of state legislative activity aimed at enhancing health-care coverage before the crisis, the multiple economic shocks experienced by American households, and President-Elect Barack Obama's promises of creating a level playing field and universal health care, this might be, in fact, the ideal time to put forward a reform agenda.

We declare that we have no conflict of interest.

*Chris Simms, Mike Rowson
christopher.simms@dal.ca

Dalhousie University, Halifax, Nova Scotia B3H 1R2, Canada

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The global financial downturn—imperatives for the health sector

Deductions in public spending on health by developing countries and cutbacks in official development assistance (ODA) by developed countries are a dreaded consequence of the current global financial downturn. Ironically, the financial crisis has hit at a time when difficulties in achieving the Millennium Development Goals, evidenced by the halfway mark reviews, the emerging focus on health systems strengthening on the global health agenda, WHO's recent effort to resurrect the primary health care approach,[1] and evidence from the Commission on Social Determinants of Health,[2] are calling for increases in public financing for health.

This situation creates several imperatives for global and domestic health policy. First, it is essential to protect public sources of financing for health against the kind of cuts that characterised the 1980s and 1990s. With assistance from development partners, governments in developing countries can be enabled to use this as an opportunity to expand social protection; expansion of social protection in the USA during the great depression in the 1930s can be instructive in this regard.

Second, the international community should strengthen its support for poorer nations. The G8's commitment to provide US$60 billion for health over the next 5 years[3] must be honoured. International development agencies should prioritise debt forgiveness to free up fiscal space and ensure that humanitarian objectives in the weakest, vulnerable, or failed states predominate in allocating ODA.

Third, more than ever, this is the time to reinforce the need to improve returns on health spending—ie, boost the performance of health systems. This can be done by reducing technical and allocative inefficiencies, rationalising transaction costs, better integrating disease control programmes, and promoting better country capacity and policies. As emphasised in Bamako, Mali, in November, 2008, we also need to invest much more in health systems research and learning.[4] Transparency-promoting measures in the health sector and systemic anti-corruption reform also need to be institutionalised.

Fourth, there is a need to promote alternatives to tax-based revenues as a means of public financing for health; regulation for employers to subscribe to global employment practices and a convergence between the previously separate agendas for health and social protection could protect impoverished communities from catastrophic spending in these financially dire times.

The current economic slowdown can be a challenge but also an opportunity to galvanise social transformation. This crisis, unlike that of the 1980s, might require boosting consumption, not cutting it, thus making health a good investment target. However, guidance on health financing in these times can only be meaningful if coupled with normative guidance on health-systems strengthening.

The views expressed in this letter are those of the authors and do not necessarily represent their institutions. We declare that we have no conflict of interest.

*Sania Nishtar, Ariel Pablos-Mendez
sania@heartfile.org

Heartfile, 1 Park Road, Chak Shahzad, Islamabad (SN); and Rockefeller Foundation and Columbia University, New York, NY, USA (APM)

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