disease-oriented vertical programmes would be more effective. Assessment of what other models work, and the cost associated, should now be done.

The effect of the Department of Health guidelines (initially set in 1999 and extended in 2001 and 2004) for ethical recruitment also needs assessment.[6,7] The Crisp report has further recommendations, including improvement to the way that countries recruit and retain health-care workers, and stricter ethical recruitment by developed countries. These recommendations are to be supported, although new work-permit regulations might impede opportunities to allow training in the UK.

In terms of enabling the release of NHS personnel, the NHS Toolkit has not fulfilled its promise. A key weakness has been the absence of funding at central level to support it. Reliance on the financial goodwill of Trusts, coupled with job insecurity, was a recipe for inertia. If support by the Government is in word only, there is a danger that Crisp's recommended NHS Framework will go the same way as the NHS Toolkit. The Department of Health must ensure that international development is recognised and funded as a mainstream activity for UK health professionals, and it should encourage NHS Trusts to participate.

The report correctly identifies the need to establish best practice in this complex arena. It provides an opportunity to develop a cohesive long-term strategy, and ties in well with the proposals for a UK Government-wide global health strategy, which were published in March, 2007, by Donaldson and Banatvala.[8]

In this world of competing priorities, we should not allow this initiative to get lost. As UK Prime Minister Tony Blair said in his foreword to Lord Crisp's report, "Improving global health is clearly in Britain's interest". The report is also an opportunity to use health as a tool of foreign policy.

Michael Pelly
Chelsea and Westminster Hospital, London SW10 9NH, UK.
m.pelly@imperial.ac.uk

As an associate director of the International Office of the Royal College of Physicians, I attended some of the workshops coordinated by the Department of Health in preparation of the Crisp report. The opinions in this Comment are mine, and not those of the Royal College of Physicians.

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The World Bank's new health strategy: reason for alarm?

See **Editorial** page 1492

The World Bank has a new 10-year health strategy.[1] Since its previous health strategy, developed in 1997, the global health landscape has been transformed. International spending on health has increased from about US$7 billion in 2000 to almost $14 billion in 2005. While the Bank used to be the pre-eminent international health-financing agency, spending about $1·5 billion a year on health, it now operates in a more crowded field, with established players, such as WHO, UNICEF, and bilateral donor agencies, and newer players such as the US President's Emergency Fund for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Bill & Melinda Gates Foundation, and the GAVI Alliance.

Unsurprisingly, the Bank has taken a step back to think about its role. In doing so it has prioritised strengthening of health systems, citing expertise in health financing; incentives for health workers; logistical, and financial management; governance of health systems; demand-side interventions, such as conditional cash transfers and reforms for patient choice; sector-wide strategic planning; health-service quality-control; epidemiological surveillance; and public-private collaboration. The Bank also seems intent on establishing itself as the lead global agency for health-systems policy-development, even suggesting that WHO and UNICEF should focus on the

Still Pictures

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technical aspects of disease control and health-facility management.[1]

On the one hand, the Bank's new strategy should be welcome, given the widespread deterioration of health-care systems caused by chronic underfunding, public-sector collapse, unregulated privatisation, and the uncoordinated proliferation of global health initiatives that have fragmented the health systems of many poor countries.[2–5] Many global health programmes have tended to seek the path of least resistance through the complex edifice of health systems by establishing vertical programmes, enlisting private providers, and using separate supply and logistics systems to attribute measurable returns to their efforts.

However, while the Bank's strategy contains much to agree with, its claims to expertise and credibility in the field of health systems are troubling. Indeed, structural adjustment programmes and health sector reforms inspired by the Bank have underpinned many of the current problems in poor countries.[6] Although some Bank loans and grants undoubtedly translate into tangible health improvements, and despite many competent and dedicated staff, the Bank's continued promotion of proprivate market-oriented policies and its view that health care can be reduced to a set of tradeable commodities and services raise important concerns.

These inclinations of the Bank were revealed in an earlier draft of the strategy which mentioned: expanding private-sector provision; exposing public providers to greater market competition; developing competitive private-insurance markets in middle-income countries; and encouraging output-based provider financing and production-based provider financing—by which health-care providers are financed through expressed demand as distinct from assessed needs. The current strategy also calls for an increased role for the Private Sector Development and International Financial Cooperation sections of the Bank, which exist explicitly to encourage private-sector growth.

By contrast, little was said about strengthening public-sector management and service provision, encouraging non-financial incentives for health workers, or building effective public accountability and mechanisms for community empowerment. In response to this stance, non-government organisations from across the world wrote to express their concerns, prompting a response from the Bank's President, Paul Wolfowitz. The flavour of the subsequent strategy is less proprivate and promarket. However, too much of the Bank's strategy is opaque and leaves important questions unanswered.

For example, what should be the role of public institutions within the health sector and what principles should determine the appropriate mix of public and private actors? Under what circumstances should for-profit providers be encouraged or discouraged? What is the policy response to improving the implementation of needs-based planning in the context of growing commercialisation and marketisation? Under what conditions and for what purposes is competition appropriate or desirable? What is the evidence that encouraging high-income users to exit the public sector improves health-systems' efficiency or equity? And what concrete steps will be taken to increase the fiscal space and health budgets of poor countries so that they have the resource base required for universal essential health-care provision.

Such questions are also inadequately addressed by donors, other global health institutions, and many civil-society organisations. Many actors, including the governments of low-income and middle-income countries, are part of a collective failure to establish

a coherent and long-term vision and strategy for health-systems strengthening. Part of the problem is that the development of health systems is complex, slow, and ultimately dependent on reversing chronic and deeply embedded public-sector failures. It seems therefore churlish to throw criticism at the Bank, which at least is addressing the issue.

However, it would be irresponsible not to raise some alarm in view of the damage the Bank has caused to health systems, its undermining of public institutions, its allergy to universalism and equity, and its one-eyed romance with markets and financial incentives. Others would add that the fundamentally undemocratic nature of the Bank, as well as its role in shaping a global political economy that has failed to alleviate poverty or promote fair global development, should disqualify it from providing policy advice on health systems in low-income and middle-income countries. Recent assessments also question the quality of the Bank's research used to support its policy prescriptions,[7,8] while a critique of the Bank's malaria programme raised even more serious issues of financial and intellectual probity.[9] The Bank's sexual and reproductive health policies are now being undermined from within by senior managers who appear to be ideologically opposed to family planning and condoms.

The Bank should be applauded for drawing attention to health-systems strengthening. And as a development bank it has a critical part to play. But the international health community needs to debate how and where the moral vision, leadership, and technical expertise for health-systems strengthening should be developed and managed. Advocates for the health of the poor must acknowledge the intrinsically political dimensions of equitable rights-based health-systems development. That hundreds of millions of people face the terrifying prospect of collapsed and collapsing health-care systems is not a case of bad luck or poor application of policy.

As we approach our final Millennium Development Goal targets, now is the time for the World Health Organization, the international donor community and civil society organisations to establish a principled, just, and robust vision for health-systems strengthening.

David McCoy
Department of Epidemiology and Public Health,
University College London, London WC1E 6BT, UK
d.mccoy@ucl.ac.uk

I was involved in the drafting of two letters that were sent to the World Bank by a group of non-governmental organisations, which provided feedback to an earlier draft of the strategy.

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