

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 (*fuentes: DeCS, BIREME*).

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Voir page 949 le résumé en français. En la página 949 figura un resumen en español.

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 acquired 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 States 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 area 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

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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.

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Round Table Discussion

Linking health and economic policy to speed up increased household welfare

Guy J. Carrin¹

Jeffrey Sachs has made a powerful plea for scaling up investment in the health sector in developing countries, as an essential element in the fight to reduce poverty. He argues that in order to meet the challenge of providing a better organized health system, drastic increases in external funds will be needed. He further counts on better health to automatically enhance productivity and enable higher economic growth. Indeed, for him, macroeconomic issues are not at the forefront of the discussion: scaling up is seen as an essentially sectoral concern. I am far from at ease with this view, however. I doubt that many developing countries will automatically and quickly benefit from the impact of better health on productivity and economic growth.

I do not want to disprove the available evidence that, on average, there is a positive nexus between health and economic growth in a large sample of countries. Rather, my worry is about the speed with which this positive interaction can be set in motion. I believe this is of great interest to many people, especially those in low-income countries who, apart from wanting good health, also hope for the material well-being that means having enough money for food, children's education, housing, etc.

In the short run, it does seem evident that health improvements will enhance or at least maintain households' welfare, for example by helping breadwinners who were previously ill and not fully able to work to restore their income position. Is this sufficient? While the employed will tend to become more productive as a result of better health — and the extra productivity should be translated fairly rapidly into higher salaries or income — this is unlikely to be the case for many of the large group of unemployed or underemployed.

I submit that there is an urgent need for extensive investment plans in the various sectors of the economy, which will boost the planned output in the economy and thus trigger employment and generate income. Without such investment plans, households' wealth will risk stagnation. As is the case with the scaling up of health services in low-income developing countries, these plans will also require foreign direct investment. Proof of the beneficial effects of investment on the economy and welfare in general can be found in many East Asian countries: in several of them foreign direct investment has played a crucial role. One can further learn from these countries how they entered into a virtuous circle of economic growth spurring health improvement spurring further economic growth, and so on. Therefore, it ought to be examined how investment can be triggered most efficiently and rapidly. Foreign direct investment ought to be stimulated through the continued opening up of developing economies as well as by the use of powerful investment incentives through new and innovative bilateral and international agreements.

To summarize, better health in developing countries, especially for the poorest people, is badly needed, and this offers an important potential for improved production capacity. Nevertheless, important investment in sectors of the economy other than the health sector alone is also required to enable people to benefit economically, and reasonably rapidly, from the investment in health. In other words, it is advanced that any new health policy ought to be accompanied by economic policy directly stimulating investment and employment, rather than merely waiting for health's economic benefits. ■

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Find out what works to achieve the MDGs

William D. Savedoff²

Professor Sachs has put forward two important arguments for dramatically scaling up efforts to improve health in developing countries. The first is based on the urgency for dealing with the extraordinarily high burden of diseases such as HIV/AIDS and malaria, because they have social and economic consequences that lock countries into continued poverty, poor health and situations of failure.

The second argument is that health investments represent a better use of public funds than other current uses. It is on this latter argument that Sachs has been most original and insistent. Rather than posing the question of allocating funds between vaccinations and hospital care, or between health and education, he emphasizes the low absolute levels of spending on critical social services compared with any number of other relatively less important uses. This second argument stops us from asking about the opportunity cost of one programme versus another. Instead, it forces us to ask: "if funds were not the limiting factor, what would we do differently?"

So far, answers to this question have been inadequate. Our lack of new ideas is not surprising — in part, because insufficient funding is only one of many reasons for the failure of public health services in developing countries. Institutional and political problems, a scarcity of skilled health professionals, and mismanagement are also to blame, but do not constitute a reason to accept current practice or our limited scope of action. With proper use of new funds, it should be possible to confront and resolve such constraints.

There is another reason, however, for the dearth of new proposals. In part, it is because we do not know what works. A recent book documents 17 successful public health interventions (1), but in preparing it another 27 cases — considered to be important successes by many experts — were excluded because no rigorous impact evaluations could be found. Consequently, we learned little about those interventions, whether or not they were really successful and what did or did not work.

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As another example, community-based funding of health services has been promoted for decades, but a recent review of 127 studies found that only 24 of them measured whether service utilization had increased. Of these, only two cases had the internal validity necessary to learn whether or not the programmes were working (2).

I believe that it is necessary to take Sachs's challenge seriously and to think boldly about what can be done when funds are not a constraint. We also have to recognize, however, the handicap of having invested so little in building knowledge about public health interventions over recent decades. Fortunately, initiatives are under way to remedy this situation at several development banks, bilateral agencies, nongovernmental organizations and private foundations. As one example, the Center for Global Development has convened a high-level working group to investigate how collective action by international agencies could effectively channel funds into studies that promote real learning. As we mobilize today to tackle urgent health problems, we must not forget to collect the information about these programmes and policies that will make it possible — in three, four or five years from now — to say “try this, it works!” ■

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Millennium Development Goals for health: building human capabilities

Jennifer Prah Ruger¹

In 2000, the world community adopted the Millennium Development Goals (MDGs), a number of which are health-related (child and maternal mortality; HIV/AIDS, malaria and other diseases; poverty; hunger; safe water; sanitation; and essential drugs), and began a process of global cooperation to achieve set targets within fifteen years. Since that time, there has been much discussion of current progress, future achievements and roadblocks to success. Virtually every international organization has weighed in on the debate.

In his thought-provoking article, Jeffrey Sachs reiterates the compact agreed to by poor and rich countries in the Monterrey Consensus — that rich countries increase donor financing, while poor countries accept responsibility for good governance, policy design, and transparency and openness in implementation. While the next step for rich countries is clear, poor countries have additional steps to take with regard to increased donor financing, Sachs argues. These steps are fourfold: a strategy for scaling up health services; implementation plans for investments in physical capital and human resources; a financing plan; and advocacy. This approach rests on the premise that the primary barrier to achieving the MDGs for health is suboptimal government health-care spending.

Improving government health-care spending and investments in human and physical capital are essential to achieving the health-related MDGs, as is improving resource allocation within the health sector through more equitable allocations targeted to primary care and specific populations and geographical areas. Greater efficiency and better health-care quality are also critical. Low-technology, cost-effective solutions exist to prevent death and disease such as antibiotics, immunizations, basic hygiene and health care, health knowledge, bednets, prenatal and obstetric care and nutrition. From a medical or public health perspective, the problem is not a lack of interventions; the predicament is that they are not being made universally available. Solving the dilemma of universal coverage and access to technology (1, 2) is a problem of collective action, not one of medicine or public health.

Achieving the health-related MDGs thus requires more than scaling up public health investment, important though it is (3); it also requires a transformation in underlying values and societal structures (2, 3). Progress towards health for all will require a strong commitment by national and local leaders who are held accountable by their electorates (4). Such assurances involve social arrangements that protect all individuals, especially the most deprived and excluded, from avoidable health deprivations and rest on principles of equality of all people and health improvement as a common goal of humanity (5, 6). Establishing social arrangements that secure the opportunity to be healthy requires, in turn, a culture of social norms and ethics and the institutions, laws and strong economic environment to provide resources for sustainable health system reform. Economic resources are indeed required to assist health spending, but a growing economy and increased health spending must be sustainable, not temporary: the international community should provide support, not promote dependence.

Achieving the MDGs for health also requires democratic systems that are inclusive and publicly accountable and that ensure free and independent media and civil society, transparent policy-making and separation of powers (4). Military dictatorships, for example, have little incentive to ensure health for all, and poor and sick people without civil and political rights have little power to establish claims to social policies that promote access to quality health care and other social services (3, 7). Greater political voice can be an important step in alleviating social disparities, and participation in collective decision-making about health is itself a valued freedom.

At the international level, global actors and conventions can help establish better policies, laws and institutions and achieve consensus on global norms and ethics (1). It is thus imperative to establish a system of global governance that is inclusive, fair and transparent, one that offers opportunities for participation of all countries and individuals so the benefits of the global economy and technology — especially technology for health — are distributed more equitably and aid in securing fundamental freedoms for all. ■

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Macroeconomic reform is necessary to progress in the MDGs

David Sanders¹

Jeffrey Sachs proposes that not only the health-related Millennium Development Goals (MDGs), but even the first and overarching goal — the reduction of global poverty by half by 2015 — are dependent on making health services available for all. Thus, he avers, “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”. This echoes an important new message from the Commission on Macroeconomics and Health (CMH) that places significantly greater emphasis on the contribution of health to economic development than on the contribution of underdevelopment and poverty to ill-health (1). But as Katz has commented: “The relationship between health and poverty is two-way but it is *not symmetric*. Poverty is the single most important determinant of poor health. But poor health is very far from being the single most important determinant of poverty. Poor health *exacerbates existing poverty*. Both the vicious cycle and the ‘virtuous’ cycle of health and poverty are misleading images, as they imply equal weight of the two poles of health and economic development” (2).

Nevertheless, Sachs asserts that health services are the key to attaining the MDGs. While health services undoubtedly have much to contribute, there is considerable historical and empirical evidence that demonstrates the major contribution of improved incomes, environmental factors (water, sanitation, housing, etc.) and social factors (education, social capital, gender and racial equity, etc.) to health improvements (3). Although Sachs recognizes this by referring to smoke-free living environments and water supply, the remainder of his article is based on a calculated gap of US\$ 30 billion per year “to enable the poorest countries to deliver basic life-saving *health services*” (my emphasis). While such a costing exercise is useful, the challenge of improving public health — and achieving even the health MDGs — is about much more than health services.

Sachs’s article is, above all, a moral challenge to the rich countries to “hold up their end of the bargain”. Developed countries are reminded of the Monterrey Consensus that urged them “to make concrete efforts towards the target of 0.7% of gross national product (GNP) as official development assistance (ODA) to developing countries”, as the evidence is that ODA from the G8 has been declining in the recent past, despite commitments to the contrary by the rich countries (4).

In order to secure what is, in effect, the charity of the rich world and obtain more donor financing for health, Sachs urges developing countries to take four ambitious

steps: develop an overall strategy for scaling up health services; develop detailed plans of implementation, including a (welcome) focus on human resource development; develop a financing plan; and undertake advocacy. In a sense, he advises poor country governments to make ambitious plans and bold demands in order to receive more largesse from the wealthy world.

The strength of this brief article is that it passionately, yet succinctly, flags the health and health-care crises in developing countries and challenges rich countries to bridge the financing gap with substantially increased (but, to them, easily affordable) overseas aid. Its fundamental weakness, however, is that, like the CMH, it carefully avoids any interrogation of currently dominant macroeconomic policies or of the structures and mechanisms that entrench developing country disadvantage, ill-health and deteriorating services. For public health and the health sector, these include the World Trade Organization — dominated by the rich and powerful countries — and its conventions regulating trade in both commodities and intellectual property, the latter being exploited as patent rights by the transnational pharmaceutical corporations and placing many essential drugs beyond the economic reach of many poor countries. Similarly, the new GATS (Global Agreement on Trade in Services) convention, which threatens privatization of public services, including health, is not mentioned nor is its likely effect in further accelerating the medical “brain drain”. As in the CMH, Poverty Reduction Strategy Papers (PRSPs) are recommended as the main mechanism to direct ODA towards strengthening developing countries’ health systems. Yet PRSPs are an integral component of the above regime of global economic governance that includes reforms such as reduced public spending on health and is leading to rapidly widening inequalities in income, access to health services and health outcomes (5).

While Sachs’s advocacy for increased aid is welcome, his silence on radical reform of the present increasingly discriminatory global economic dispensation, of which more equitable ODA should be part, is akin to focusing on palliative care rather than on primary prevention of global economic inequity and its effects. Without such macroeconomic reform, it is not only unlikely that the MDGs will be achieved for the poor, but it is almost certain that progress towards them will not be sustained. ■

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