being provided and used to improve performance. Japan started the process for a yearly review of commitments at the Toyako summit; this process should be expanded and institutionalised.

The implementation of actions to strengthen health systems will require the G8 to move from summitry to accountability, and to collaboration with H8 organisations and national institutions (in both donor and recipient countries). Although the G8 summit, as an organisation, has restricted capacity to implement decisions, it can be very effective in reviewing important global problems, setting priorities for policy agendas, and raising money for specific activities. The G8–H8 relationship is still evolving, as is the nature of decision making within the H8 itself. Both entities are more informal networks than formal institutions. Thus, effective action by G8 to strengthen health systems will need some creative approaches for implementation globally and nationally. The G8 does not have the capacity to become a global health apex institution, but the G8's special leverage can help drive health-system strengthening forward in new ways.

The specific recommendations in the policy papers, therefore, adopt different strategies to strengthen health systems. Some seek to clarify and reinforce existing institutions and frameworks. Others seek to create new entities but without proposing a new global fund. We have sought innovative solutions to challenges for health systems, to articulate ideas not stated elsewhere,

including ideas that might be unpopular or uncomfortable for existing organisations. We aim to provoke creative thinking and action for health-system strengthening; yet we also seek to avoid unnecessary politicisation of the global health community, with a focus on substantive functions rather than political questions. Another overarching objective is to contribute to strengthening the capacity and clarifying the role of WHO in the global health setting.

These follow-up activities to the Toyako summit show a concerted effort by Japan and its partners to enhance its substantive contributions to global health policy making, rather than just providing financial donations. The nature of global challenges in many areas now outruns the capacity of institutions for global governance. This institutional gap represents both an opportunity and an obligation for the G8 countries, as a new leverage point for global health policy making. We have witnessed a substantial growth in worldwide flows of health workers, finances, and data. The G8 summit provides a setting of personal engagement by national leaders who can shape policy responses to tackle crucial problems. This project has identified concrete actions, in the context of the revived approaches of human security and primary health care, which can be pursued by the G8 nations. These actions will need collaboration with the H8 organisations, other interested high-income and middle-income countries, and recipient countries.

The global financial crisis makes it all the more important for the G8 to address health-system strengthening and deliver on existing commitments to global health. Fears are increasing about potential cutbacks from high-income countries in official development assistance, as well as private contributions to non-governmental organisations.<sup>46</sup> But, as the UK Prime Minister Gordon Brown stated in September, 2008, the international community should do more, not less, to help the world's poorest people in this time of economic crisis.<sup>47</sup> The G8 can play a catalytic role in assuring that pledged funds are delivered in ways that create tangible benefits for the poorest people. The G8 can also work to protect government budgets for social welfare in developing countries from being tightened by the financial crisis, and to avoid a repetition of the financial cutbacks that occurred under the structural adjustment and economic turmoil of the 1980–90s.

#### Conflict of interest statement

We declare that we have no conflict of interest.

#### Acknowledgments

We thank Susan Hubbard, Laura Frost, Masamine Jimba, Scott Gordon, Michael Goroff, Sofia Gruskin, Ravi Rannan-Eliya, Marc Roberts, and Kenji Shibuya for their comments on earlier drafts of this report; Meghan K Reidy for research assistance; and the Bill & Melinda Gates Foundation, the Rockefeller Foundation, and the government of Japan for the generous support that they have provided to this project. An earlier version of this paper was presented at the International Conference on Global Action for Health System Strengthening in Tokyo, Nov 3–4, 2008; we appreciate the comments received from many participants at the conference.

References

- 1 Summary of the Hokkaido Toyako Summit. Ministry of Foreign Affairs of Japan. July 9, 2008. <http://www.mofa.go.jp/policy/economy/summit/2008/news/summary.html> (accessed Dec 19, 2008).
- 2 G8 Health Experts Group. Toyako framework for action on global health. Toyako, Japan. July 8, 2008. [http://www.g8summit.go.jp/doc/pdf/0708\\_09\\_en.pdf](http://www.g8summit.go.jp/doc/pdf/0708_09_en.pdf) (accessed Oct 15, 2008).
- 3 Reich MR, Takemi K, Roberts MJ, Hsiao WC. Global action on health systems: a proposal for the Toyako G8 summit. *Lancet* 2008; **371**: 865–69.
- 4 Sepúlveda J, Bustreo F, Tapia R, et al. Improvement of child survival in Mexico: the diagonal approach. *Lancet* 2006; **368**: 2017–27.
- 5 Ooms G, Van Damme W, Baker BK, et al. The 'diagonal' approach to global fund financing: a cure for the broader malaise of health systems? *Global Health* 2008; **4**: 6.
- 6 Uplekar M, Raviglione MC. The 'vertical-horizontal' debates: time for the pendulum to rest (in peace)? *Bull World Health Organ* 2007; **85**: 413–17.
- 7 Atun RA, Bennett S, Duran A. When do vertical (stand-alone) programmes have a place in health systems? Policy Brief. Copenhagen: WHO Regional Office for Europe, 2008.
- 8 Naimoli JF. Global health partnerships in practice: taking stock of the GAVI Alliance's new investment in health systems strengthening. *Int J Health Plann Manage* 2008; **21**: 1–23.
- 9 WHO, UNICEF. Primary health care: report of the International Conference on Primary Health Care. Alma-Ata, USSR. Sept 6–12, 1978. Geneva: World Health Organization, 1978.
- 10 WHO. The world health report 2008—primary health care: now more than ever. Geneva: World Health Organization, 2008.
- 11 Chan M. Return to Alma Ata. *Lancet* 2008; **372**: 865–66.
- 12 WHO. Health and the millennium development goals. Geneva: World Health Organization, 2005.
- 13 Mills A, Rasheed F, Tollman S. Strengthening health systems. In: Jamison DT, Breman JG, Measham AR, et al, eds. Disease control priorities in developing countries, 2nd edn. New York: Oxford University Press, 2006: 87–102.
- 14 WHO. World health report 2000—health systems: improving performance. Geneva: World Health Organization, 2000.
- 15 WHO. Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization, 2007.
- 16 World Bank. Healthy development: the World Bank strategy for health, nutrition and population results. Washington, DC: The World Bank, 2007.
- 17 Roberts MJ, Hsiao W, Berman P, Reich MR. Getting health reform right: a guide to improving performance and equity. New York: Oxford University Press, 2004.
- 18 Horton R. WHO: the casualties and compromises of renewal. *Lancet* 2002; **359**: 1605–11.
- 19 Select Committee on Intergovernmental Organisations, House of Lords, UK. Diseases know no frontiers: how effective are intergovernmental organisations in controlling their spread? (HL Paper 143–I). London: Authority of the House of Lords, 2008.
- 20 WHO. Informal Meeting of Global Health Leaders. Geneva: World Health Organization, 2007. <http://www.who.int/dg/reports/31072007/en/index.html> (accessed Oct 13, 2008).
- 21 Kirton JJ, Mannell J. The G8 and global health governance. Paper prepared for a conference on Global Health Governance: Past Practice: Future Innovation, sponsored by the Centre for International Governance Innovation, the Institute of Population Health, University of Ottawa, the G8 Research Group, Munk Centre for International Studies, University of Toronto, and Rotary International, Ottawa and Waterloo; Nov 10–12, 2005.
- 22 Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand. Oslo Ministerial Declaration—global health: a pressing foreign policy issue of our time. *Lancet* 2007; **369**: 1373–78.
- 23 Horton R. Health as an instrument of foreign policy. *Lancet* 2007; **369**: 806–07.
- 24 Koumura M. Global health and Japan's foreign policy. *Lancet* 2007; **370**: 1983–85.
- 25 Commission on Human Security. Human security now: protecting and empowering people. New York: United Nations, 2003.
- 26 Takemi K, Jimba M, Ishii S, Katsuma Y, Nakamura Y, on behalf of the Working Group on Challenges in Global Health and Japan's Contributions. Human security approach for global health. *Lancet* 2008; **372**: 13–14.
- 27 Joint Learning Initiative. Human resources for health: overcoming the crisis. Cambridge: Harvard University Press, 2004.
- 28 WHO. World health report 2006: working together for health. Geneva: World Health Organization, 2006.
- 29 WHO. The Kampala declaration and agenda for global action. Geneva: World Health Organization, 2008. [http://www.who.int/workforcealliance/forum/2\\_declaration\\_final.pdf](http://www.who.int/workforcealliance/forum/2_declaration_final.pdf) (accessed Dec 19, 2008).
- 30 Bossert T, Barnighausen T, Mitchell A, Bowser D, Gedick G. Assessing financing, education, management and policy context: strategic planning for human resources for health. Geneva: World Health Organization, 2007.
- 31 Boerma JT, Stansfield SK. Health statistics now: are we making the right investments? *Lancet* 2007; **369**: 779–86.
- 32 Lopez AD, AbouZahr C, Shibuya K, Gollogly L. Keeping count: births, deaths, and causes of death. *Lancet* 2007; **370**: 1744–46.
- 33 Murray CJ. Towards good practice for health statistics: lessons from the Millennium Development Goal health indicators. *Lancet* 2007; **369**: 862–73.
- 34 Murray CJL, Lopez AD, Wibulpolprasert S. Monitoring global health: time for new solutions. *BMJ* 2004; **329**: 1096–100.
- 35 Chandramohan D, Shibuya K, Setel P, et al. Should data from demographic surveillance systems be made more widely available to researchers? *PLoS Med* 2008; **5**: e57.
- 36 Boerma T, Bos E, Walford V, Bryce J, AbouZahr C. A common framework for monitoring performance and evaluation of the scale-up for better health, 2008. [http://www.internationalhealthpartnership.net/pdf/IHP\\_Monitoring\\_and\\_Evaluation\\_EN\\_FINAL\\_%20June\\_2008.pdf](http://www.internationalhealthpartnership.net/pdf/IHP_Monitoring_and_Evaluation_EN_FINAL_%20June_2008.pdf) (accessed Oct 1, 2008).
- 37 Lim S, Stein DB, Charrow A, Murray CJL. Tackling progress towards universal childhood immunisation and the impact of global initiatives: a systematic analysis of three-dose diphtheria, tetanus, and pertussis immunisation coverage. *Lancet* 2008; **372**: 2031–46.
- 38 Shibuya K. Conditional cash transfer: a magic bullet for health? *Lancet* 2008; **371**: 789–91.
- 39 WHO. World Health Report 2007—a safer future: global public health security in the 21st century. Geneva: World Health Organization, 2007.
- 40 Gottret P, Schieber G. Health financing revisited: a practitioner's guide. Washington: World Bank, 2006.
- 41 van Doorslaer E, O'Donnell O, Rannan-Eliya RP, et al. Effect of payments for health care on poverty estimates in 11 countries in Asia: an analysis of household survey data. *Lancet* 2006; **368**: 1357–64.
- 42 WHO. Federal Ministry for Economic Cooperation and Development. Report on the Technical Meeting on Providing for Health Initiative, 29–30 Nov 2007. Bonn: International Health Partnership, 2007.
- 43 IMF. Letter from IMF Managing Director Dominique Strauss-Kahn to the G-20 Heads of Governments and Institutions, Nov 6, 2008. Washington: International Monetary Fund, 2008.
- 44 Chan M. Primary health care as a route to health security. *Lancet* 2009; published online Jan 15. DOI:10.1016/S0140-6736(09)60003-9.
- 45 Frenk J. Strengthening health systems to promote security. *Lancet* 2009; published online Jan 15. DOI:10.1016/S0140-6736(09)60002-7.
- 46 Mitnick J. Financial crisis threatens aid for world's poorest. *Christian Science Monitor*, Oct 15, 2008; 4. <http://www.csmonitor.com/2008/1015/p04s02-wome.html> (accessed Oct 20, 2008).
- 47 United Nations. Press conference by Secretary-General, Prime Minister of United Kingdom, Chair of Gates Foundation on Millennium Goals High-Level Event. New York: United Nations Department of Public Information, 2008. [http://www.un.org/News/briefings/docs/2008/080925\\_MDG\\_Event.doc.htm](http://www.un.org/News/briefings/docs/2008/080925_MDG_Event.doc.htm) (accessed Oct 20, 2008).