

### 1) Speaking points :

- We welcome the selection of global health as the priority topic for discussion in the ECOSOC Annual Ministerial Review next July in Geneva.
- Experience has shown that economic growth alone, especially when it is largely based on rising commodities prices, has not correlated with poverty alleviation and progress towards the MDGs. The present financial crisis is a clear proof that economic growth on its own does not guarantee sustainable development and social cohesion. We need to balance continued and sustained growth with greater equity to ensure that all can benefit.
- Health in developing countries is overall close to stagnant in the countries with worst health indicators and lowest domestic public financing capacities, especially in Africa.
- But also the Asian region faces great challenges: while the regional picture shows an overall improvement, when we exclude China, the picture is not so positive : malnutrition rates are the highest in the world and have not improved much; maternal mortality is neither showing progress at the regional level; under 5 mortality, especially in the first year of life remains very high in many countries and the rates of HIV/AIDS and malaria are increasing in many countries.

- The evolvement of the health situation and trends in developing countries, their financing and management capacities, together with the aid architecture globally, give a picture of major challenges and also opportunities for us all. The question is : Where does the EC and the EU fit in this global picture? What is or potentially may be our added value?
- There is a strong correlation (with notable exceptions on both sides) between the levels of public funding for health, especially if under the minimum threshold of € 20 per capita, and the access to basic (often vital) health care services, especially for the poor; and the sustained progress towards health MDGs (especially MDGs 4 and 5, as 6 is often dealt by projects in parallel to the public comprehensive health services). Clearly public financing is not the only and often not even the main factor influencing health; but in most of the countries I mentioned earlier, it is a pre-condition for equity of health care and health indicators.
- Economic growth (highest in Asia and also improving even in Africa although often not reaching the poor) and fiscal revenues (also in the increase in many countries), may increase public spending in health. Is this situation is combined with progress towards the Abuja 15% commitment (15% of national budget allocation to health, adopted by the African Union) and adopted by other regions in the world such as the Asian region; the potential increase of domestic spending in health is very significant. Such mobilization of additional domestic resources would lower the global gap of public spending below the CMH threshold from over € 40 b to some € 13 b in some 50 countries, most of them in sub-

Saharan Africa. The remaining gap is a challenge for the international community.

- Interestingly, the health ODA might surpass that level already, especially due to the large mobilization of funds to confront HIV/AIDS. This reflects one of the main challenges in the health sector at country level: a large proportion of health ODA is fragmented in different disease (vertical) programmes and a myriad of projects. These are often not captured by DAC and even by the national governments, far from the SWAP dialogue principles and the Paris commitments on alignment. Besides this fragmentation, health ODA is highly volatile and has very low degrees of predictability
- Besides the financing gap, and the space for increased domestic and external allocations to the recurrent costs of national and comprehensive (patient-centered) health strategies; there are of course many other bottlenecks and leaks in the system. When donors progress on aligning support through the budget, this does not always translate in increased health spending, and when that happens, central and decentralized management also faces weaknesses, imbalances and shocks from the globalization of flows of health workers and health commodities as well.
- In this global context, what is the EC role, and more important, what might be the EC added value? The very question implies a conceptual dilemma, as the EC cannot, and less and less so (in the spirit of the EU Consensus on development) be extracted from the EU joint role in the

external action. If we look only at figures of direct support to health, the EC will not be seen as a leading health donor by this analysis, although it has a weight, often a leading role, in many fragile contexts.

- However, in the ACP region mainly, the trend is to provide increasing share of ODA through general budget support, based on its value in the context of the Paris principles on alignment and predictability; and how these elements are fundamental to allow financing the main components of the health sector: the recurrent costs of salaries, medicines and decentralized management.
- The EC is in many countries the leading grant donor of budget support; and links such support with inputs, dialogue and outputs on health, in line with the growing understanding, that vertical interventions have not only a high opportunity cost, but can also seriously undermine the efforts towards sustained development of comprehensive health services. We favor the direct support to our partner countries and promote and respect their participatory choice of priorities and strategies, instead of the priority attention you request for global initiatives and disease-specific programmes
- If I may be provocative : The life of a child dying of an acute diarrhoea without access to even simple rehydration salts or even clean water is as valuable as that of any other diseases which have received greater attention and powerful vertical interventions and specific international funds and targeted support.

- This is why we need to support health systems with public financing which can ensure equitable access to comprehensive basic health services prioritized in the countries and not in New York, Geneva or Brussels, and facilitate the participatory analysis and the setting and rolling of those strategies in close dialogue with them.
- This does not mean that we also look into some global problems that deserve global actions. Regarding health systems, we will give more attention to human resources for health, to access to medicines, to health financing and to decentralized-participatory management.
- Regarding health financing, the EC is preparing a Communication this year, through a very intense consultation process (next week, representatives from over 30 developing countries share in Brussels their experiences in this area). We want to assess health financing principles among its diverse modalities, which ensure progress towards equitable basic health care. In the EU-AU Africa action plan, we have committed to support the process towards the elimination of user fees for basic health care linked. We aim at defending fair financing schemes towards the EU value of equity of social rights such as the right to health.
- We believe that the **increased scale, greater predictability and better alignment of EU aid** will encourage sound policies and adequate financing to ensure equitable access to basic services, including health.

- We also look forward to enhancing the **level and depth of development and sector policy dialogue** so as to effectively link **general budget support** with the desired progress towards MDGs.

In this context, the EC recognizes the **International Health Partnership** as the reference framework to advance in the commitments to aid effectiveness in the area of health; and we will encourage all development partners, including the US major role in health ODA; and developing countries, to join this process. Health ODA suffers from a high degree of fragmentation and the IHP shows a very clear line, rescuing the SWAP principles in today's aid architecture, to increase the volume, ownership, alignment and predictability of aid.