Copyediting by Susan Hubbard and Kimberly Ashizawa.
Cover and typographic design by Patrick Ishiyama.

Printed in Japan.
ISBN 4-88907-127 X C

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# List of Abbreviations

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| AIDS | acquired immune deficiency syndrome |
| CBHI | community-based health insurance |
| DHS | Demographic and Health Surveys |
| EHRP | Emergency Human Resources Program (Malawi) |
| EU | European Union |
| G8 | Group of Eight |
| GAVI | Global Alliance for Vaccines and Immunization |
| GDP | gross domestic product |
| GHWA | Global Health Workforce Alliance |
| Global Fund | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| H8 | Health Eight |
| HEP | Health Extension Program (Ethiopia) |
| HEW | health extension workers (Ethiopia) |
| HIV | human immunodeficiency virus |
| HRH | human resources for health |
| ICN | International Council of Nurses |
| IHP+ | International Health Partnership and Related Initiatives |
| ILO | International Labour Organization |
| IMF | International Monetary Fund |
| JCIE | Japan Center for International Exchange |
| JLI | Joint Learning Initiative |
| MDG | Millennium Development Goal |
| MMR | maternal mortality ratio |
| NGO | nongovernmental organization |
| NHS | national health services |
| ODA | official development assistance |
| OECD | Organisation for Economic Co-operation and Development |
| P4H | Providing for Health |
| PEPFAR | President's Emergency Plan for AIDS Relief (United States) |
| PHC | primary healthcare |
| SHI | social health insurance |
| U5MR | under-five mortality rate |
| UN | United Nations |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| USAID | US Agency for International Development |
| WHO | World Health Organization |
| WHS | World Health Survey |

# The G8 and Global Health: Emerging Architecture from the Toyako Summit

*Keizo Takemi and Michael R. Reich**

The declaration of the G8 Toyako Summit, held in Japan in early July 2008, covered global health issues under the topic of "Development and Africa." The official summary made the following statement on health:

> 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. Furthermore, regarding the G8 commitment to provide $60 billion for health agreed at last year's G8 Heiligendamm Summit, the G8 leaders agreed to provide the said amount over five years. In addition, with regard to malaria prevention, leaders agreed to provide 100 million mosquito nets by the end of 2010.[1]

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 a number of critical issues in global health.[2] The report reflected growing policy attention to health system strengthening by Japan and the global health community more broadly.[3] Prior to the summit, Keizo Takemi and a group of leaders from diverse sectors in Japan organized a Working Group on Challenges in Global Health and Japan's Contributions,

* The authors appreciate comments on earlier drafts of their paper received from Susan Hubbard, Laura Frost, Masamine Jimba, Scott Gordon, Michael Goroff, Sofia Gruskin, Ravindra Rannan-Eliya, Marc Roberts, and Kenji Shibuya. They also benefited from the research assistance provided by Meghan Reidy.

run by the Japan Center for International Exchange (JCIE)—a nonprofit and nongovernmental organization in international affairs and global issues—and involving key actors from government ministries, Japan's development agencies, academia, and NGOs. At the summit's conclusion, the government of Japan decided it needed a mechanism for following up on the new policy initiatives to which the G8 leaders had committed and engaged in a Track 2 process with the study group and JCIE to explore policy options. Those efforts were designed to identify action-oriented policy recommendations for the G8 on health system strengthening and to maintain momentum and continuity for future G8 summits, especially the 2009 meeting to be hosted by Italy.

This chapter provides an overview of Japan's activities on global health to follow up on the Toyako Summit declaration and presents the context for three chapters with policy recommendations for G8 action. Below, 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 chapters and conclude with a discussion of future directions.

## A Growing Focus on Health Systems

The world is currently experiencing a shift in the global health agenda from an emphasis on disease-specific approaches to a focus on health system strengthening. These two approaches are often called the "vertical" and "horizontal" approaches to health improvement. In this debate, some have argued for a third compromise strategy that would combine the two into a "diagonal approach."[4] Others have called for this debate to "rest in peace."[5] We believe that a better balance needs to be found between the two approaches so that efforts at fighting specific diseases and strengthening health systems can support each other more effectively. But balance is difficult to define with precision, especially when the knowledge base is thin and contested about how vertical programs affect horizontal efforts; there is no good evidence that this is a zero-sum game, where improving one necessarily injures the other. Yet, clearly the disease-focused programs are nervous 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 consequences.[6] The disease-specific approaches have contributed greatly to health improvement, particularly since existing multilateral and national health agencies could not deal with the devastating

effects of diseases like HIV/AIDS in many developing countries. But, now recipient countries are confronted with a fragmented array of uncoordinated disease control programs promoted by multiple donors. The opportunity costs of servicing the disease-specific programs have been recognized as reducing the effectiveness of health ministries. In addition, the disease-specific programs attract financial and human resources away from government agencies and may be contributing to a weakness of health systems. Two of the major disease-specific programs—the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the Global Alliance for Vaccines and Immunization (GAVI) Alliance, a consortium of organizations to promote immunization and vaccination—have launched significant efforts to strengthen health systems in recipient countries. While those programs have encountered problems in implementation, they nonetheless reflect recognition of the need to develop both disease-specific and health-system-strengthening approaches.[7]

A second factor contributing to the focus on health systems is recent efforts by the World Health Organization (WHO) to restore policies for primary healthcare (PHC). The PHC approach was officially launched on the global stage through the Alma Ata Declaration of 1978.[8] Implementation of PHC at the country level, however, confronted many challenges in poor countries. The WHO is now seeking to resurrect the PHC approach with the *World Health Report 2008*, issued in October on the 30th anniversary of the Alma Ata Conference,[9] and with a renewed emphasis on the principles of universal coverage, people-centered approaches, and effective delivery of primary care.[10]

A third factor is growing recognition about the difficulties that health system weaknesses present in achieving the Millennium Development Goals (MDGs).[11] Problems in health system performance are considered major causes for the delays in achieving key targets of the health-related MDGs—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 particularly pronounced in countries in sub-Saharan Africa.

Fourth, the growing demand for aid effectiveness and donor harmonization at the country level, based on the principles of the Paris Declaration, reflects concerns about system-wide impacts 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 impacts (such as effective coverage and improved health). Yet, there is limited evidence that previous attempts to achieve strong donor coordination (through poverty reduction strategies and sector-wide approaches) have helped improve health system performance.

Advocates of single-disease control programs are concerned that the renewed emphasis on health systems could move resources away from their programs and undermine progress achieved to date. The risk of allowing infectious diseases to 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.

## Health System Strengthening

No consensus exists on the operational definition of health system strengthening. Several competing approaches are currently popular in the global health community, promoted by different agencies.[12] We briefly present several of the main approaches here.

The WHO's *World Health Report 2000* raised a broad international debate on issues related to health systems.[13] The report defines a health system as including "all the activities whose primary purpose is to promote, restore, or maintain health." The main focus of the report and the ensuing debate, however, was on how to measure different aspects of health systems rather than on how to strengthen health system performance.

The WHO presents its updated approach to health system strengthening in *Everybody's Business*. This 2007 report, however, 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."[14] In addition, the report's framework is not easy to apply in practice. The book identifies six "building blocks" for a health system: service delivery, health workforce, information, medical technologies, financing, and leadership/governance. But it is not clear how they fit together, how they relate to one another, or how one builds a health system with the blocks.

The World Bank describes its approach to health system strengthening in its 2007 strategy document on "healthy development."[15] The document recognizes that the bank needs a "collaborative division of labor with global partners" (p. 18), including the WHO, UNICEF, and the United Nations Population Fund (UNFPA), which are viewed as providing technical expertise in disease control, human resource training, and service delivery. The 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 macroeconomics

and health. A major challenge for the bank is implementing its strategy at a time when the bank's own financing is becoming a smaller proportion of global health funds, when the substantive problems encompass more than the bank's areas of comparative advantage, and when the previous bank strategy of 1997 has not been effectively evaluated (p. 38).

With the growth of interest in health system strengthening, the world now confronts a proliferation of models, strategies, and approaches. The WHO and World Bank efforts represent just two approaches; other frameworks also exist. How do we evaluate these different conceptual models and select an appropriate one? Unfortunately, there is no cookie-cutter approach to health system strengthening, no single formula that can be applied to all countries. Improving health system performance is a process, and that process must be adapted to the situation of each country—its political and economic circumstances, its social values, and its national leadership.

From a policymaker's perspective, a strategic framework on health system strengthening should help in deciding what to do, how to do it, and what results to expect. In addition, the framework should relate to appropriate theories while it helps to produce practical results. The framework should also provide guidance on how to implement the ideas in real-world political conditions and how to relate the objectives to different ethical perspectives. We believe that one approach to health system strengthening proposed by Marc J. Roberts, William Hsiao, Peter Berman, and Michael R. Reich[16] takes important steps in meeting these criteria and can help sort through the diverse concepts promoted by different agencies.

## Global Health Architecture and the G8

### *The G8's role in global health*

The global health architecture is undergoing fundamental structural changes. As noted in the World Bank's strategy document, the once-dominant players are increasingly marginal and less influential. This is true for both the World Bank's prior financial dominance and the WHO's prior normative dominance. Global health policymaking has become a multi-stakeholder process but without an explicit institutional process and with competition and confusion at global and national levels. The proliferation of overlapping yet opposing frameworks for health system strengthening reflects this disorganization. We believe that

the G8 can play a major role in catalyzing 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 declining role of the 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. At the same time, public-private collaboration has become a maxim of health policy at both the global and country levels.

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

Calls to reform the WHO have a long history. Each new director-general has pursued change at the organization, but implementation of new ideas remains a challenge.[17] Recent calls for the reform of the WHO reflect broader attempts to reform the UN, and these appeals have gained increasing persuasiveness and priority on the global agenda.[18] It is imperative for the WHO, as the world's principal agency for global health policymaking, to clarify and strengthen its core functions and improve its technical and organizational competencies.

Into this increasingly crowded field of global health has emerged a new entity known as the Health 8 or H8—comprised of the WHO, the World Bank, GAVI, the Global Fund, UNICEF, the UNFPA, UNAIDS, and the Gates Foundation. This meeting of global health leaders resembles the meeting of global political leaders, providing a locus for discussion with limited organizational 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."[19] Among the five themes discussed was "the renewed interest in health systems."

The H8 leaders agreed that health system strengthening should be judged by its ability to deliver health outcomes, and they urged the WHO and the World Bank "to fast-track the completion of the normative framework for health systems strengthening." The H8 thus creates an opportunity for enhanced

communication, collaboration, and consensus building on global health policy, including interactions with the G8.

The national leaders of the major market economies began meeting on an annual basis in 1975, creating a new generation of global institutions. The G8 has considered global health issues at every meeting since 1996, according to a systematic analysis of the G8 and global health governance.[20] The study found that the G8 has emerged as an "effective, high-performing centre of global health governance across the board." Japanese and Italian leadership have been important in pushing the G8 to address global health issues, exemplified by the 2000 Kyushu-Okinawa Summit that led to the formation of the Global Fund.

The nature of the G8 provides a highly personal, visible, and flexible mechanism for addressing global health policymaking. The once-a-year meeting of national leaders allows for focused discussions with key stakeholders from outside the G8 circle. For example, the G8 has included four core African partners at several meetings to discuss critical issues of development and health. The emergence of the G8 in global health governance reflects the need for a more flexible mechanism than the existing multilateral health institutions in order to tackle emerging global health threats that require collective action. The G8 can think and act outside of the existing global health bureaucracies and stakeholders and is thus uniquely positioned, through its power and vision, to help shift the global health agenda and priorities. Yet, at the same time, the G8 does not have its own implementation capacity and therefore must depend on existing organizations or new entities for action.

The rise of the G8 and the H8 in global health reflects a power shift in global politics. The globalization of health issues means that common agendas stretch across national boundaries, so individual states cannot focus solely on their own geopolitical issues. Nation states with the ability to deal with transnational challenges will consequently have more influence in international politics. The G8 process encourages the eight political leaders to tackle global issues and at the same time provides incentives for stakeholders outside the G8—in the private sector, NGOs, and international agencies—to find ways to influence what happens inside the G8. This power shift is restructuring the architecture of global health policymaking. The 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, the 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. 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."[21] This initiative by foreign ministers on global health calls for new forms of global governance to address health challenges and asserts a set of common values, including the belief that "every country needs a robust and responsive health system." The UK and Japanese governments have embraced the global-health-as-foreign-policy strategy with particular enthusiasm.[22]

### *Global health and human security*

The agenda for global health thus encompasses more than population health; it now intersects with foreign policy, economic development, and human rights and human dignity. Nations ignore these broader dimensions at their own peril. Such people-centered approaches have converged into the concept of human security over the past decade. Human security complements the traditional concept 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,"[23] with particular attention to freedom from want and freedom from fear. Human security is achieved through two kinds of strategies: protection strategies that shield people from critical and pervasive threats, and empowerment strategies that enable people to develop the capacity to cope with difficult situations. 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 well-being.

Japan is one of the strongest advocates for human security. This approach provides a context for reframing Japan's postwar pacifism, 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 an entry point for its policy on human security and given global health high priority on its foreign policy agenda.[24] Within the human security framework, the global health agenda offers a field for developing concrete strategies that can be implemented through both bilateral and multilateral agencies and through G8 processes.[25] The dual strategies embedded in human security—protection and empowerment at the community level—are consistent with the WHO's

renewed commitment to PHC and with Japan's postwar efforts to strengthen its own national health system.

## Policy Recommendations for the Toyako Follow-Up

To continue the momentum on health system strengthening created by the Toyako Summit, the Japanese government asked for policy recommendations on how to follow up on the commitments made in Toyako, encouraging the Takemi Working Group and JCIE to launch a new project to explore concrete recommendations. Since its inception, the Takemi Working Group has enjoyed the participation of leaders of diverse sectors in Japan, including the strong continuing involvement of the three relevant government ministries: foreign affairs; health, labor, and welfare; and finance. The project prepared three policy papers on themes highlighted in the Toyako Framework for Action on Global Health: health workforce, health finance, and health information. The project has been conducted outside the formal channels of government agencies as a Track 2 diplomatic effort with the informal participation of Japan's ministries of health, finance, and foreign affairs, plus representatives from H8 agencies, G8 governments, and civil society organizations. This Track 2 strategy provides flexibility for the project organizers to listen to various experts and consider ideas outside the conventional wisdom, while assuring collaboration with key stakeholders. The strategy is designed to identify innovative approaches to health system strengthening that can gain acceptance by the G8 and the relevant implementing agencies.

The chapters—on people, money, and data—address three necessary components of health system strengthening. They cover topics that are important inputs to health systems: managers and policymakers need people, money, and data to make decisions on what a health system should do. At the same time, health information is an output, providing 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 required to hire people; those people work in the health system where they collect, analyze, and interpret health information; and the data are used by people to decide how to spend more money. The chapters' main findings and specific recommendations for G8 action outlined below.

*Health workforce*

Human resources for health has been a long-standing concern in health planning and management, and there are currently monumental shortages of health workers around the world. But Professor Masamine Jimba, who heads the research team on health workforce, identifies other major challenges beyond the sheer number of health workers, including inadequate payment, motivation, training, and supervision, as well as poor working environments. Professor Jimba also identifies a massively unequal distribution of health workers within and among countries and across specialties and skills. In response, his paper recommends three major actions by the G8 to address these problems:

1 Strengthen the capacity of countries to plan, implement, and evaluate health workforce programs so that they can more effectively use the existing health workforce and implement the G8 commitments
   1.1 Develop mechanisms for evaluating health workforce progress at the country level
   1.2 Identify ways to change macroeconomic policies to reduce constraints on expanding the health workforce
   1.3 Strengthen international networks of higher education institutions to provide access to health and medical education in areas with limited resources
2 Address the demand-side causes of international health worker migration
   2.1 Clean their own houses by increasing the number of health workers in their own countries using their own resources
   2.2 Support the WHO code of practice to address migration issues
   2.3 Seek practical solutions that protect both the right of individuals to seek employment through migration and the right to health for all people
3 Conduct an annual review of actions by G8 countries to improve the health workforce
   3.1 Assess what the G8 countries are doing, what has worked, and evidence to support this, using a standard set of common measures
   3.2 Use this review to evaluate how health systems are performing, to identify gaps in financing and information, to develop evidence-based best practices, and to increase knowledge on how to improve health system performance through strengthening of human resources, as well as to see how well G8 countries are carrying through on what they have pledged to do

### *Health financing*

There are no fully accurate estimates of health financing in developing countries, but recent trends show that external and domestic sources of funding for health have been increasing. Yet, in his chapter on this topic, Dr. Ravindra P. Rannan-Eliya emphasizes that "more money has not necessarily meant better results." Some countries are able to achieve better health system performance with limited financial resources, while others that have made high investments in health have been less successful. This wide variation in country performance provides an opportunity for understanding the conditions under which some health systems work better with limited financing. There is a growing global consensus that public financing represents an important necessary condition, although the form of public financing (i.e., tax financing versus social health insurance) remains a point of debate. Better performance also depends on how the available funds are used and how health system coverage is expanded to hard-to-reach populations. Dr. Rannan-Eliya recommends three major actions by the G8 to address these challenges of financing for health systems in the developing world:

1. Complement 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.
2. Build on the existing consensus among technical experts with an explicit G8 commitment to prioritize support for country health financing policies that place public financing for health, in the form of tax financing and/or social health insurance, at the core of efforts to expand coverage for poor people and vulnerable groups in society.
3. Invest in the ability of developing country partners to make better financing policies. This will require increased investments in building national capacity for health systems policy assessment and in the mechanisms to understand and share the lessons of best practice countries.

### *Health information*

The chapter on health information, written by Professor Kenji Shibuya, identifies two major types of challenges in this area: technical and allocative inefficiencies. In the former, he explains that appropriate data do exist but are not used by policymakers or policy analysts, either because they do not have access to the information or because they do not have the capacity to analyze and

use the data to answer questions about health system performance. Professor Shibuya describes the allocative inefficiency as uncoordinated data collection and compilation without well-defined measurement strategies. To correct these inefficiencies, he recommends three major actions by the G8:

1 Implement a G8 annual review to assess the G8's commitments to health systems and programs
   1.1 Define a standard set of metrics and measurement strategies for monitoring and evaluating aid effectiveness, health programs, and systems
   1.2 Plan and assess future health-related activities by the G8 and its partners using a common framework and metrics
2 Establish a digital commons using a network of global and regional centers of excellence to improve access to—and the quality of—datasets and analyses at the country and global levels
   2.1 Promote the principles of open access and data sharing in the public domain
   2.2 Develop a global databank for common indicators (starting with MDG targets, human resources, and resource tracking) and a data exchange and quality assurance mechanism
   2.3 Establish a Cochrane-type process for global health monitoring to generate empirical evidence for health policy
3 Pool resources for health metrics at the global and country levels to create a Global Health Metrics Challenge
   3.1 Develop capacity and create an incentive structure for countries and data producers to collect, share, analyze, and interpret better-quality data
   3.2 Make health funding contingent upon third-party evaluation that is compliant with agreed principles, including developing a standard measurement strategy, putting data in the public domain, strengthening local capacity, and making appropriate use of information technologies
   3.3 In countries with incomplete or inexistent civil registration, prioritize development of civil registration systems
   3.4 Invest in a series of nationally representative household surveys for multiple diseases and risk factors

## Discussion

The three chapters on health workforce, health financing, and health information express several common themes on global health policy. While 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.

First, all three chapters stress the need for the G8 to address the quality of resource use as well as the quantity of resource provision. The authors agree on the need to make more effective use of existing resources (people, money, and data) in addition to the need for more resources from both external and domestic sources. The G8, for example, could promote efforts to identify best practices and the conditions under which existing resources are effectively used to improve health system performance.

Second, all three chapters call on the G8 to enhance country capacity and ownership for health system strengthening. The G8 can help ensure that countries have adequate human and financial resources in order to collect, analyze, and interpret data and evaluate their own health system performance. The G8 can help countries build their capacity to use their health system resources more effectively.

Third, all three chapters agree that the G8 should implement an annual review on global health commitments, with a standard set of common measures to assess how resources are being provided and used to improve health system performance. Japan started the process for an annual review of commitments at the Toyako Summit; this process should be expanded and institutionalized.

Actually strengthening health systems will require the G8 to move from summitry to accountability, and it will require collaboration with H8 organizations and national institutions in both donor and recipient countries. The G8 Summit is a thin body, effective in reviewing critical global problems and setting priorities for global policy agendas. The G8-H8 relationship is still evolving, as is the nature of decision making within the H8 itself. Both entities are informal networks rather than formal institutions. As a result, effective G8 action on health system strengthening will require creativity at the global and national levels and more interactions across levels. The G8 does not have the capacity to become a global health apex institution, but the G8's special leverage can help move health system strengthening forward in new ways.

The specific recommendations, therefore, adopt different strategies on health system strengthening. Some seek to clarify and strengthen existing institutions and frameworks. Others seek to create new entities but without proposing a new

global funding mechanism. We have sought innovative solutions to problems in health systems and attempted to articulate ideas not stated elsewhere, including ideas that may be unpopular or uncomfortable for existing organizations. We seek to provoke creative thinking and action on health system strengthening. Yet we also seek to avoid unnecessary politicization of the global health community, focusing on substantive functions rather than political questions. Another overarching objective of this report is to contribute to strengthening the capacity and clarifying the role of the WHO in the global health architecture.

These activities to follow up on the Toyako Summit declaration mark a concerted effort by Japan and its partners to enhance their substantive contributions to global health policymaking, rather than just providing financial donations. The nature of global problems in many spheres now outruns the capacity of global governance institutions. This institutional gap represents both an opportunity and an obligation for the G8 countries as a new leverage point for global health policymaking. The world has witnessed a remarkable growth in global flows of health workers, health finances, and health data. In our increasingly globalized world of health, the G8 Summit provides a setting for personal engagement by national leaders who can shape policy responses to meet critical problems. This project has identified concrete actions, in the context of the revived approaches of human security and PHC, to be pursued by the G8 nations. These actions will necessarily require collaboration with the H8 organizations, other sympathetic developed and middle-income countries, and recipient countries. We believe that the government of Japan, for its part, should integrate global health more fully into its bilateral and multilateral diplomacy and that it can enhance its diplomacy by working more closely with international civil society networks and encouraging their further development.

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 rising about potential cutbacks from rich countries in official development assistance as well as private giving to NGOs.[16] But as Prime Minister Gordon Brown of the United Kingdom 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.[17] The G8 can play a catalytic role in assuring that pledged funds are delivered in ways that create tangible benefits for the world's poorest people. We recommend that the G8 also consider promoting the development of innovative financing mechanisms for health system strengthening. The G8 can also work to protect government budgets for social welfare in developing countries

from being squeezed by the financial crisis, and to avoid a repetition of the cuts that occurred under the structural adjustments and economic turmoil of the 1980s and 1990s.

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