

**The Italian Contribution to Global Health**

Unleashing the unexploited potential

*Il contributo italiano alla salute globale*

*Puntare al potenziale inesplorato*

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# **THE ITALIAN CONTRIBUTION TO GLOBAL HEALTH**

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## I. Executive Summary

Italy, as the chair of the 2009 G8 summit, will have a dramatic opportunity to renew its commitment to global health and lead the effective follow-up of the decisions taken last year at the Toyako Summit.

Italy has a longstanding position and commitment toward both domestic and international health, with its Constitution recognising health as a fundamental human right. The Italian Healthcare System (SSN) is founded on equity and has gained international recognition. Thus, the SSN may provide a vital contribution to the strengthening of health systems, especially in countries willing to achieve universal coverage and access.

In this regard a crucial role is played by Italian development NGOs. They have a long tradition of partnering both private and public institutions in low income countries, with a significant number of them being “on the field” since the early nineteen-sixties. Most NGOs developed a deep understanding of local needs and appropriate answers, today they are rather focussed on increasing the capacity of hosting countries’ health systems. Thus they often collaborate directly with those institutions, providing and fostering at the same time the synergy with thousands of charitable health services (mostly linked to the Catholic Church), that – as known – still constitute a fundamental backbone of DCs’ health systems, especially in Africa.

Beside the historical and professional role of development NGOs, an additional strength is represented by the Italian non profit sector. This is in fact increasingly active internationally, especially in the case of associations aiming at providing socio-economic integration to immigrants.

If we should try to answer the question about what could be the comparative advantage of Italy in contributing to global health, no doubt the answer would be: its integrated approach to health, its experience in developing an national health service providing universal coverage, its alignment with the principles and practices of Primary Health Care, based on wide and active citizenship.

However, Italy’s ODA financial commitments have been poor for many years. Its ODA/GNI ratio has been constantly less than 0.20% since 2000 which is substantially below the average of the OECD-DAC countries. The effects of the recent financial crisis may continue this downward trend, and the current Government anticipates substantial cuts in traditional sources of ODA.

In addition, Italy continues to suffer from structural weakness. It has not been able to modernise the management and coordination structure of its ODA, which remains marked by fragmentation among various governmental bodies, the lack of a clear political

direction, and unstable funding. The health sector has been no exception. Excluding the contributions to the GFATM, ODAH financing has not increased significantly over the years, with 2008 disbursements being just over half (56%) of 2001's in nominal terms.

Italy is also supporting new financing mechanisms, including the IFFIm and AMC initiatives, by pledging substantial funds. Nevertheless, these commitments to vertical initiatives have not been accompanied by attempts to address concerns about the system-wide effects of global health initiatives, nor they have taken into account the comparative advantage of Italian experience, coherence with its vision in health, or the recent shift of the global health agenda towards the strengthening of health systems.

Italy's official position towards global health does not seem to be suitably sound at a time in which it is replacing Japan as the G8 chair. In an attempt to cover Italy's inability, to meet its longstanding and recent ODA commitments, the current Government insists on the involvement of "Italy's System" to mobilize resources for development assistance.

Such an approach, however, does not detract from the urgent need for a substantial increase in ODA funding and structural reform to ensure appropriate strategic direction, operational coordination, and administration of a renewed Italian effort on the global development and health scene.

To stay relevant, Italy, which pledged to be among the major players in establishing the GFATM and supporting a number of new financing mechanisms, should push for the harmonization of global initiatives and their alignment with beneficiaries' management systems. Thus, keeping in line with recent international trends, and including the G8's endorsement of Toyako Framework for Action on Global Health.

Hosting the G8 summit can be an exceptional opportunity for the Italian Government to catalyse the energies of "System Italy" for global health. Fostering correct information through the media and public initiatives; promote global health through specific formal and non-formal educational programmes; supporting coordination and interchange between multiple stakeholders; sharing experiences and knowledge, are all indispensable ways to get attention, involvement and societal backing to a renewed Italian role in global health.

Achieving this will, however, require a clear understanding of the needs of the poor and a genuine wish for equity to close the increasing social and economic gap produced by globalisation, rather than seeking maximum visibility or commercial interests.

## Sommario

L'Italia, come presidente di turno del summit dei G8 del 2009, avrà l'opportunità di rinnovare il proprio impegno per la salute globale e di portare avanti quanto deciso lo scorso anno al summit di Toyako.

L'Italia ha una lunga tradizione di tutela della salute sia a livello nazionale che internazionale. La Costituzione Italiana riconosce la salute come diritto umano fondamentale. Il Sistema Sanitario Nazionale si fonda sul concetto di equità ed è ampiamente riconosciuto a livello internazionale. Per queste ragioni il SSN può fornire un contributo essenziale al rafforzamento dei sistemi sanitari nazionali, particolarmente nei paesi in cui è forte la volontà di garantire accesso universale alle cure.

In questo senso, le ONG di cooperazione allo sviluppo italiane possono giocare un ruolo fondamentale. Le ONG italiane hanno, infatti, una lunga tradizione di cooperazione con le istituzioni pubbliche e private nei paesi a basso reddito, con un significativo numero di loro impegnate "sul campo" sin dagli anni sessanta. La maggior parte di esse hanno sviluppato una profonda conoscenza dei bisogni locali e risposte appropriate, focalizzandosi sull'accrescere le capacità dei sistemi di salute dei paesi beneficiari. In questo modo le ONG spesso collaborano direttamente con le istituzioni locali, garantendo allo stesso tempo sinergie con centinaia di servizi sanitari, frequentemente collegati alla Chiesa Cattolica, che ancora fanno parte della spina dorsale dei sistemi di salute nei paesi in via di sviluppo, soprattutto in Africa.

Al di là del ruolo delle ONG di cooperazione allo sviluppo, un ulteriore punto di forza è dato dal settore no profit, sempre più attivo a livello internazionale, soprattutto nel caso delle associazioni impegnate sul fronte della integrazione dei migranti.

Se dovessimo indicare il vantaggio comparativo dell'Italia rispetto alla salute globale, non avremmo dubbi nell'indicare: l'approccio integrato alla salute, l'esperienza nello sviluppare un sistema sanitario nazionale a copertura universale, l'adesione ai principi e alle pratiche della Primary Health Care, basata sul coinvolgimento attivo dei cittadini.

L'impegno italiano in termini finanziari rimane però decisamente debole. Il rapporto tra Aiuto Pubblico allo Sviluppo (APS) e reddito prodotto è stato costantemente al di sotto dello 0,20%, meno della media dei paesi OCSE/DAC. Gli effetti della recente crisi finanziaria possono contribuire a questo trend negativo e il governo italiano ha già annunciato tagli sostanziosi all'APS.

Inoltre l'Italia continua a soffrire di debolezze strutturali. Non è ancora stata in grado di modernizzare la gestione dell'APS, che rimane segnata da frammentazione istituzionale, mancanza di un chiaro indirizzo politico e da finanziamenti irregolari. Il settore della salute non fa eccezione. Contributi al Fondo Globale a parte, l'APS in salute non è aumentato significativamente. Nel 2008 la spesa in questo ambito è cresciuta poco più della metà (+56%) di quella del 2001 in termini nominali.

L'Italia sta inoltre sostenendo nuovi meccanismi di finanziamento, comprese le iniziative IFFIm e AMC. Questo sostegno ad iniziative "verticali" non è stato però accompagnato da uno sforzo in grado di dare risposta alle preoccupazioni legate all'impatto sui sistemi sanitari locali delle suddette iniziative verticali. Non si è tenuto conto in questo modo nè dell'esperienza italiana nel sostegno ai sistemi nè del fatto che l'agenda della salute globale ha posto il tema del rafforzamento dei sistemi sanitari al centro dei lavori.

La posizione italiana rispetto alla salute globale non sembra essere sufficientemente chiara nel momento in cui l'Italia sta ricevendo il testimone dal Giappone, come presidente di turno del G8. Nel tentativo di mascherare la propria difficoltà nel rispettare gli impegni presi in termini di APS, l'attuale governo ha deciso di puntare sul coinvolgimento del "Sistema Italia" per mobilitare risorse rispetto all'aiuto allo sviluppo.

Tale meritevole approccio, non può però esimere l'Italia dal bisogno di un deciso aumento dei fondi destinati all'aiuto allo sviluppo, nè da quelle riforme in grado di assicurare direzione strategica e condizioni operative per un rinnovato impegno italiano nei riguardi dello sviluppo e della salute globale.

Per continuare ad essere un paese di prima grandezza, l'Italia, che è tra i primi sostenitori del Fondo Globale e dei nuovi meccanismi di finanziamento, dovrebbe spingere verso l'armonizzazione delle iniziative globali e del loro coordinamento con i sistemi di gestione dei paesi beneficiari. In questo modo l'Italia sarebbe in linea con i recenti trend internazionali, compreso quanto stabilito a Toyako (Toyako Framework for Action on Global Health).

Ospitare il G8 rappresenta una grande opportunità per l'Italia di catalizzare l'energia del Sistema Italia in favore della salute globale. Diffondere una corretta informazione attraverso i media, promuovere la salute globale attraverso programmi di educazione formale e non formale, sostenere il coordinamento e lo scambio tra i diversi stakeholders, condividere esperienze e conoscenza, sono le vie attraverso le quali suscitare attenzione e coinvolgimento della società verso un rinnovato ruolo dell'Italia per la salute globale.

Per fare questo però è necessaria una chiara comprensione dei bisogni dei più deboli e di un reale desiderio di equità che riduca il crescente divario sociale ed economico prodotto dalla globalizzazione, piuttosto che la ricerca di visibilità o la tutela di interessi commerciali

## II. Glossary

AAA: Accra Agenda for Action

AMC: Advance Market Commitment

APPI: Anti Poverty Partnership Initiatives

ART-GOLD: Apoyo a las Redes Territoriales y Tématicas para la cooperación al desarrollo humano (Support to territorial and thematic networks of human development cooperation) – Governance and Local Development

ASL: Aziende Sanitarie Locali (Local Health Authorities)

CEBES: Centro Brasileiro de Estudos de Saúde (Brazilian Centre of Health Studies)

DGCS: Direzione Generale Cooperazione allo Sviluppo (Directorate General for Cooperation and Development)

DAC: Development Assistance Committee

DCs: Developed Countries

EU: European Union

GAVI: Global Alliance for Vaccines and Immunizations

GDP: Gross Domestic Product

GFATM: Global Fund for Aids Tuberculosis and Malaria

GNI: Gross National Income

GPPPs: Global Public Private Partnerships

HEDIP: Health and Development for Displaced Population

IDA: International Development Association

IFFIm: International Financing Facility for Immunization

IHP: International Health Partnership

ILO: International Labour Organisation

ISS: Istituto Superiore di Sanità (Italian National Institute of Health)

LDCs: Least Developed Countries

MDGs: Millennium Development Goals

MoH: Ministry of Health

MS: Member States

NGOs: Non Governmental Organisations

NTDs: Neglected Tropical Diseases

ODA: Official Development Assistance (or Aid)

ODAH: Official Development Aid in Health

ODI: Overseas Development Institute

OECD: Organisation for Economic Cooperation and Development

OISG: Osservatorio Italiano sulla Salute Globale (Italian Global Health Watch)

PASARP: Programme of Activities in Support of the Albanian and Refugee Population

PDHI: Programa Desarrollo Humano Integrado (Integrated Human Development Programme)

PDHL: Programa Desarrollo Humano Local (Local Human Development Programme)

PESS: Plan Strategique du Secteur Santé (Health Sector Strategic Plan)

PRODERE: Programa de Desenvolvimento para Desplazados y Refugiados (Programme for Displaced Persons, Refugees and Returnees)

SEHD: Small Enterprise and Human Development

SMALP: Salud, Medio Ambiente y Lucha Contra la Pobreza (Health, Environment and Struggle Against Poverty)

SSN: Servizio Sanitario Nazionale (Italian National Health Service)

SWAp: Sector Wide Approach

TB: Tuberculosis

UN: United Nations

UNAIDS: United Nations Joint Programme for HIV/AIDS

UNCDF: United Nations Capital Development Fund

UNESCO: United Nations Educational, Scientific and Cultural Organisation

UNIFEM: United Nations Development Fund for Women

UNITAR: United Nations Institute for Training and Research

UNOPS: United Nations Office for Project Services

USAID: United States Agency for International Development

WHO: World Health Organization

### III. Introduction

Italy, as the chair of the 2009 G8 summit, will have a dramatic opportunity to renew its commitment to global health and lead the effective follow-up of the decisions taken last year at the Toyako Summit.

At that summit, the government of Japan decided it needed a mechanism for following up the new policy initiatives the G8 leaders had committed. It therefore engaged in a process designed to identify action-oriented policy recommendations for the G8 on health system strengthening and to maintain momentum and continuity for future G8 summits starting with the 2009 meeting to be hosted by Italy<sup>1</sup>.

Two parallel Japanese initiatives offered the basis for an active role of the Italian G8 Chair and civil society organisations sensitive to global health issues. On one side the Working Group on "Challenges in Global Health and Japan's Contributions" and the Japan Center for International Exchange pursued follow-up activities to the Toyako summit which led to an International conference held in Tokyo in early November 2008 and to a set of recommendations for the Japanese Government to handover to the Italian G8 Chair<sup>2</sup>. On the other hand the Health Policy Institute Japan facilitated the continuity between the Japanese experience and expected Italian action in 2009, including the Global Health Forum (12-13 February 2009) where this paper is presented.

Italy's task is not an easy one. Budget constraints due to the economic downturn, as well as to the enormous accumulated public debt undoubtedly represent an additional challenge. In fact, Italy's Official Development Assistance (ODA) quantitative record is poor, and Organisation for Economic Co-operation and Development (OECD) peer reviews have been critical regarding its management and its capacity to overcome structural deficiencies<sup>3</sup>. However, besides striking financial and strategic contradictions, a more in depth analysis highlights an unveiled potential for Italy to contribute to global health beyond traditional ODA.

This paper provides background information and recommendations that may help the Italian chair to contribute with a more pro-active role to a renewed collective effort of the G8 in support of global health.

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<sup>1</sup> Reich MR, Takemi T. G8 and Strengthening of Health Systems: Follow-up to the Toyako Summit. *The Lancet* 2009.

<sup>2</sup> *Ibidem*.

<sup>3</sup> OECD Development Assistance Committee. Peer Review of Italy. Paris: Organization for Economic Cooperation and Development(OECD), 2004.

## IV. The context: global commitments and challenges

### 1. Global development commitments

In 2000, the heads of State and Government committed to the achievement of the Millennium Development Goals (MDGs). The eighth MDG entails a commitment to “..more generous ODA for countries committed to poverty reduction”. Since the 2000 Millennium Summit, a series of international events set the stage for debates and setting concrete targets regarding donors’ commitment and ODA impact. The most important commitments of the last decade are highlighted in Table 1.

Table 1- Main International ODA related Commitments

Date	Initiative	Commitment /Target
<b>United Nations</b>		
2000	Millennium Summit, New York, 2000.	Achieve MDG targets by 2015 MDG-8 - "... and more generous ODA for countries committed to poverty reduction." No quantitative targets set in MDG – 8
2001	<a href="#">Declaration and Programme of Action for the LDCs for the Decade 2001-2010</a> (2001) (also known as the <i>Brussels Plan of Action</i> )	(a) Donor countries providing more than 0.20 per cent of their GNI as ODA to LDCs: continue to do so and increase their efforts; (b) Other donor countries which have met the 0.15 per cent target: undertake to reach 0.20 per cent expeditiously (c) All other donor countries which have committed themselves to the 0.15 per cent target: reaffirm their commitment and undertake either to achieve the target within the next five years or to make their best efforts to accelerate their endeavours to reach the target.
2002	<a href="#">Monterrey Consensus</a> on Financing for Development, Monterrey 2002.	Urged developed countries toward the ODA target of 0.7 per cent of their GNI Target of 0.15 – 0.20 per cent of GNI of developed countries to least developed countries.
2008	UN High-Level meeting on Africa's Development needs and on the Millennium Development Goals, New York, 25 September 2008. <sup>4</sup>	Renewal commitments made in Monterrey, the Brussels Plan of Action and aid effectiveness.
2008	UN international conference on “Financing for Development” , Doha, Qatar	No new ODA commitment. Re-affirms previous ODA commitments and MDG achievements.
<b>OECD</b>		
2001	Rome High-Level Forum, 2001.	Commitment "...to improve the management and effectiveness of aid."
2005	<a href="#">Paris Declaration on Aid Effectiveness</a> , 2005	Ownership, alignment of aid, harmonization, management for results and mutual accountability to be reached by 2010.
2008	Third High-Level Forum on Aid Effectiveness, Accra, 2008.	Accra Agenda for Action (AAA). Commitment to stepping up progress towards the commitments outlined in the Paris Declaration by: -committing signatories to accelerating the pace of change by focusing on key areas that should enable them to meet the 2010 targets agreed in Paris. -undertaking strict monitoring and peer reviews
<b>European Union</b>		

<sup>4</sup> UN, “Committing to action: achieving the Millennium Development Goals - Compilation of initiatives and commitments relating to the Highlevel Event on the Millennium Development Goals”. 20 October 2008.

2002 and 2005	European Union: 2002 Barcelona Commitment (European Council, March 2002) and 2005 commitments.	-For EU15 <sup>5</sup> : individual target of 0.51% by 2010, with the aim of reaching 0.7% by 2015; -For EU 10 (new EU MS) individual target of 0.17%, which represents the midpoint towards the Barcelona 'acquis' of 0.33% in 2015. -For EU25: collective average of 0.56% by 2010. Channel at least 50 per cent of collective aid increases to Africa.
<b>G8</b> 2005	<a href="#">G8 Gleneagles</a> Summit, 2005	"On the basis of donor commitments ... the OECD estimates that ODA from the G8 and other donors to all developing countries will increase by around \$50 billion a year by 2010, compared to 2004." "The commitments of the G8 and other donors will lead to an increase in ODA to Africa of \$25 billion a year by 2010, more than doubling aid to Africa compared to 2004 <sup>6</sup> ." G8 donor countries committed themselves to individual intermediary targets for the year 2010.  <b>Italy</b> has undertaken to reach 0.51 per cent ODA/GNI in 2010 and 0.7% ODA/GNI in 2015  <b>EU</b> has pledged to reach 0.7 per cent ODA/GNI by 2015 with a new interim collective target of 0.56 per cent ODA/GNI by 2010.
2006		
2007	G8 Heiligendamm Summit, 2007	Recommitment to the promises made, including commitment to financing for a peacekeeping force in Africa. Increase in ODA commitment of single countries: - Italian promise to double aid to Africa.
2008	G8 Hokkaido Toyako Summit, 2008	Renewal of commitments made at Gleneagles and reaffirmed at Heiligendamm. Encourage innovative approaches to leverage private investments in connection with domestic public financing and official development assistance.

## ODA level

The UN played a major role in determining targets on ODA for LDCs (*Brussels Plan of Action*) and for DCs (Monterrey Consensus) for 2015. At the 2002 Monterrey Conference on Financing for Development and at the World Summit on Sustainable Development (Johannesburg 2002), world leaders pledged to "make concrete efforts towards the target of 0.7 per cent" of their GNI as ODA. The UN set up monitoring tools (such as the MDG Monitor and the MDG Gap Task Force) to track progress towards the eight MDGs. The G8, at their 2002 Summit in Kananaskis, stated that "no country genuinely committed to poverty reduction, good governance and economic reform will be denied the chance to achieve the Millennium Development Goals through lack of finance" and in 2005 at the Gleneagles G8 summit head of state personally signed the joint Communiqué outlining their individual and collective commitments on the level of development assistance with special intermediary targets for year 2010.

At the Gleneagles summit (2005) each individual G8 member committed itself to ODA intermediary targets. The EU "...pledged to reach 0.7 per cent ODA/GNI by 2015 with a new interim collective target of 0.56 per cent ODA/GNI by 2010..." and now stands at a mere 0.40 per cent rate with three subsequent reductions in 2005, 2006 and 2007 (Figure 1).

<sup>5</sup> EU15 – Fifteen was the number of member countries in the European Union prior to the accession of ten candidate countries on 1 May 2004.

<sup>6</sup> ODA to Africa in 2004 was USD 29.5 billion so that for the promise to be fulfilled, ODA to Africa would need to be at least \$54.5 billion in 2010, at 2004 prices and exchange rates.

OECD-DAC data<sup>7</sup>, show that in 2007 the United Nations target of 0.7% of GNI was achieved by only five countries: Denmark, Luxembourg, the Netherlands, Norway and Sweden. None of them belongs to the G8. G8 countries are all well below the average country effort for DAC countries (Figure 2).

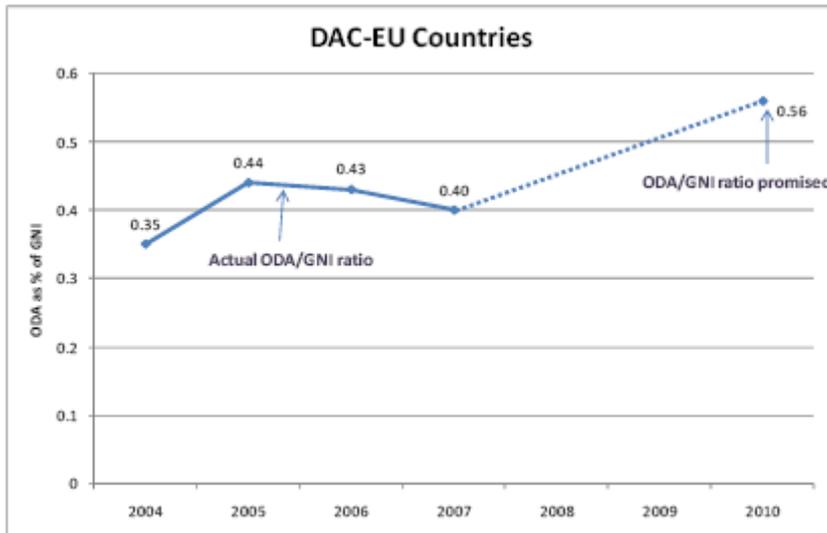


Figure 1- Net ODA in 2007 as percentage of GNI (Source: OECD/DAC)

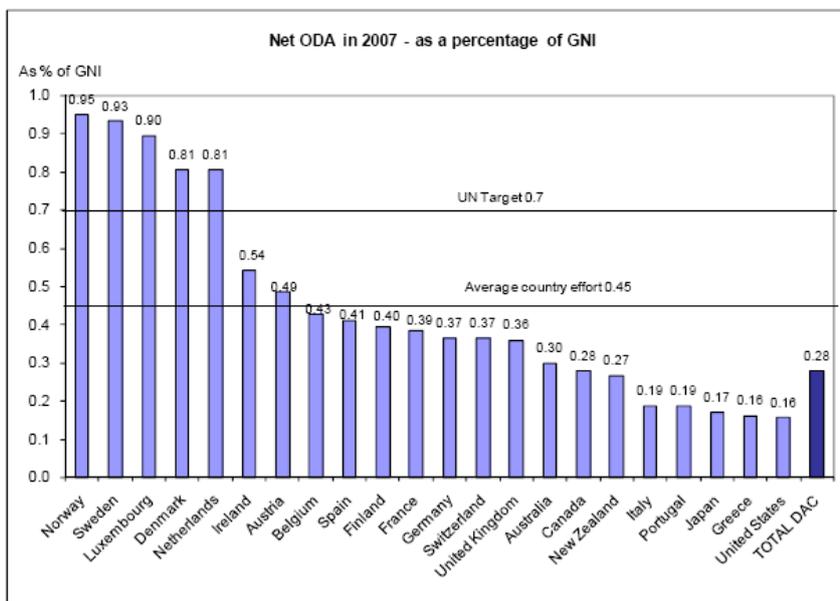


Figure 2- ODA as % of GNI, DAC-EU countries trend. (Source: "Aid Targets Slipping Out of Reach?", OECD-DAC, 2008)

<sup>7</sup> OECD, "Aids Targets Slipping Out of Reach?", October 2008.

## ODA Effectiveness

Regarding quality of aid, the *OECD High-level Forums on Aid Effectiveness* helped shaping the [2005 Paris Declaration on Aid Effectiveness](#), formalizing the actions that donor countries would take to improve the effectiveness of aid, emphasizing national ownership of development priorities, harmonization and alignment of donor activities, predictable and untied aid, programme based approaches, improved procurement and financial management systems, results oriented frameworks, and mutual accountability. The OECD also established the DAC Working Party on Aid Effectiveness in May 2003 to monitor progress. Individual countries' ODA performance is peer reviewed approximately every four years. Past Peer-reviews for Italy were in 1996, 2000 and 2004.

In 2008 the *Accra Agenda for Action* identified three main areas where progress towards reform is still too slow: (i) Country ownership, (ii) building more effective and inclusive partnerships, and (iii) achieving development results and openly accounting for them<sup>8</sup>. This year both Italy and Japan will undergo their OECD peer review session on aid effectiveness.

## 2. The changing scenario: the economic crisis

The unprecedented financial crisis of 2008 inevitably put at risk financial flows to Developing Countries. According to a recent study, the financial flows to developing countries may drop up to 25%, over 2007-2009<sup>9</sup>. The [International Monetary Fund](#) is downgrading its forecasts for world growth significantly for 2009, while the [Asian Development Bank](#) downgraded those for Asia to 5.8% in 2009, down from 9% in 2007. The global financial crisis is bound to have a major impact on [developing countries](#) economies and budgets.

The economic downturn could have profound implications on global health, depending on how much the crisis will affect official development assistance levels, how it will impact on other non-official aid flows to developing countries, and how it will affect health spending plans of national governments.

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<sup>8</sup> "Accra: Agenda for Action - Statement". 4 September 2008.

<sup>9</sup> ODI, Cali, Massa and te Velde, "The Global Financial Crisis: financial flows to developing countries set to fall by one quarter". 13 November 2008.

## The effects on ODA

With the current financial crisis, and economic slowdown in most donor countries, there is a general fear that aid budgets could be cut as it happened after the recession in the early 1990s. Experience shows that overall ODA is pro-cyclical, thus tends to increase when the overall economy is growing, and vice versa<sup>10</sup>. Between 1992 and 1997, ODA from DAC donors fell from 0.33% to 0.22% of their collective GNI. At a more disaggregated level, a recent note of the [Centre for Global Development](#)<sup>11</sup>, shows how the financial crises in Japan and Norway, Sweden and Finland between 1990 and 1993 determined a decline in aid funding which, in some cases, never really resumed to pre-crisis levels<sup>12</sup>.

However, there is high international pressure to keep ODA commitments during this financial crisis, as the achievement of the MDGs in 2015 depends on them. A recent Aid Pledges by the OECD issued on 28 October 2008, urged members of the OECD-DAC not to repeat the mistakes made following previous recession when many OECD governments let aid efforts decline and urged them to stand by their development pledges despite the economic slowdown<sup>13</sup>.

The UN international conference on “Financing for Development” held in Doha in December 2008, emphasised the importance on honouring ODA commitments despite the current financial crisis, pledged to advance global financial reforms and urged donor nations to persist with the UN Millennium Development Goals (MDGs) in spite of the turbulence in the global economy.

Up to now, there has been no major signal of decrease in ODA. The US Agency for International Development (USAID) has not anticipated a decrease in funding.

Among European countries, Spain and France have confirmed their commitment on increasing their ODA levels. The UK Department of Treasury is increasing even its resources for concessional loans and is considering new approaches to providing foreign assistance to poor countries<sup>14</sup>. Ireland is the first European donor country to announce it would cut its overseas aid budget due to shrinking resources<sup>15</sup>. Italy seems to follow this trend with its recent cut to aid resources to the Ministry of Foreign Affairs. Italian ODA is examined in detail below.

Historically, official aid for health follows ODA trends<sup>16</sup>. Therefore if the current financial

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<sup>10</sup>

<sup>1</sup> Bulir A. and Pallage and Robe 2007

<sup>11</sup> [http://blogs.cgdev.org/globaldevelopment/2008/10/history\\_says\\_financial\\_crisis.php](http://blogs.cgdev.org/globaldevelopment/2008/10/history_says_financial_crisis.php)

<sup>12</sup> Aid spending fell by 40% in Finland and Japan during a period of crisis.

<sup>13</sup> October 2008, Paris.

<sup>14</sup> A proposal of the UK government is to entice wealthy UK citizens to increase donations toward the Millennium Development Goals with a 50% tax relief on donations<sup>7</sup>. The impact still needs to be seen.

<sup>15</sup> 3 February 2009.

<sup>1</sup> <sup>6</sup> [Amanda Glassman](#) and Christopher Lane, February 28, 2008, The Brookings Institution

crisis, and subsequent recession, will negatively affect global ODA, health-committed ODA will also suffer.

## **The effects on Aid from private sources**

ODA, however, is only one category of development aid to Developing Countries and their health services. The aid is changing as the number and diversity of funders increases. Although statistics are not available, some indicators suggest that non-official aid - aid provided by foundations, corporations, non-governmental organisations, and individuals - has doubled over the past decade and may soon overtake 'official' foreign aid.

Foundations became key players in this field. Alone the approximately US\$800 million that the Bill and Melinda Gates Foundation gives every year for global health approaches the annual budget of WHO<sup>16</sup>. The financial crisis is having an important impact on foundation endowments which stand at a reduced value today than it did only a few months ago. Foundations are restating their willingness to meet old commitments, but are being more conservative about new ones. Therefore there may be less new resources to DCs from foundations in the next few years. The Bill and Melinda Gates Foundation issued a statement on the financial crises in November 2008 to inform about its commitment to actually grow its spending level in 2009 by 10%<sup>17</sup>. However, the figure is lower than the previously planned increase. Other similar statements indicate that the trend is to keep up the funding for old commitments but, at the same time, be more cautious (and efficient) regarding new ones<sup>18</sup>.

Some of the biggest development and humanitarian NGOs are also laying off staff or revising programmes for 2009<sup>19</sup>. NGOs rely on funding from individual donors, foundations, corporations and governments. According to three of the world's top NGOs<sup>20</sup>, the biggest reductions, as expected, are coming from corporate donors in the financial sector. As for individual giving to NGOs, experience has shown that individuals tend to be very loyal and private donations usually don't drop dramatically even when families experience financial difficulties.

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<sup>17</sup> BMGF website, "Statement on the Financial Crisis". 21 November 2008.

<sup>18</sup> Council on Foundations, "Weathering the Storm: Corporate Philanthropy and the Financial Crisis", Seminar Paper. 15 October 2008

<sup>19</sup> According to the UN Global Policy Forum.

<sup>20</sup> Oxfam GB, Save the Children UK and World Vision USA. The three agencies have an annual income of US\$3.1 billion.

## The effects on DC's Health Spending

An even greater consequence of the crisis is the possibility that it will induce DC's budgetary cuts in social spending including the health sector. Historically, during global economic downturns, the revenue base of aid recipient governments contracts leading to decreased public spending on health. Governments play an essential role in the health sector and WHO has been warning that global financial crisis could have profound implications for health spending of DCs. In the past many low income countries, have been forced to undertake cuts in social spending (i.e. health, education and social protection) when pressured by global recession. In general total health expenditure has tended to fall in countries during a recession though not always<sup>21</sup>.

### *3. Italy and the compliance with global ODA commitments*

In 2007, Italy's ODA amounted to 0.19% of its Gross National Income (GNI). This is far below the UN's target of 0.7%, as well as the EU's more recent (2005) target of 0.51% for UE15 member states, who should achieve it by 2010<sup>22</sup>. At constant 2006 prices, Italy's "genuine" ODA (that is, not including debt relief) increased between 2006 and 2007 by 33.6%, compared to an average decrease of 2.43% for G7 countries. Unfortunately, this increase may not be sustained, as the 2009 Finance Law drastically reduces the amount of resources allocated for Italian<sup>23</sup> (Table 2 and Figure 3).

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<sup>21</sup> WHO, High Level Consultation on the Financial and Economic Crisis and Global Health, Information Note 16 January 2009.

<sup>22</sup> Action for Global Health. Health Warning. Brussels: Action for Global Health, 2007.

<sup>23</sup> Repubblica Italiana. Legge 22 Dicembre 2008 No.203. Disposizioni per la formazione del bilancio annuale e pluriennale dello Stato (Legge finanziaria 2009). 2008.

Table 2 - "Genuine ODA" - net disbursements at 2006 constant prices (Source: OECD/DAC)- Million US\$

Year	2006	2007	2007-2006
<b>DAC</b>	M US\$	M US\$	variation %
Total ODA	104,369.6	95,462.0	-8.5
total debt relief	18,599.9	8,875.5	
Genuine ODA	85,769.7	86,586.5	1.0
<b>G7</b>			
Total ODA	75,487.4	65,028.6	-13.9
total debt relief	15,793.0	6,786.0	
Genuine ODA	59,694.4	58,242.6	-2.4
<b>EU-DAC</b>			
Total ODA	59,035.3	55,146.6	-6.6
total debt relief	13,065.2	6,524.9	
Genuine ODA	45,970.1	48,621.7	5.8
<b>ITALY</b>			
Total ODA	3,641.0	3,546.7	-2.6
total debt relief	1,379.2	524.2	
<b>Genuine ODA</b>	2,261.8	3,022.5	33.6

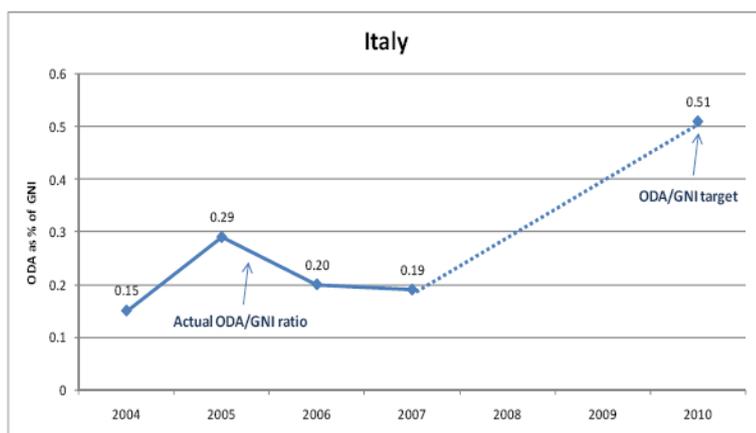


Figure 3 - ODA as % of GNI, Italy, trend (Source: "Aid Targets slipping out of reach?", OECD-DAC, 2008)

#### 4. Trends in global health and the way forward indicated at the G8 Toyako summit

The diffusion of the HIV-AIDS epidemic -which unlike other diseases of the South also affected industrialised countries-, has been one of the key factors that favoured the inclusion of health related issues in the global agenda.

For the first time in its history, in the year 2000, the UN Security Council became interested in disease and included the theme of AIDS in the agenda. At Okinawa G8 summit, later the same year, the fight against infectious diseases received special attention and particularly

against HIV-AIDS, malaria and tuberculosis. The following year, at the Genoa G8 summit the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM), was launched. With the launch of the GFATM the G8's influence on the global health agenda received an important push.

Summit after summit the G8 assumed new commitments (Table 3) related to polio eradication, to improved access to health care and drugs at affordable prices; addressing research on diseases mostly affecting developing countries; international co-operation against new epidemics such as SARS; the establishment of a Global HIV Vaccine Enterprise to accelerate HIV vaccine development; the strengthening of health systems (including supply chain management and reporting, and training and retaining health workers); research, development and production of vaccines, microbicides and drugs for HIV, TB, malaria and other diseases; launching innovative clinical research programs, private-public partnerships and other innovative mechanisms<sup>24</sup>. Among these the so called Advance Market Commitment (AMC) was promoted by Italy, based on the commitment of donors to subsidize the purchase of future vaccines that they would be developed. The AMC is being piloted to foster the development of a new anti-pneumococcal vaccine<sup>25</sup>.

A similar initiative, known as International Financing Facility for Immunisation (IFFIm), was launched in 2006 by Gordon Brown when he was the British Chancellor of the Exchequer. IFFIm is based on the issue of bonds to collect funds for the purchase of drugs and vaccines by GAVI.

*Table 3 - G8 Commitments to Global Health: 2000-2008*

G8 COMMITMENTS AT OKINAWA SUMMIT 2000	<p>Strengthened partnership with governments, the World Health Organisation (WHO) and other international organisations, industry (notably pharmaceutical companies), academic institutions, NGOs and other relevant actors in civil society to reduce the number of HIV/AIDS-infected people by 25 percent and the number of TB and malaria deaths by 50 percent by 2010.</p> <ul style="list-style-type: none"> <li>- Mobilising own additional resources</li> <li>- Giving priority to the development of equitable and effective health systems, expanded immunisation, nutrition and micro-nutrients and the prevention and treatment of infectious diseases;</li> <li>- Committing to support innovative partnerships;</li> <li>- Working to make existing cost-effective interventions, including key drugs, vaccines, treatments and preventive measures more universally available and affordable in developing countries;</li> <li>- Addressing the complex issue of access to medicines in developing countries;</li> <li>- Strengthening co-operation in the area of basic research and development on new drugs, vaccines and other international public health goods.</li> </ul>
G8 COMMITMENTS AT GENOA SUMMIT	Launched new Global Fund to fight HIV/AIDS, malaria and tuberculosis (first commitment US\$ 1,3 billion)

<sup>24</sup> Kirton, J. and Mannell, J., The G8 and Global Health Governance, Paper prepared for a conference on "Global Health Governance: Past Practice: Future Innovation," , Ottawa and Waterloo, November 10-12, 2005

<sup>25</sup> Tremonti G. Minister of the Economy and Finance, Italy. Background papers to Advanced Market Commitments for vaccines. A new tool in the fight against disease and poverty. Report to the G8 Finance Ministers, London, 2/12/2005

2001	<ul style="list-style-type: none"> <li>- promote an integrated approach emphasising prevention in a continuum of treatment and care</li> <li>- offer additional financing consistent with existing programmes,</li> <li>- integrated into the national health plans of partner countries.</li> </ul> <p>Strong national health systems will continue to play a key role in the delivery of effective prevention, treatment and care.</p>
G8 COMMITMENT AT KANANASKIS SUMMIT 2002	<p>In addition to ongoing commitments to combat these diseases, committed to provide sufficient resources to eradicate polio by 2005.</p> <p>Launch of the G8 Africa Action Plan - supporting African efforts to build sustainable health systems; including: (i) enhancing polio immunisation efforts, (ii) promoting the availability of an adequate supply of life-saving medicines, (iii) assisting African producers in meeting product and health standards, (iv) supporting HIV/AIDS programmes.</p>
G8 COMMITMENTS AT EVIAN SUMMIT 2003	<p>Strengthen the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other bilateral and multilateral efforts;</p> <p>improve access to health care, including to drugs and treatments at affordable prices, in poor countries;</p> <p>encourage research on diseases mostly affecting developing countries;</p> <p>mobilise the extra funding needed to eradicate polio by 2005 (announced US\$ 500 mn);</p> <p>improve international co-operation against new epidemics such as SARS.</p> <p>Issued a G8 Health Action Plan.</p>
G8 COMMITMENTS AT SEA ISLAND SUMMIT 2004	<p>Endorse and establish a Global HIV Vaccine Enterprise to accelerate HIV vaccine development (agreed to a US\$375 million plan).</p> <p>Take all necessary steps to eradicate polio by 2005 and close the funding gap by our next Summit.</p>
G8 COMMITMENTS AT GLENEAGLES SUMMIT 2005	<p>Committed to achieving universal access to treatment on HIV/AIDS by 2010 and ensuring proper support to all children left orphaned or vulnerable by AIDS or other pandemics.</p> <p>Replenishment of the Global Fund.</p> <p>Support to meet the needs identified by the Stop TB Partnership.</p> <p>Committed \$1.5 billion a year on malaria in sub-Saharan Africa.</p> <p>Support to the Polio Eradication Initiative for the post-eradication period in 2006–08.</p> <p>Health systems: Committed to giving all children access to basic health care (free wherever countries choose to provide this) by 2015 to reduce mortality among those most at risk from dying from preventable causes, particularly women and children by investing in improved health systems in partnership with African governments, by helping train and retrain doctors, nurses and community health workers.</p>
G8 COMMITMENT AT ST PETERSBURG 2006	<p>Commitment to making progress in addressing infectious disease outbreaks (avian flu and other pandemics).</p> <p>Ensure availability of \$20–\$23 billion for HIV/AIDS programmes annually by 2010.</p> <p>Facilitate replenishment of the Global Fund for the 2006–2007 period.</p> <p>Facilitating delivery of the Global Plan to Stop TB, launched in January 2006, and the Global Strategic Plan to Roll Back Malaria, launched in November 2005.</p> <p>Committed \$210 million to fund Polio Eradication.</p> <p>Health systems: Focus on strengthening the capacity of health systems and the training, deployment and retention of qualified health workers.</p> <p>AMC – presentation and expressed support for a pilot phase.</p>
G8 COMMITMENTS AT HEILIGENDAMM 2007	<p>First G8 Health Review on commitments and achievements on:</p> <p>HIV / AIDS, tuberculosis, malaria</p> <p>strengthening of health systems,</p> <p>achievements in research and development,</p> <p>financing.</p> <p>Provide \$60 billion by 2010 for comprehensive HIV/AIDS programs and strengthening health systems.</p> <p>Commitment of \$1.8 billion till 2010 for paediatric treatments.</p> <p>Committed \$1.5 billion for maternal and child health care and voluntary family planning.</p> <p>Commitment of providing universal coverage of PMTCT programmes by 2010.</p> <p>Committed to integration of efforts against TB and HIV/AIDS and the integration of DOTS-treatment and other comprehensive approaches necessary to control TB.</p> <p>Acceleration of financial commitments to enable the 30 highest malaria prevalence countries in Africa reach at least 85 percent coverage of the most vulnerable groups with</p>

	<p>effective prevention and treatment measures and achieve a 50 percent reduction in malaria related.</p> <p>Health systems: Acknowledgement of the 'Providing for Health' initiative.</p>
<p>G8 COMMITMENTS AT HOKKAIDO 2008</p>	<p>Toyako Framework for Action', which includes the principles for action, and actions to be taken on health.</p> <ul style="list-style-type: none"> <li>- health systems strengthening for addressing health challenges as a whole. Disease specific approaches and health systems strengthening should be mutually reinforcing.</li> <li>- human security perspective focusing on protection and empowerment of individuals and communities is critica. Focus on “the right to the highest attainable standard of health, which is one of the fundamental human rights of every human being” Local communities are indispensable in tackling such health challenges.</li> <li>- a longer-term perspective which extends beyond the 2015 deadline for the MDGs</li> <li>- effective utilization of resources requires the leadership and good governance of developing countries and the respect of their ownership consistent with the Paris Declaration. Health-related initiatives should enhance in a coherent manner the efforts of partner developing countries. Assistance to be coordinated in support of national health plans.</li> </ul> <p>Committed to increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people, and support Global Health Workforce Alliance.</p> <p>Commitment to support the control or elimination of neglected tropical diseases (NTDs) to reach at least 75% of the people with NTDs.</p> <p>Commitment to provide 100 million antimalarial bed nets in partnership with other stakeholders by the end of 2010.</p>

The influence of private foundations (e.g. Bill & Melinda Gates Foundation) and public-private partnerships (e.g. GFATM, GAVI) has been growing over the years, undoubtedly representing the most significant trend in the global health scene. Although in some cases GPPPs seem having facilitated access to drugs and services for the treatment of specific diseases<sup>26</sup>, the fragmentation produced by the increasing number of “vertical” initiatives in the wider context of development aid, their arguable sustainability, the waste of resources due to duplication and lack of alignment to national health plans, gave rise to increasing doubts about effectiveness of that approach<sup>27,28,29,30</sup>.

WHO's Director General Dr Lee Jong-Wook in 2003 came back to “Health for All” indicating the MDGs as “strategic focal points within a broad health agenda that build on the Alma Ata legacy”<sup>31</sup>. Introducing World Health Report 2003 “Shaping the future”, the first published under his term as Director General, Dr Lee stated: “Today's global health

<sup>26</sup> Buse, K., Harmer, A.M., Seven habits of highly effective global public-private health partnerships: Practice and potential, *Social Science & Medicine*, 2007, 64 : 259-271

<sup>27</sup> IDA, Aid Architecture: an overview of the main trends in official development assistance flows, IDA, 2007

<sup>28</sup> Hsiao, W., Heller, P.S., What should Macroeconomists Know about Healt Care Policy?, IMF, Working Paper, WP/07/13, January 2007

<sup>29</sup> Conway, M.D., Gupta, S., Prakash, S., Building better partnerships for global health, *The McKinsey Quarterly*, December 2006

<sup>30</sup> Garrett, L., The Challenge of Global Health, *Foreign Affairs*, January-February, 2007, 14-38

<sup>31</sup> Minelli, E., *op. cit.*

situation raises urgent questions about justice”<sup>32</sup>. The report reaffirmed the need for strengthening health systems, and urged to do so building on the values and practices of primary health care. It drew on notions of responsiveness to population needs and stewardship toward pro-equity health systems. Some authors considered that Report “refreshing in its attempt to offer an integrated approach to improving health”<sup>33</sup>. The Report also reminded to Lee's flagship initiative to treat three million people with AIDS with antiviral therapy by the year 2005 (known as “3 by 5”). Although focussing on particular diseases, emphasis was on how health systems would play a part in meeting overall health goals.

In March 2005, the Commission on Social Determinants of Health (CSDH) was launched. Chaired by Professor Michael Marmot, the CSDH brought together leading scientists and practitioners to provide evidence on policies that improve health by addressing the social conditions which people live and work and to collaborate with countries to support policy change and monitor results<sup>34</sup>. The CSDH work, which concluded in 2008, redefined the overarching significance of health as possibly the most comprehensive indicator for development: “The development of society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health”. It called for a new understanding of development, by stating that: “Growth by itself, without appropriate social policies to ensure reasonable fairness in the way its benefits are distributed, brings little benefit to health equity”<sup>35</sup>.

After one and a half year in her position, the new Director General of WHO, Dr Margaret Chan –who succeeded to Lee Jong-wook after his sudden passing away- addressed the World Health Assembly underlining that “investment in technology and interventions alone will not automatically 'buy' better health outcomes”. For the Director General more investment should go into institutional capacity and in systems for delivery; to that effect she insisted on a “return to primary health care”, its values, principles and approaches.

Published in October 2008, in the 30<sup>th</sup> anniversary of the declaration of Alma Ata, WHO's 2008 annual report insisted on the need for a holistic approach to health and health systems. It critically assessed the way that health care is organized, financed, and delivered in rich and poor countries around the world, with powerful forces driving Health systems away from their intended directions, ending up with hospital-centrism, fragmentation deriving from multiplication of programmes and projects, and the pervasive commercialization of health care. The way forward proposed in the Report, put

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<sup>32</sup> Haines, A., Shaping the future of global health, *Bulletin of the World Health Organization*, 2003, 81: 855

<sup>33</sup> Walt, G., WHO's World Health Report 2003. Shaping the future depends on strengthening health systems. *BMJ*, 2004, 328 : 6

<sup>34</sup> WHO, [www.who.int/social\\_determinants/about/en/](http://www.who.int/social_determinants/about/en/) (last accessed 12th July 2008)

<sup>35</sup> WHO, Commission on Social Determinants of Health, Final Report, *Closing the gap in a generation, Health equity through action on the social determinants of health*, WHO, Geneva, 2008

the accent on equity and universal coverage, primary care and people centered health systems, public policies for health and leadership reforms, reaffirming main governmental responsibility<sup>36</sup>.

Implicitly recognising the failure of an approach based on the promotion of individual initiatives that led to the current hyper-fragmented context both at global and at country level, in 2007 UK's Prime Minister, Gordon Brown, led the launch of the "International Health Partnership" (IHP). Signed by the representatives of other seven governments\* (but the US, Japan and the Russian Federation were not on board) and eleven multilateral and non governmental partners\*\*, the IHP aims to make health aid work better for poor countries and accelerate progress by doing three things: a) providing better coordination among donors; b) focusing on improving health systems as a whole and not just on individual diseases or issues; c) and developing and supporting countries' own health plans<sup>37</sup>. In fact the IHP is a call for the implementation of the 2005 Paris Declaration<sup>38</sup>.

At the Toyako Summit in 2008 the G8 endorsed the report prepared by the G8 Health Experts Group under Japanese leadership, representing an indicator of growing policy attention to health-systems strengthening by the global health community<sup>39</sup>..

The accent was put on the "human security" perspective, with focus on protection and empowerment of individuals and communities. The right was recalled "to the highest attainable standard of health, which is one of the fundamental human rights of every human being". The report also recognised the indispensable role of Local communities in tackling health challenges, as well as the need for long-term perspective, and for assistance in support of national health plans, respecting ownership consistent with the Paris Declaration.

## V. The Italian contribution to Global Health

### 1. *The Italian vision of global health*

In the Italian Constitution, health is a "fundamental right of the individual and (an) interest of the community" (art. 32), and "political, economic and social solidarity" are

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<sup>36</sup> WHO, *The World Health Report 2008, Primary Health Care, Now More Than Ever*, WHO, Geneva, 2008

\* Canada, France, Germany, Italy, Norway, Portugal, The Netherlands.

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<sup>37</sup> The International Health Partnership Launched Today, 5 September 2007. [www.dfid.uk.gov](http://www.dfid.uk.gov) accessed July 2008

<sup>38</sup> Paris declaration on aid effectiveness, Ownership, Harmonisation, Alignment, Results and Mutual Accountability, High Level Forum, Paris, February 28 – March 2, 2005

<sup>39</sup> G8 Health Experts Group. Toyako Framework for Action on Global Health. Toyako, Japan, 2008.

identified as “intransgressible duties” (art. 2).

The Italian National Health Service (SSN- Servizio Sanitario Nazionale), founded in 1978, aims to provide uniform and comprehensive care, financed by general taxation. The SSN, despite a certain degree of variability in the quality of its services across Italian regions, provides universal coverage, ensuring free choice of providers to patients through a pluralistic delivery structure (public and private), at relatively low cost. In 2007, public health expenditure, which accounts for more than 78% of total health expenditure, was around 6.7% of GDP, lower than most developed countries<sup>40</sup>

Indeed, the SSN, and the principles it is based on, could be a model for low income countries. An example of this is the development of the Brazilian Health System in the nineteen-eighties, following support from the Italian Development Cooperation<sup>41</sup>.

In the SSN's 30-year history, more medical doctors have been trained than were required by the Italian health system. Italy has thus more medical doctors than most other developed countries (according to the latest data, as of 2005, there were 4.5 practicing physicians per 1000 inhabitants in Italy, versus a median of 3.5 in the other developed European countries – the EU15)<sup>42</sup>, and is a net exporter of medical doctors. Many Italian health workers also serve in the health services of developing countries, often taking advantage of the special leave and service recognition given to employees of Italian public institutions when they engage in development cooperation activities.<sup>43</sup>

Italy's foreign aid programme is carried out under the authority of Law No. 49 of 1987.<sup>44</sup> This places both the political direction and implementation of its international development cooperation under the responsibility of the Ministry of Foreign Affairs, and specifically, it's the Directorate-General for Development Cooperation (DGCS). Although the three most recent peer reviews by the OECD's Development Assistance Committee (DAC) (1996, 2000, 2004) noted deficiencies resulting from the application of the law, as well as the managerial limitations of the bureaucratic structure, successive parliamentary attempts at reform have failed.

The guiding principles for Development Cooperation in the health sector were published in 1989,<sup>45</sup> and are currently being reviewed. These principles reflect both the Alma-Ata Declaration and the SSN's approach to providing health for everyone. They have been

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<sup>40</sup> OECD (Organisation for Economic Cooperation and Development). OECD health data: statistics and indicators for 30 countries. In: 2006. I, editor. Paris, 2006.

<sup>41</sup> Centro Brasileiro de Estudos de Saúde (CEBES). Encontro Italo-Brasileiro de Saúde 18 a 21 de Junho de 1989. *Divulgação em Saúde para debate.*: CEBES, Londrina Junho 1991, 1991.

<sup>42</sup> OECD (Organisation for Economic Cooperation and Development). OECD health data: statistics and indicators for 30 countries. In: 2006. I, editor. Paris, 2006.

<sup>43</sup> Repubblica Italiana. Legge 49/87 - Nuova Disciplina della Cooperazione dell'Italia con i Paesi in Via di Sviluppo., 1987.

<sup>44</sup> Repubblica Italiana. Legge 49/87 - op.cit

<sup>45</sup> Direzione Generale della Cooperazione allo Sviluppo. La Cooperazione sanitaria italiana. Principi guida.: Ministero degli Affari Esteri, 1989.

repeatedly mentioned in the annual reports to the Italian Parliament, where health has a high priority. Some of these fundamental principles of the Italian approach to health are the equitable distribution and access to health resources, an emphasis on prevention, community participation, technological appropriateness, inter-sectorality, promotion of local self-sufficiency, and supporting the development of local health systems.<sup>46</sup> In addition, health is a regular component of the wider, integrated human development programmes carried out by the Italian Development Cooperation since the early nineties, in collaboration with the United Nations Development Programme (UNDP) and other UN agencies, as part of its poverty reduction strategy.<sup>47</sup>

In keeping with these principles and with its integrated approach to health and development, Italy abstained from purely vertical (i.e. targeted at a specific disease) initiatives until 1999, when the fight against HIV/AIDS became a central issue. Since the launch of the GFATM in 2002, the majority of Italian resources devoted to international health-care cooperation have been directed towards it.

The guidelines of the Italian Development Cooperation for 2009-2011<sup>48</sup> state that Italy will continue to commit to global health supporting multilateral initiatives such as the GFATM, the AMC for vaccines, the IFFIm, and “at the same time it will promote an increased commitment in support of health systems in the context of the Toyako Framework for Action”.<sup>49</sup>

Taking advantage of the legislative autonomy granted constitutionally to them, some Italian Regions and a few autonomous Provinces have adopted regional laws to regulate decentralised international cooperation activities. The five most committed Regions (Emilia Romagna, Lombardia, Toscana, Umbria, Veneto) have also introduced specific regulations for their development aid for healthcare, allocating responsibilities to dedicated offices within their Regional Health Departments. The Italian Law also grants to Municipalities and other local institutions the right to allocate a limited proportion of their annual budget to international cooperation and solidarity initiatives.<sup>50</sup>

Italy's National Civil Protection department participates in Italian-led relief operations and medium-term reconstruction projects at the sites of natural disasters that occur overseas. For example, it was involved with the relief work that followed the 2004 tsunami.

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<sup>46</sup> Ministero degli Affari Esteri, Direzione Generale per la cooperazione allo sviluppo. Relazione annuale sull'attuazione della politica di cooperazione allo sviluppo nel 2006, Rome, 2006

<sup>47</sup> Carrino L, *Perle e pirati. Critica della cooperazione allo sviluppo e nuovo multilateralismo*. Trento: Erickson eds., 2005.

<sup>48</sup> Direzione Generale della Cooperazione allo Sviluppo. La Cooperazione Italiana allo sviluppo nel triennio 2009-2011: Linee guida e indirizzi di programmazione. Roma: Ministero degli Affari Esteri., 2008.

<sup>49</sup> *Ibidem*

<sup>50</sup> Repubblica Italiana. Legge 68/93 - Conversione in legge con modificazioni del decreto-legge 18 gennaio 1993 n.8 recante disposizioni urgenti in materia di finanza derivata e di contabilità pubblica, 1993.

On that occasion, the department's coordination with the Ministry of Foreign Affairs was a source of contention.<sup>51</sup>

## 2. Development cooperation

### The characteristics of Italian ODA in Health (ODAH)

1. Notwithstanding the above mentioned instability of Italian ODA (Figure3), sectoral data are consistent with the declared priority attributed to health. For the period 2001-2007, the Italian Official Development Aid in Health (ODAH)/Total Sector Allocable Aid ratio (13.3%) is close to that of G7 (13.8%) and of that of DAC group (13.7%) (Figure 4). In the same period, Italian commitments to ODAH (at constant prices) almost tripled; this represented the highest increase among G7 countries and almost twice the increase experienced by the DAC group (Figure 5).

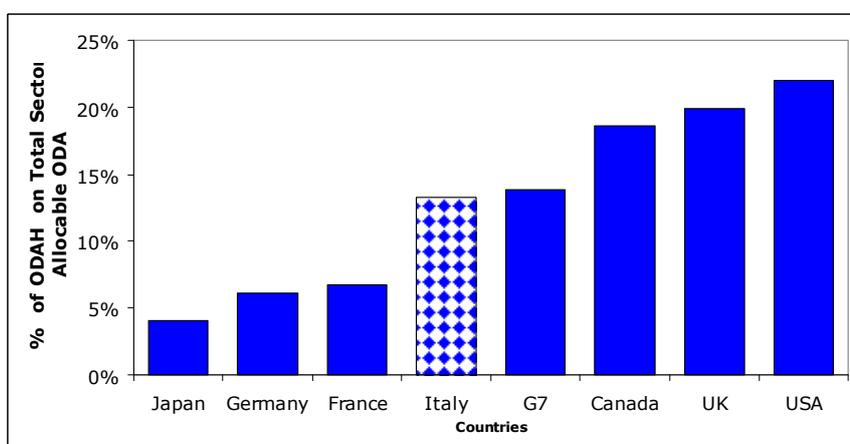


Figure 4 - Proportion of ODAH (Health and Population) on Total Sector Allocable ODA - Aggregated values - years 2001-2007 (Source: OECD/DAC)

<sup>51</sup> Repubblica Italiana, Legge n.49 del 26 febbraio 1987

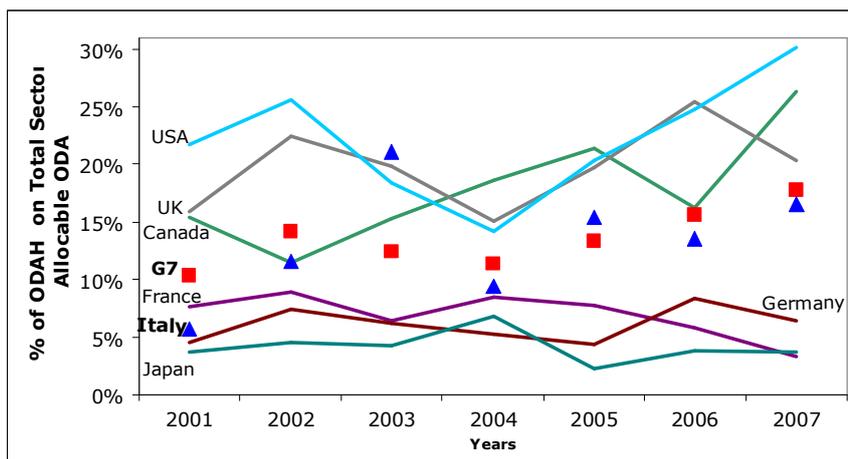


Figure 5 - Proportion of ODAH (Health and Population) on Total Sector Allocable ODA - years 2001-2007 (Source: OECD/DAC)

Unfortunately, the data from the OECD and the DGCS are not directly comparable because of different aggregation rules. However, our analysis of the latter data indicates that the dramatic increase in ODAH was due entirely to Italy's contribution to the GFATM, with a consequent shift from bilateral to multilateral channels of aid. Table 4, which combines data from the DGCS and the Ministry of Economics and Finance<sup>52</sup> the two institutions that independently channel resources to the GFATM, shows that bilateral cooperation did not vary significantly over the observed period (2001-2008), while contributions to international organizations (whether earmarked or not) underwent a pendulum-like swing. A similar pattern can be seen for the rather unstable contributions to the GFATM, where a late payment in 2007 exceptionally provided advance resources for the following year.

On the other hand, we should point out that OECD/DAC figures do not include health activities carried out in multisector interventions; nor do they include intervention classed as emergency or humanitarian aid, of which health activities comprise a significant part in some cases.

Africa remains the main beneficiary of Italian ODAH initiatives, accounting in 2008 for 57% of ODAH geographically allocable funds (Figure 6).

Between 2000-2008, DGCS financed health initiatives in 79 different countries: 37 out of 79 were Sub-Saharan African countries. In the same period 2370 projects were registered into the DGCS database.

<sup>52</sup> Ministero dell'Economia e delle Finanze. Relazione unificata sull'economia e sulla finanza pubblica. Roma, 2008.

Table 4 Italian ODAH net disbursements by channel - years 2001-2008

Year	2001	2002	2003	2004	2005	2006	2007	2008
<b>ODAH Net disbursements by channel</b>	<b>M € %</b>	<b>M € %</b>	<b>M € %</b>	<b>M € %</b>	<b>M € %</b>	<b>M € %</b>	<b>M € %</b>	<b>M € %</b>
Bilateral	34,0 60,3%	30,0 19,6%	27,3 21,9%	23,3 82,1%	24,0 10,5%	24,8 71,2%	29,8 6,7%	27,8 87,9%
Contributions to International Organizations (excluded GFATM)	22,4 39,7%	10,7 7,0%	9,5 7,6%	5,1 17,9%	23,8 10,5%	10,0 28,8%	5,1 1,1%	3,8 12,1%
Contributions to GFATM	- 0,0%	112,0 73,4%	88,0 70,5%	- 0,0%	180,0 79,0%	- 0,0%	410,0 92,1%	- 0,0%
<b>Total</b>	<b>56,4 100%</b>	<b>152,7 100%</b>	<b>124,8 100%</b>	<b>28,3 100%</b>	<b>227,8 100%</b>	<b>34,8 100%</b>	<b>444,9 100%</b>	<b>31,7 100%</b>

Source: Ministry of Foreign Affairs and Ministry of Economy and Finance, Italy

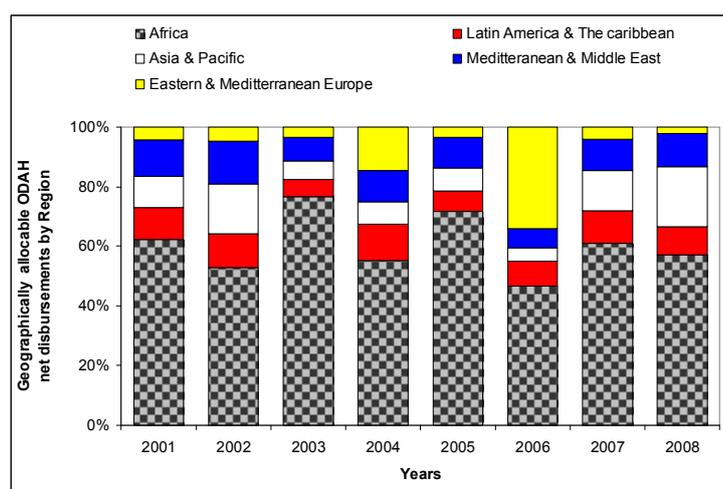


Figure 6 - Italian geographically allocable ODAH net disbursements by Region (only allocable funds) - years 2001-2008

(Source: DGCS - Ministry of Foreign Affairs, Italy)

## Bilateral cooperation

### Support to National and Local Health Systems

Besides the shift towards multilateral “vertical” initiatives, Italy’s bilateral ODAH initiatives continue to follow two main strategic lines: support to national health systems, and support to local health systems and decentralization processes. Besides these, Italy has increasingly shown interest since 1997 in Sector Wide Approaches (SWAp)<sup>53</sup>, which entails a reduction in the more traditional project-based approach and the involvement of

<sup>53</sup> Under SWAp, international agencies contribute to the financing of the entire sector, sacrificing their priorities and projects. In return, they have the right to participate in the drafting of national development policies and in decision-making regarding the destination of resources. Participation in SWAp programmes comes in a range of forms: financial participation in the national budget of the beneficiary country (called Channel I); direct contribution to the Ministry of Health budget (Channel II); and the direct implementation and financing of activities included in the health plan drawn up by national authorities and undersigned by all donors (Channel III).

Italian cooperation with other donors<sup>54</sup>. A 2004 report to parliament stated that under this scheme “in 2003 the first sector wide programmes were launched, contributing 15 and 10 million euros over a three-year period to the national health development plans of Ethiopia and Uganda respectively, through General Budget Support and directly managed technical assistance”<sup>55</sup>. More recent reports based on these two experiences read that contributions to state health sector budgets had been extended to Mozambique, the Palestinian Territories, Niger and Burkina Faso<sup>56</sup>.

Among the specificities of the Italian approach – both in the case of SWAp and traditional projects- there is the promotion of links between strengthening national and local health systems, as well as accompanying the financial support with Technical Assistance at both levels to ensure results oriented implementation<sup>57</sup>.

Similarly, local ownership, the promotion of a wide involvement of local civil society and coordination with all locally relevant actors, are other characteristics of development initiatives supported by Italy. In some countries, where the indigenous health system is highly relevant to public health, the integration with the national health system has been fostered through pilot experiences that eventually strongly influenced national policies, as in the case of Bolivia <sup>58</sup> <sup>59</sup>.

The same project in Bolivia is also a very good example of another common approach of Italian ODAH, the promotion of international networking among local communities and institutions in Italy and in partner countries, in what is known as “decentralised cooperation”. A study has shown the added value deriving from such a networking activity through the analysis of sociograms (Figure 7). The Italian development cooperation project has promoted the interlinking of International Organizations, local and Italian institutions, the Catholic Church, local civic committees, etc.; the network represents an additional factor of long-term sustainability and further autonomous development<sup>60</sup>.

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<sup>54</sup> OECD / DAC. Development Cooperation Review Series, Italy, 2000

<sup>55</sup> Ministero degli Affari esteri, DGCS, Relazione annuale see above, 2004

<sup>56</sup> Cooperazione Italiana. DIPCO n. 22, 7/7/2007, pp. 97-104

<sup>57</sup> Direzione Generale della Cooperazione allo Sviluppo. Delibera 187 - Comitato direzionale Riunione del 14-10-2008: Cooperazione Italiana, Bollettino settimanale DIPCO n. 38, 2008:151-152. (E' QUESTA??)

<sup>58</sup> Fornabaio, R., I servizi sociosanitari in contesti interculturali: l'esperienza Willaqkuna – Potosì (Bolivia). Individuazione di un approccio metodologico per la sua replicabilità, Università degli Studi di Milano Bicocca, Tesi di laurea, anno accademico 2002-2003

<sup>59</sup> The author recently participated in the evaluation of this development programme in Potosì (Bolivia); some public information is to be found on the Italian Development Cooperations official website <http://www.cooperazioneallosviluppo.esteri.it/pdgcs/italiano/Speciali/sanita/Intro.htm>

<sup>60</sup> Greco, G., L'approccio di rete come elemento strategico nella gestione delle iniziative di cooperazione allo sviluppo. Il caso Potosì, Università Commerciale “Luigi Bocconi” – Milano, Tesi di laurea, anno accademico 2002-2003

### The case of HEALTH SWAp in Mozambique

Mozambique health SWAp shows many of the advantages linked to SWAp: stronger local government leadership, more focus on health policies and strategies, lower transactions costs, a more effective resource allocation. Mozambique health SWAp has been the result of an open and inclusive process started in 2002. It relied on some specific tools:

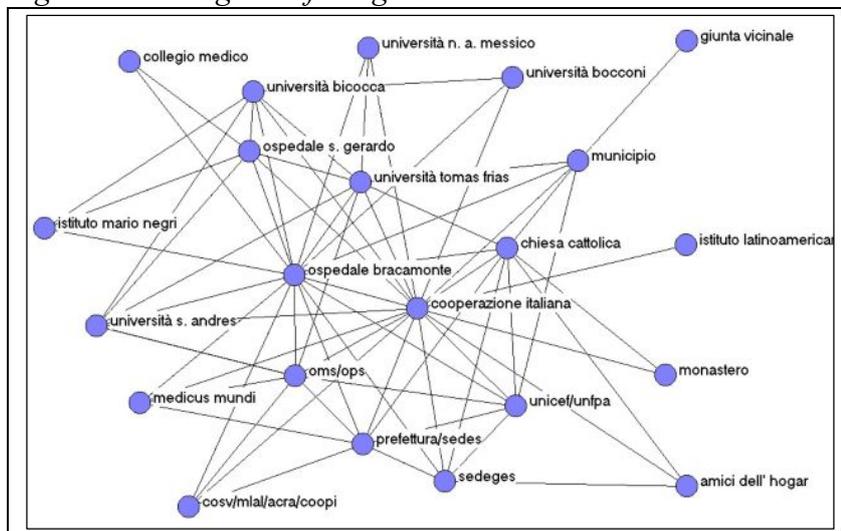
- an health strategic plan (PESS) shared by all the partners;
- a Code of Conduct shared by all the partners;
- coordination mechanisms between MoH (Misau) and its partners: coordination committees, work groups;
- a shared monitoring and evaluation system.

Main aid alignment and harmonization mechanisms implemented in Mozambique are: General Budget Support and health common basket, known as PROSAUDE.

In 2007 Italy decided to join PROSAUDE through 2.25 million Euro of contribution in three years. Italy decided also to support SWAp implementation ensuring technical assistance and coordination, through an additional contribution of 2.4 million Euro, in three years.

Emphasis has been put on supporting the link between Provincial Health Systems (with longstanding support from Italian Cooperation) and the National Health system.

Figure 7 - Sociogram of the global Potosi network



### Multilateral cooperation

Since the early nineties Italy supported integrated local human development programmes implemented under the auspices of a number of UN programmes and agencies (under acronyms such as PRODERE, SMALP, HEDIP, PDHL, PDHI, SEHD, ATLANTE, PRINT, PASARP, CITY TO CITY, APPI, UNIVERSITAS) coordinated by the United Nations Development Programme (UNDP) and other UN agencies, as part of its poverty reduction strategy.

The results of that experience and the approach adopted, led among others to integrated in multilateral initiatives such as ART (a French acronym for "support to territorial and thematic networks of human development cooperation"), that brings together the programmes of several United Nations Agencies (eg UNDP, UNESCO, UNIFEM, WHO, UNAIDS, ILO, UNITAR, UNCDF, UNOPS,).

The programme ART- GOLD (Governance and Local Development), launched in 2004 helps regional and local authorities in the South and the North to set up alliances and partnerships in support of local development and governance processes prioritised by countries through ART GOLD programmes. More than 300 decentralized cooperation partnerships operate in different countries and, in the North, include regional and local governments of Belgium, Canada, France, Greece, Italy, Spain and Switzerland.

ART involves local communities in development processes, and promotes a new type of multilateralism in which the United Nations system works together with governments to promote the active participation of regional and local authorities, local communities and social stakeholders in the South and the North, while striving to fulfil the objectives of the Millennium Development Goals.<sup>61</sup>

### *The contribution to global health initiatives and new financial mechanisms*

Besides supporting certain specific WHO-led initiatives through extra-budgetary contributions, Italy did not directly engage in global public-private partnerships until the GFATM was launched at the Genoa G8 summit in 2001. The GFATM soon became the most important beneficiary of Italian ODAH, receiving a total contribution of US\$ 1,008.3 million between 2001 and 2008. Italy is one of the major contributors to the GFATM (it is the fourth largest donor along with Japan, after France, US, and UK) and has a seat in the GFATM's board like US and Japan. However, Italy's contribution has been rather unstable. In fact, the 2007 payment was only made by the new Italian Government at the beginning of 2008 because of its predecessor's insolvency. It also paid the 2008 contribution in advance in order to regain credibility.

Following this new trend, over the observed period (2001-2008) Italy also engaged in a number of other global health initiatives. For example, it contributed to the Global Polio Eradication Initiative (US\$ 34,8 million)<sup>62</sup>; Roll Back Malaria (over US\$ 10 million)<sup>63</sup>; the Stop TB initiative (US\$ 15.8 millions)<sup>64</sup>.

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<sup>61</sup> UNDP, <http://www.undp.org/partners/region-local/art.shtml>

<sup>62</sup> Global Polio Eradication Initiative. <http://www.polioeradication.org/poliodonors.asp>

<sup>63</sup> Ministero degli Affari Esteri, Direzione Generale per la Cooperazione allo Sviluppo, Italy and the fight against AIDS, Tuberculosis and Malaria, July 2005

<sup>64</sup> Stop TB partnership, personal communication

Italy also played an important role in the setting up of the so called AMC, aimed at accelerating the development of new vaccines, ensuring the subsequent purchase by donors according to criteria arranged in advance with pharmaceutical companies<sup>65</sup>. Italy pledged US\$635 millions out of the US\$1.5 billions (other donors are Canada, Norway, Russia, UK, and the Bill and Melinda Gates Foundation) to pilot the scheme to foster the development of a new pneumococcal vaccine. Italy also participates in the Global Alliance for Vaccines and Immunizations (GAVI) through the IFFIm. Italy pledged €473.5 billions over 20 years in support of this new financial mechanism based on the issue of bonds in order to collect funds that GAVI will use to purchase drugs and vaccines<sup>66</sup>.

***Other public actors: the Ministry of Health, Regional and Local governments, Health authorities***

ODAH interventions are undertaken also by the Ministry of Health (MoH) and the Istituto Superiore dei Sanità (ISS- the leading technical and scientific public body of the SSN), which have set up specialised offices for these activities. The MoH is involved in many twinning projects, including those funded by the EU, with new EU member countries, non-EU Mediterranean countries, and countries that were part of the former Soviet Union. These projects often involve the ISS, the Regions, other research institutions, parts of the SSN such as the Regional agencies for public health and environment, and health care providers.

Additionally, the MoH has signed bilateral agreements on scientific cooperation, health information exchange, and health research with several countries. It has also set up a coordinating body for health cooperation initiatives with Mediterranean and Middle East countries.

ISS is involved in ODAH through the development of networks for promoting evidence-based medicine, health information systems, and training. Currently, the ISS is undertaking scientific and developments projects with several countries. These include China, South Africa, the Central Asian Republics, and various countries in Latin America, the Balkans, and the Middle East. It is engaged in development partnerships in Africa and in countries in turmoil, by providing humanitarian and technical assistance in

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<sup>65</sup> GAVI Alliance. Advanced Market Commitments for Vaccines (AMC) Fact Sheet. [http://www.vaccineamc.org/files/AMC\\_FactSheet\\_v2.pdf](http://www.vaccineamc.org/files/AMC_FactSheet_v2.pdf), 2007-2008.

<sup>66</sup> International Financial Facility for Immunization Donors' Page. <http://www.iff-immunisation.org/donors.html>.

collaboration with other international agencies.

Since the late 1990s, the Italian Regions have increasingly undertaken development cooperation activities. Most of these have been in the health sector, due to the fact that this accounts for almost 80% of Regional . The Regions' ODAH initiatives are implemented both directly through regional health services, and indirectly through the funding of local and international NGOs. They cover a wide range of activities including: the provision of health services by regional health care providers to patients (mainly children) from developing countries; the provision of medicines, health technologies, and health personnel to developing countries (mainly as humanitarian intervention); training and exchange programmes for health workers; health promotion and prevention projects. Italian Regions provide also direct financial contributions to WHO programs (e.g. the Lombardia Region contributed to more than US\$600,000 to Stop TB). Finally, they are involved in (and co-fund) research programs of the EU and other international organisations, and ODAH initiatives initiated by the Minister of Foreign Affairs, the MoH, and the ISS<sup>67</sup>.

The total financial contribution of the Regions to overall ODAH is difficult to estimate, as information is only available on the budget allocated to initiatives that have been entirely funded by Regional Governments. This budget is indeed still rather low; for instance, in 2007, the official expenditure on ODAH of the five most important Regions (Emilia Romagna, Lombardia, Toscana, Umbria, and Veneto) was estimated to be around 8.5 million Euro. Nevertheless, we assume that this is only a fraction of the resources that the Regions invest in ODAH, considering their extensive participation in initiatives that: a) involve partnerships with other national or international bodies, which are not included in the official budget, b) are implemented by Aziende Sanitarie Locali (ASL), which are public enterprises funded by the Regions that are responsible for the health of the population in a given area, or other regional health care providers that have their own budgets.<sup>68</sup>.

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<sup>67</sup> Istituto superiore di Sanità. <http://www.iss.it/>.

<sup>68</sup> Pietrogrande E. Stocchiero A. Coletti R. Indagine sulla cooperazione sanitaria internazionale delle Regioni italiane. *Working Papers Osservatorio Interregionale Cooperazione e Sviluppo: Centro Studi di Politica Internazionale (CESPI)*, 2008.

## The contribution of Non-governmental actors

### *Non-profit organizations and development NGOs*

In Italy there are other actors playing an increasingly important role in promoting global health. According to most recently collected data, in Italy there are 221,412 non for profit organizations, including 4,720 foundations. Many of them (1,433) are involved in international cooperation and solidarity activities - including in the health sector<sup>69</sup>. Not-for-profit organizations play an important advocacy role and have shown to be able to mobilize relevant amounts of resources from the private sector - in 2007 they raised approximately 341 millions euro - and to involve the civil society<sup>70</sup>. Out of that universe of organizations, 239 NGOs are accredited by the Ministry of Foreign Affairs thus being able to access ODA funding for their projects and to act as implementing agencies of governmental projects.

Over the period 2000-2008, DGCS funded 991 projects proposed by accredited NGOs, with a total disbursement of 53.9 million euros. These projects have been implemented in 51 different countries. Projects geographical distribution is reported in Figure 8.

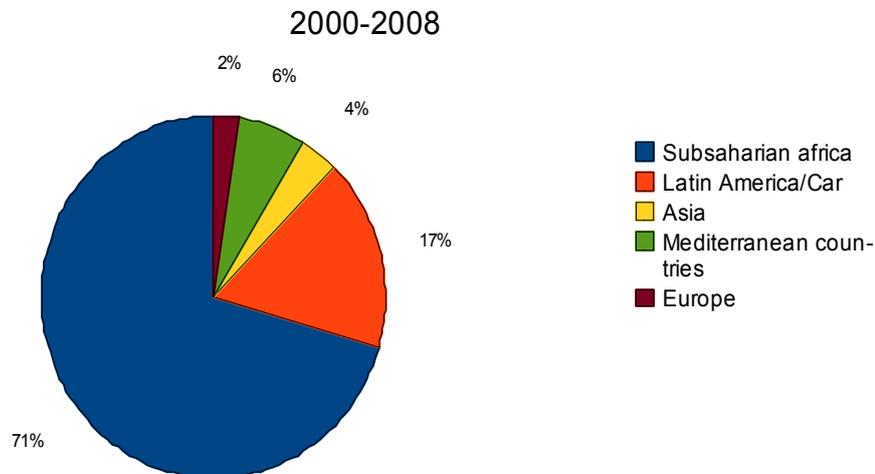
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<sup>69</sup> Consiglio Nazionale dell'Economia e del Lavoro/Istituto Italiano di Statistica. Primo Rapporto sull'Economia Sociale. Dimensioni e caratteristiche strutturali delle istituzioni non profit in Italia. Roma: Consiglio Nazionale dell'Economia e del Lavoro, 2008.

<sup>70</sup> Consiglio Nazionale dell'Economia e del Lavoro/Istituto Italiano di Statistica. Primo Rapporto sull'Economia Sociale. Dimensioni e caratteristiche strutturali delle istituzioni non profit in Italia. Roma: Consiglio Nazionale dell'Economia e del Lavoro, 2008.

Figure 8 Geographical distribution of NGO projects funded by DGCS

### Geographical distribution of NGOs projects funded by DGCS



A number of accredited NGOs also act as implementing agencies for governmental projects identified by DGCS. Between 2000 and 2008 there were 128 projects implemented by accredited NGOs on behalf of the Italian Government. Total disbursement for those projects was 19.6 million euros. In addition often NGOs with their local counterparts implement also projects funded through aid funds allocated to Italian embassies. Over the period 2000-2008, 253 projects were funded locally using this mechanism.

In 2007 there were 104 accredited NGOs implementing 507 projects in the health sector. Interestingly, 48.3% of out these projects were entirely funded by private sources, 22,3% were either funded or co-funded by the Ministry of Foreign Affairs, and the rest by a number of public national and international sources<sup>71</sup>.

Italy is also home of many faith based organizations involved in providing health services in low income countries. These organizations, though independent and with international constituencies, often rely on Italian personnel and refer to the Italian government for institutional support, including overseas where priests and nuns often refer to Italian Embassies for support to their activities.

<sup>71</sup> Damiano P. Dragone M. Grandi M. Lagasi I., editor. *ONG - Guida alla cooperazione e al volontariato internazionale*. Milano: Comune di Milano, 2008.

## *Foundations and Philanthropies*

An increasing interest in global health is shown by big Italian corporate foundations and the Italian Banking Foundations. The latter represent 88 non profit autonomous entities that spun off the banking assets in the 90s in accordance to specific legislation<sup>72</sup> to continue with the socially-oriented activities that the former Savings Banks and Pledge Banks had conducted together with their lending business.- are increasingly interested in global health. These Foundations are already funding numerous domestic and international health projects and biomedical research (e.g. in 2007 they disbursed 134 millions Euro for public health projects and 247 millions Euro for research including biomedical research)<sup>73</sup>, and could soon become major players in supporting Italian initiatives in the global health scene: among these, *Fondazione CARIPLO*, one of the largest Foundations in the world, who recently approved specific projects for research and training in Global Health.

## *Corporate Sector*

The Italian corporate sector has also been showing increasing interest in global health. Interestingly, for instance, ENI and Giorgio Armani are among the few corporations in the world, which contributed directly to the GFATM. In the countries where it has extracting activities (i.e. Azerbaijan, Nigeria, Congo, Libya), ENI funds several health system development projects, as well as activities of international organizations, such as UNICEF and WHO<sup>74</sup>. For example in Lybia (Sabratha archeologic area) ENI is supporting local healthcare system through training programs for health care professionals, and health facilities building.

## *Universities and other research and training institutes*

Finally, the Italian academic community has recently introduced global health training programmes in several medicine schools - e.g. electives in Global Health are organized at 24 Italian Medicine faculties<sup>75</sup> - in some Faculties of Social Sciences, Economics and Management, and even in Business Schools. Many of these initiatives were promoted by and receive the technical contribution from the Italian Global Health Watch (*Osservatorio Italiano sulla Salute Globale, OISG* – [www.saluteglobale.it](http://www.saluteglobale.it)). This is a grouping of

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<sup>72</sup> Repubblica Italiana. Legge "Amato" No. 218/90., 1990.

<sup>73</sup> Associazione di Fondazioni e di Casse di Risparmio S.P.A. (ACRI). Annual Report, 2008.

<sup>74</sup> ENI, Divisione E&P, personal communication

<sup>75</sup> Equal opportunities for health Action for development.

<http://www.mediciconlafrica.org/globalhealth/pagina.asp?ID=224&sezione=13>, 2008.

multidisciplinary scientists and professionals active in the domain of public health aimed at promoting the right to health and at disseminating evidence to inform Italian policy makers and the general public on global health. A recent project of the OISG aims to bring students, faculty, professional staff, researchers, representatives of medical companies, health and education organisations/institutions, and health community members together to create new synergies, strengthen partnerships and networks, and outline a plan of action to advocate and teach Global Health.

## **VI. Mobilizing the “System Italy” for Global Health**

### *Italy’s interests and strengths for Global Health*

Italy needs to regain international credibility in the area of development aid and, specifically in the area of global health; commitments need to be honoured. This is not only a moral obligation but an unavoidable foreign policy task to keep its position among leading world economies and remain a respected member of the European community.

On the other hand Italy has a longstanding position and commitment toward both domestic and international health, with its Constitution recognising health as a fundamental human right, and the obligation for international solidarity deriving from its development cooperation law n.49/87 which indicates the satisfaction of primary needs and safeguarding human life (i.e. “human security”) as primary purposes.

Italian civil society is very sensitive to the human condition in the rest of the world, and the public opinion generally favours aid to poorest countries considering it an unavoidable moral obligation.

Important investments have been made over the years in the establishment of direct technical and scientific relations between institutions in Italy and in the developing countries. Besides the contribution to the development of partner countries, it is in the interest of Italy to nurture and further develop those human, professional, cultural and institutional links.

A more strategic approach to global health, would not only be welcomed by most organisations, whose purpose is directly linked with international solidarity and aid to development, but could also elicit the healthy interest of the Italian corporate sector which needs to respond to public national and international quest for social responsibility.

There is a considerable amount of Italian knowledge and expertise in several domains of

health, that could greatly benefit from a more coordinated and consistent engagement of Italy in Global Health.

In relation to the role it may play in promoting global health, Italy counts with a number of strengths. Spirit of solidarity and sense for social justice is deeply rooted in Italian society and constitutes a basis for mobilization of energies toward improving health of those most in need.

The Italian SSN is founded on equity (it is financed through general taxation, providing universal access to health services) and has gained international recognition (e.g. it ranked second in WHO's world health systems review published in 2000)<sup>76</sup>. Thus, the SSN may provide a vital contribution to the strengthening of health systems, especially in countries willing to achieve universal coverage and access.

Italian development NGOs have a long tradition of partnering both private and public institutions in low income countries, with a significant number of them being "on the field" since the early nineteen-sixties. If in early years their approach tended to support charitable services "parallel" to the public health system, through the personal experience of thousands of volunteers and professionals, most NGOs developed a deep understanding of local needs and appropriate answers, today they are rather focussed on increasing the capacity of hosting countries' health systems. Thus they often collaborate directly with those institutions, providing and fostering at the same time the synergy with thousands of charitable health services (mostly linked to the Catholic Church), that – as known – still constitute a fundamental backbone of DCs' health systems, especially in Africa.

Beside the historical and professional role of development NGOs, an additional strength is represented by the Italian non profit sector. This is in fact increasingly active internationally, especially in the case of associations aiming at providing socio-economic integration to immigrants. Not to mention the vital network of local institutions and public organizations involved in development programmes, mostly in partnership with homologous entities in DCs.

If we should try to answer the question about what could be the comparative advantage of Italy in contributing to global health, no doubt the answer would be: its integrated approach to health, its experience in developing an national health service providing universal coverage (including lessons learned form draw-backs), its alignment with the principles and practices of Primary Health Care, based on wide and active citizenship.

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<sup>76</sup> WHO, World Health Report 2000, World Health Organization, Geneva, 2000.

## VII. Conclusions

Italy's ODA financial commitments have been poor for many years. Its ODA/GNI ratio has been constantly less than 0.20% since 2000 which is substantially below the average of the OECD-DAC countries, though following in keeping with the overall trend. The effects of the recent financial crisis may continue this downward trend, and the current Government anticipates substantial cuts in traditional sources of ODA.

In addition, Italy continues to suffer from structural weakness. It has not been able to modernise the management and coordination structure of its ODA, which remains marked by fragmentation among various governmental bodies, the lack of a clear political direction, and unstable funding. The health sector has been no exception. Excluding the contributions to the GFATM, ODAH financing has not increased significantly over the years, with 2008 disbursements being just over half (56%) of 2001's in nominal terms (Table 4).

However, as a result of the contributions to the GFATM, total Italian ODAH has increased considerably. Italy is also supporting new financing mechanisms, including the IFFIm and AMC initiatives, by pledging substantial funds. Nevertheless, these commitments to vertical initiatives have not been accompanied by attempts to address concerns about the system-wide effects of global health initiatives, nor they have taken into account the comparative advantage of Italian experience, coherence with its vision in health, or the recent shift of the global health agenda towards the strengthening of health systems.

The "social marketing" of selective measures to control specific diseases is obviously easier, but common sense, long standing international orientations and commitments, and increasing evidence highlight the need for an integrated approach to health: on one side tackling social determinants of health and on the other side working for equitable and effective health systems. The next World Health Assembly will indeed be asked to resolve in this direction<sup>77</sup>.

Italy's official position towards global health does not seem to be suitably sound at a time in which it is replacing Japan as the G8 chair. In an attempt to cover Italy's inability, to meet its longstanding and recent ODA commitments, the current Government insists on the involvement of "Italy's System" to mobilize resources for development assistance.

Italy's contribution to development, and specifically to global health, could indeed be enhanced by appropriate legislative and managerial measures to unleash the full potential of the experience of its SSN, its decentralised public institutions, its extremely active civil society, the increasing relevance of its Foundations, the growing social responsibility of its corporate sector, the growing link between its academic institutions and partners in poorer

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<sup>77</sup> WHO, 124th Session EB124.R6, 23 January 2009.

countries, and possibly its traditionally privileged connection with the Catholic Church and its overseas missions.

Such an approach, however, does not detract from the urgent need for a substantial increase in ODA funding and structural reform to ensure appropriate strategic direction, operational coordination, and administration of a renewed Italian effort on the global development and health scene.

To stay relevant, Italy, which pledged to be among the major players in establishing the GFATM and supporting a number of new financing mechanisms, should push for the harmonization of global initiatives and their alignment with beneficiaries' management systems. Thus, keeping in line with recent international trends, and including the G8's endorsement of Toyako Framework for Action on Global Health.

Hosting the G8 summit can be an exceptional opportunity for the Italian Government to catalyse the energies of "System Italy" for global health. Fostering correct information through the media and public initiatives; promote global health through specific formal and non-formal educational programmes; supporting coordination and interchange between multiple stakeholders; sharing experiences and knowledge, are all indispensable ways to get attention, involvement and societal backing to a renewed Italian role in global health.

Achieving this will, however, require a clear understanding of the needs of the poor and a genuine wish for equity to close the increasing social and economic gap produced by globalisation, rather than seeking maximum visibility or commercial interests.



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