Round Table

Health in the developing world: achieving the Millennium Development Goals

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Abstract The Millennium Development Goals depend critically on scaling up public health investments in developing countries. As a matter of urgency, developing-country governments must present detailed investment plans that are sufficiently ambitious to meet the goals, and the plans must be inserted into existing donor processes. Donor countries must keep the promises they have often reiterated of increased assistance, which they can easily afford, to help improve health in the developing countries and ensure stability for the whole world.

Keywords Public health/economics; Delivery of health care/organization and administration; Investments; Financial management; Development; Goals; Advisory committees; Developing countries (*source: MeSH, NLM*).

Mots clés Santé publique/économie; Délivrance soins/organisation et administration; Investissement; Gestion financière; Développement; Objectif; Comité consultatif; Pays en développement (*source: MeSH, INSERM*).

Palabras clave Salud pública/economía; Prestación de atención de salud/organización y administración; Inversiones; Administración financiera; Desarrollo; Metas; Comités consultivos; Países en desarrollo (*fuente: DeCS, BIREME*).

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Voir page 949 le résumé en français. En la página 949 figura un resumen en español. يمكن الاطلاع على الملخص بالعربية في صفحة 949.

A revolution in public health thinking and practice is under way, as part of a broader campaign to end extreme poverty. There is a growing recognition worldwide that the time has come to fulfill the long-standing pledge to make health services available for all, including the poorest of the poor. Poor countries around the world are taking bold steps to scale up the health services in their countries. They are now looking to the rich countries to hold up their end of the bargain.

The Millennium Development Goals (MDGs), the international objectives on poverty reduction adopted by the world community in 2000, provide the broad context for this revolution in thinking and practice. The MDGs place a central focus on public health, in recognition of the fact that improvements in public health are vital not only in their own right but also to break the poverty trap of the world's poorest economies. A significant number of the MDGs are explicitly about health: reducing the child mortality rate by two-thirds by 2015; reducing the maternal mortality rate by three-quarters by 2015; controlling the great pandemic diseases of aquired immunodeficiency syndrome (AIDS), malaria and tuberculosis; giving access to safe drinking-water and sanitation; and alleviating hunger and undernutrition. Moreover, the first MDG — to reduce by half the proportion of the population in extreme poverty (so-called "dollar a day" poverty) by 2015 — cannot conceivably be accomplished if the health goals are not achieved. Societies burdened by large numbers of sick and dying individuals cannot escape from poverty.

The MDGs emerged from the Millennium Declaration adopted by all Member Statess of the United Nations. They provide political leverage for health ministries to use within their own societies and in negotiations with the donor world. Not only did the world subscribe to these goals, but the United Nations member governments reaffirmed these commitments several times since, including at the International Conference on Financing for Development (Monterrey, Mexico, March 2002) and the World Summit on Sustainable Development (Johannesburg, South Africa, September 2002). In the Monterrey Consensus, the rich and poor countries adopted a compact. The poor countries accepted the responsibilities of good governance, serious policy design, transparency and openness to real implementation, while the rich countries accepted the responsibilities of greatly increased donor financing. Specifically, paragraph 42 of the Monterrey Consensus reads: "We urge developed countries that have not done so to make concrete efforts towards the target of 0.7% of gross national product (GNP) as official development assistance (ODA) to developing countries" (*1*). Honouring that commitment would signify an increase in donor aid from

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roughly US$ 70 billion per year to US$ 210 billion per year, in view of today's donor GNP of some US$ 30 trillion at current prices and exchange rates.

Keeping in mind that the Monterrey Consensus is signed by the rich countries as well as the poor, the amount of additional funding needed to solve the global health crisis should be readily available. Developing countries should not be reticent about making clear that they need more financial help, without which they will be a danger to themselves and to richer countries. If malaria and AIDS are not brought under control, if children are dying of respiratory infections because they breathe wood smoke inside huts for lack of modern cooking fuels, if they are not drinking safe water, the result is a tragedy not only for the poor world but also a danger for the rich world. The rich countries have to understand that there is no chance for political and social stability in the world if they do not help the poor to fight the war against disease. Disease leads to extreme poverty; extreme poverty leads to political instability; political instability leads to state failure; and state failure, alas, leads to violence, criminality, and havens for terrorism, not to mention the international transmission of disease itself.

The Commission on Macroeconomics and Health (CMH) found that roughly US$ 27 billion per year (at 2001 prices and exchange rates) would be needed from donors as of 2007 to enable the poorest countries to deliver basic life-saving health services (*2*). At today's prices and exchange rates, that is probably closer to US$ 30 billion per year. The figure represents around 0.1% of donor income, that is, ten cents per every hundred dollars of rich-world income. Since the current level of ODA is 0.25% and the promised level is 0.7%, the gap — equal to around 0.45% of donor GNP — would easily accommodate the increased spending in health services.

The common objection to plans for increased aid to scale up health systems is "absorptive capacity", that is, the human, infrastructure and macroeconomic constraints that may limit a country's ability to effectively absorb aid. In considering this issue, however, the CMH and now the United Nations Millennium Project, an advisory project to United Nations Secretary-General Kofi Annan which I have the honour to direct, have concluded that developing countries can absorb substantial increases of assistance if directed towards investments in health, especially if those investments are phased in over time in a sensible manner and according to an overall plan. In terms of macroeconomics, increased health investments financed by donor assistance will not destabilize countries, but will actually give a tremendous boost to productivity and to their ability to achieve economic growth. The main issues are not macroeconomic, but rather sectoral: ensuring that increased spending on health actually leads to increases in the capacity of the health system to deliver health services. This can be accomplished with well-designed plans for scaling up health services that extend over several years.

In order for poor countries to obtain more donor financing for health, they should take four steps. First, they must have an overall strategy for scaling up health services. Many ministries of health have already developed strategies for increasing the coverage of health services, but have often been told by donors to shelve the plans because they are too expensive. Now it is time to take those strategies off the shelf, if they exist, or to make new plans if the first step has not yet been taken. The strategies should be ambitious enough to meet the health MDGs, and to offer essential health services to the whole society, with special attention to the needs of the poorest of the poor. The rich countries must understand that the time to duck behind the excuse that the plan is "too expensive" is long past, given the very commitments that those countries have made repeatedly in recent years.

Second, there need to be detailed plans of implementation, especially a sequence of investments in physical capital (clinics, hospitals, training centers) and in health professionals. The implementation plans must be logistically thorough, focusing on details in each major areas of public health: how communities will be reached when there are not enough doctors, what kind of community health workers must be trained, what logistics systems will be in place for managing the supply of medicines, and so forth. The plans should present with great care the kinds of human resource development – doctors, nurses, community health workers, health-sector managers – that will be required and when.

Third, there has to be a financing plan, combining additional resources from donors and from domestic tax revenues. The CMH agreed that all developing countries should be allocating more of the national budgetary revenues to health. Specifically, as an overall guideline, the CMH called for an increase of 1 percentage point of GNP in annual health spending in public-sector budgets by 2007, and an increase of 2 percentage points of GNP in annual health spending by 2015. For middle-income countries, such an increase in budget spending on health might be enough to ensure universal access to basic health services. For the poorest countries, however, added donor assistance will be vital.

Consider the case of an impoverished sub-Saharan African country with a GNP of US$ 300 per person per year as of 2003. The cost of universal access to basic health services might be around US$ 36 per person per year, or roughly 12% of GNP. Currently, budgetary spending might be on the order of only US$ 3 per person per year, or 1% of GNP. According to CMH guidelines, the domestic effort should rise by 1 percentage point of GNP as of 2007 and 2 percentage points of GNP as of 2015. Suppose that per capita income is rising at 2% per year. In 2007, GNP per capita is around US$ 325. Public spending on health should by then be 2% of GNP according to the CMH guidelines, or US$ 6.50 per year, leaving a shortfall of US$ 29.50 that would have to be made up by donors. By 2015, GNP per capita would be around US$ 380, and public spending on health would be 3% of GNP, or US$ 11.40, leaving a shortfall relative to US$ 36 per capita of US$ 24.60, again requiring donor assistance to fill the financing gap.

Can the rich world really begrudge the poor this amount of help? The United States currently spends about US$ 5000 per person to run its health system: health systems need computers, information systems, management, doctors and nurses. Donor agencies should not expect developing countries to run a health system for US$ 5 per capita and then accuse them of being inefficient when the system does not work. Salaries have to be good enough to keep qualified health personnel in the health posts rather than migrating in search of better prospects. Poor countries cannot afford a good system without help from the richer ones. The fact is that the donors would hardly notice it — a few billion dollars a year is a rounding error in the US budget — yet millions of people could be saved with that money.

The financing plans that developing countries will present at consultative discussions, or to the International Monetary Fund (IMF) and The World Bank, should explain that funding essential health services requires not the few million dollars that

they have been receiving for the health sector, but hundreds of millions or perhaps one billion for large countries. It should remind donors that they have promised on many occasions to provide the needed funding.

The fourth step is advocacy. Developing countries' plans must be transparently designed, and they have to involve not only health ministries but also civil society: mission hospitals, nongovernmental organizations, community centres, and the country coordinating mechanisms that bring together all these critical stakeholders.

These plans must be brought into the real donor processes. Developing countries prepare Poverty Reduction Strategy Papers (PRSPs) for submission to the IMF and The World Bank. Health ministers must start getting bold health-sector programmes into these PRSPs, based on real financing needs. Above all, the programmes have to be ambitious enough to achieve the MDGs because those are what the world signed up to and what the PRSPs aim to accomplish (at the minimum). Countries have to plan to get on track to reduce under-5 mortality by two thirds by 2015. If getting on track means tripling the development assistance needed for health, they must say so.

In addition to the PRSPs, another important donor process revolves around the Global Fund to fight AIDS, Tuberculosis and Malaria. Most developing countries have programmes that are too small. Countries have to resist the pressure from donors who are trying to get programmes scaled down and instead present ambitious, realistic plans on a national scale to the Global Fund: not what the donors say can be paid for, but what is really needed.

This is a very important time. Poor countries are increasingly clamouring for real results and have plans to achieve them. This is a moment of truth. Do we live in a civilized world with a truly global community? Do we acknowledge our common humanity and understand that it is uncivilized to let people die for the lack of a small sum that could easily be mobilized? Do we understand the dangers to the entire world if we fail to act? ■

Résumé

Amélioration de la santé dans le monde en développement : réalisation des objectifs de développement pour le Millénaire

La réalisation des objectifs de développement pour le Millénaire dépend de façon critique de l'expansion des investissements en santé publique dans les pays en développement. Les gouvernements de ces pays doivent d'urgence présenter des programmes d'investissement détaillés, suffisamment ambitieux pour remplir ces objectifs, et ces programmes doivent être intégrés aux processus de don existants. Les pays donateurs doivent tenir les promesses d'assistance renforcée qu'ils ont souvent réitérées et qu'ils peuvent facilement se permettre de respecter pour contribuer à l'amélioration de la santé dans les pays en développement et assurer la stabilité du monde entier.

Resumen

La salud en el mundo en desarrollo: realización de los Objetivos de Desarrollo del Milenio

Para lograr los Objetivos de Desarrollo del Milenio es fundamental aumentar las inversiones en salud pública en los países en desarrollo. Los gobiernos de estos países deben presentar con carácter urgente planes de inversión detallados que sean suficientemente ambiciosos para lograr esos objetivos y que se inserten en los procesos de donación existentes. Los países donantes deben cumplir sus promesas de aumentar las ayudas, que han reiterado con frecuencia y a las que pueden hacer frente sin dificultad, con el fin de contribuir a mejorar la salud de los países en desarrollo y de asegurar la estabilidad mundial.

ملخص

مائدة مستديرة

الصحة في البلدان النامية، بلوغ المرامي الإنمائية للألفية

الملخص: يعتمد بلوغ المرامي الإنمائية للألفية بشكل حاسم على النهوض بالاستثمارات في الصحة العمومية في البلدان النامية. وينبغي على حكومات البلدان النامية أن تعرض، وبأقصى سرعة ممكنة، خططاً استثمارية طموحة لدرجة يمكن معها بلوغ تلك المرامي، وخططاً يمكن إدراجها ضمن العمليات التي يقوم بها المانحون في الوقت الراهن. إن البلدان التي تقدِّم المِنَح يجب أن تفي بوعودها التي كرَّرتها مراراً بزيادة المعونات التي يسهل عليها تقديمها، للمساعدة في تحسين صحة البلدان النامية وضمان الاستقرار في العالم بأَسْرِه.

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