Technical approach paper

Achieving the MDGs: at what cost?

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More spending is needed if progress towards the Millennium Development Goals (MDGs) is to be accelerated. Extra funding is vitally important, particularly for the poorest countries, but it can come with risks. Those working to achieve the health MDGs cannot ignore the macroeconomic implications of injecting additional external resources into weak economies. These issues remain relevant despite the challenges of the current financial and economic crisis.

This paper provides an overview of the debates surrounding how much is needed to achieve the health MDGs, how such funds might be raised, and some of the impacts of scaling up, particularly on macroeconomic stability.

Economic growth is important, and macroeconomic stability, which contributes to it, is likely to make a major contribution to achieving the health MDGs. However, increased spending can have a detrimental impact. Those who advocate for additional resources for the health sector need to consider the wider context, as achieving a balance between increasing health expenditure and macroeconomic stability is vital. Experience also shows that some types of spending or donor behaviour work better than others towards enhancing macroeconomic stability and improving the health sector.

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1. Introduction

The international community has committed to achieving the Millennium Development Goals (MDGs) by 2015. Health features prominently in the MDGs (see Table 1). We are now just past the mid point, but progress to date has been patchy. Although not the only constraint, lack of adequate funding has been at least partly responsible for the failure to scale up adequately. The current financial and economic crisis is presenting a new set of challenges, and the UN Secretary-General has repeatedly called on countries not to forget MDGs commitments as they seek to mitigate the impact of the crisis on their economies.

This paper does not seek to address the concerns arising from the financial crisis.[1] Instead, it aims to provide an overview of the debates about how much is needed to achieve the health MDGs, how such funds might be raised, and some of the implications of scaling up, with a particular focus on the potential impact on macroeconomic stability. These issues remain relevant despite the new challenges facing the international community.

Table 1: The MDGs for health

Goals and Targets	Indicators for monitoring progress
Goal 4: Reduce child mortality	
Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of 1 year-old children immunised against measles
Goal 5: Improve maternal health	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use at last high-risk sex 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bednets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with TB 6.10 Proportion of TB cases detected and cured under DOTS

[1] High level discussions on how to sustain investment in health are taking place, such as the consultation convened by WHO on 19 January 2009 http://www.who.int/mediacentre/events/meetings/2009_financial_crisis_report_en_.pdf

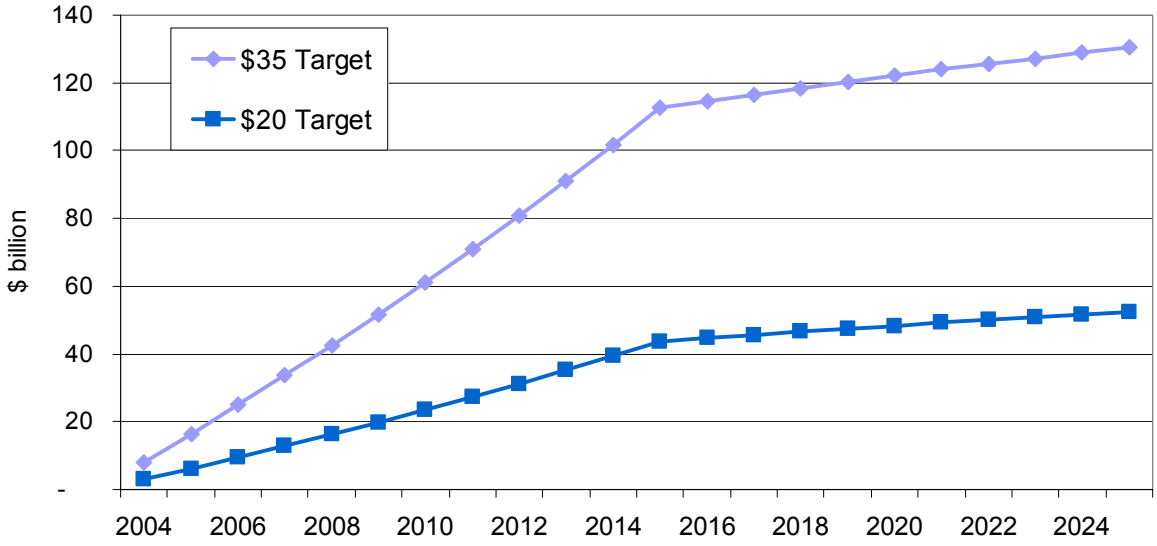
2. What is the cost of meeting the health MDGs?

It is widely recognised that achieving the health MDGs will require action in a number of areas – both within and outside health – but that above all it will need a rapid increase in the amount of money spent on health. However, just how much will be required is difficult to estimate, given that health spending is only one of a number of factors which affect health outcomes. Economic growth, for example, plays a key role in reducing poverty levels and improving health outcomes.

In 2001 the Commission for Macroeconomics and Health (CMH) estimated that countries needed to spend around $35 per head on a range of essential health services to achieve the health related MDGs.[2] Figure 1 presents estimates of the additional resources required to meet this target, as well as a lower target of $20 per head. To meet the CMH target, countries need to find an extra $100 billion. Even at the lower target, the additional requirements are still substantial at over $40 billion.

More recent work carried out by the Millennium Project suggests that the figure required per head may actually be much higher, especially in parts of sub-Saharan Africa where HIV prevalence is high.[3]

Figure 1: Financing the essential CMH package: how much is needed?



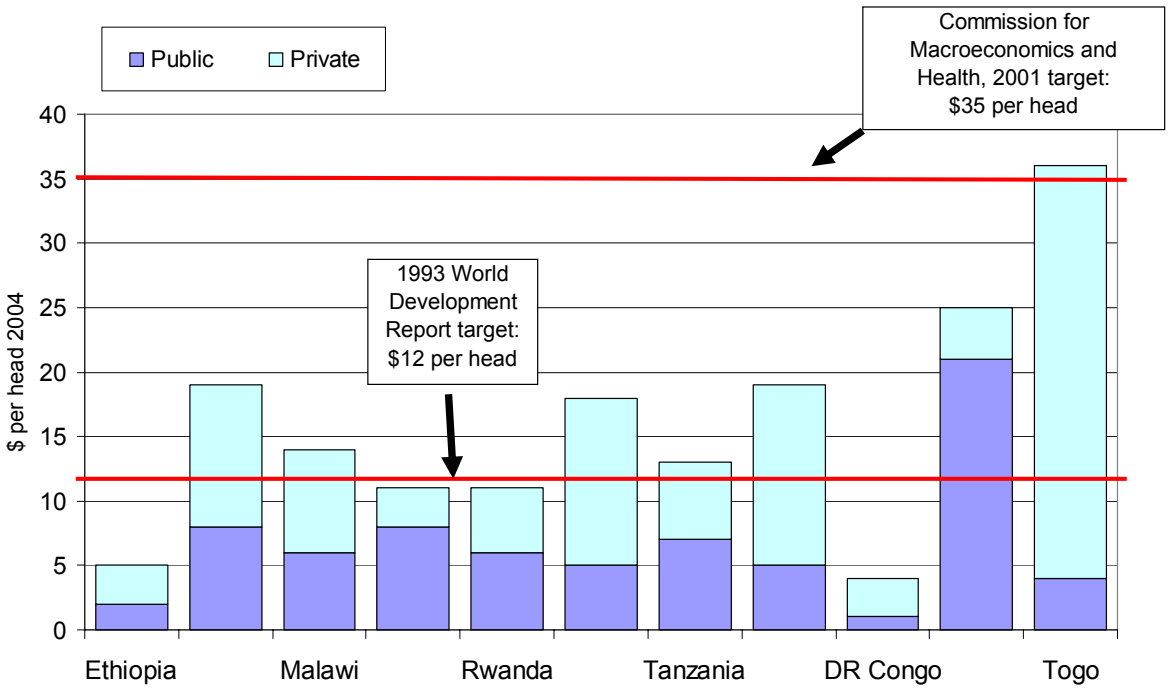
3. What is being spent on health?

Public expenditure on health in low income countries remains pitifully low. Public spending in the 50 least developed countries (LLDCs) − with a population over 650 million − is estimated by the World Health Organisation (WHO) to have been around $7.5 billion in 2003. This is equivalent to the monthly spend in the UK (for a population of 60 million). This equates to $11.5 per capita spent on health in the 50 LLDCs, against $1,500 per capita spent on health in the UK.

Figure 2 shows the per capita spend for a selected number of countries in 2004 (public and private spending)[4] against the targets recommended by the Commission for Macroeconomics and Health in 2001 ($35 per capita to reach the MDGs) and the $12 basic package identified in the World Bank's 1993 World Development Report.[5] Clearly, current public spend in many countries falls well below the 1993 target, let alone the 2001 CMH target.

[2] *Macroeconomics and health: investing in health for economic development*, 2001
[3] *MDGs needs assessments: country case studies of Bangladesh, Cambodia, Ghana, Tanzania and Uganda*, 2004.
[4] WHO estimates.
[5] *Investing in health*, World Bank, 1993.

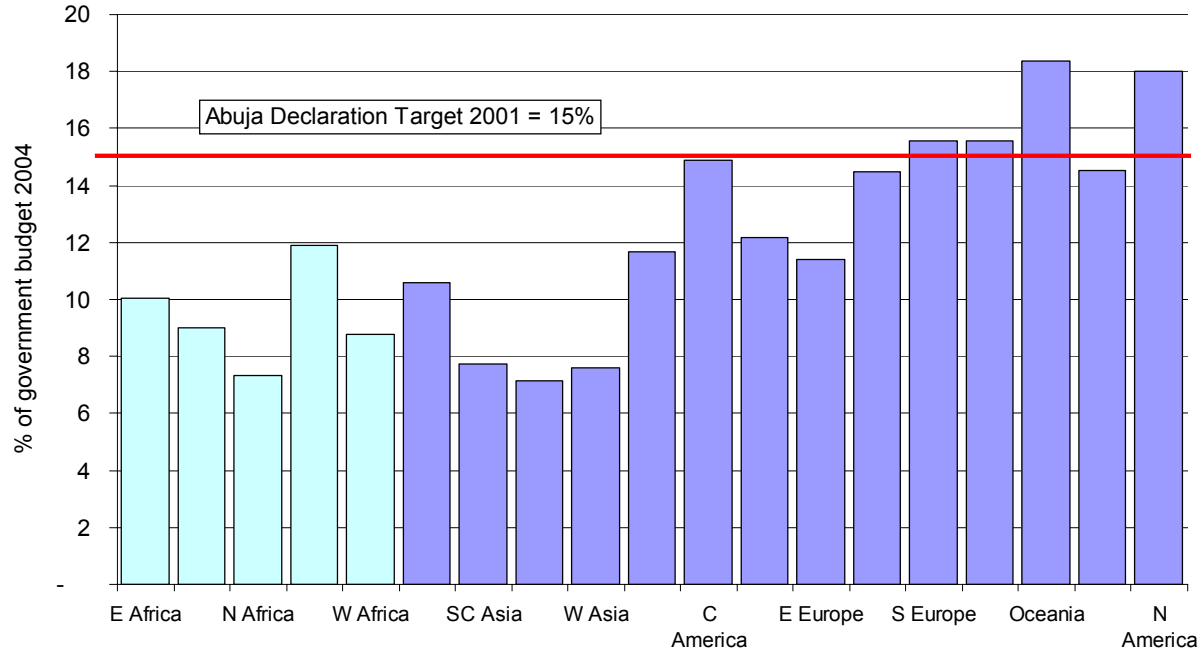
Figure 2: per capita expenditure on health, selected countries



Gupta et al[6] have stated that if countries increased spending on primary health care, MDG4 (on child mortality) could be achieved. However this would require a significant increase in the share of public finances allocated to health – around 12% of GDP – greater than in most developed countries.

Figure 3 shows the share of (already limited) public finances allocated to health in lower income countries. Average allocations in Africa are well below 10%.

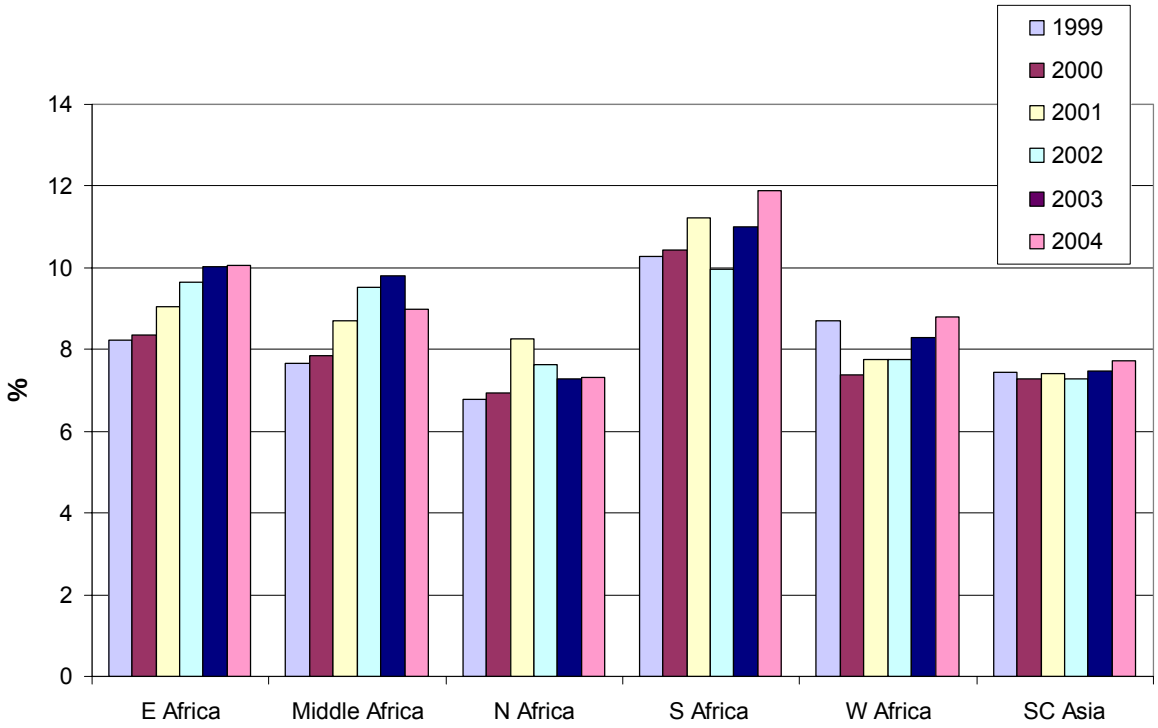
Figure 3: Health as share of public spending, by region



[6] S. Gupta, M. Verhoeven and E. Tiongson, *Public spending on health care and the poor*. IMF, 2001.

While it is unrealistic to expect any drastic changes in the pattern of public finances in the short term, there is also very little evidence that health spending has increased more than marginally in recent years. This is despite initiatives supposed to have channelled more resources into the social sectors, such as the Heavily Indebted Poor Countries Initiative (HIPC). The latest HIPC evaluation revealed that "governments are increasing their expenditures on education as a share of GDP and total expenditures (based on five countries), but they are spending the same or less on health".[7]

Figure 4: Changes over time in share of government expenditure on health, 1994-2004



4. How might we get more resources for health?

There are a number of ways of creating the **fiscal space** necessary to support increased spending on health. They include:

A. Increasing domestic expenditure on health through:
   - increased government revenue mobilisation efforts
   - increased borrowing
   - reallocating existing government resources.

B. Increased donor support for health (either provided through direct sector support or indirectly through general budget support).

The question remains − will this be enough? Clearly the future is uncertain, but we can make educated guesses as to what might be possible.

[7] *Debt relief for the poorest: an evaluation update of the HIPC Initiative*. World Bank, Independent Evaluation Group, 2006.

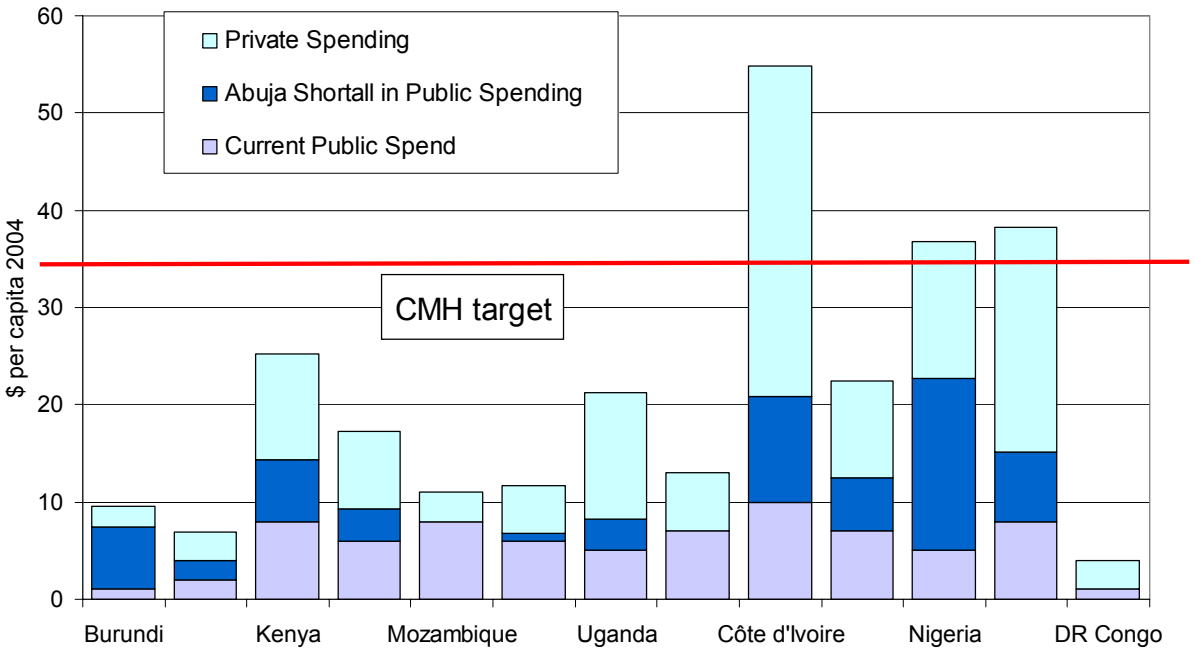
A. Increased domestic expenditure on health

Increasing the overall mobilisation of domestic resources would help, but the fact that most of the poorest countries are still heavily reliant on subsistence agriculture makes this unlikely. Most of the easier gains in improving tax administration have already been made; the establishment of regional trading agreements also limits the scope for taxation of traded goods. These considerations suggest that the prospects for further increasing the level of resources available from domestic sources are limited.

Would it make a difference?

The 2001 Abuja Declaration committed African countries to spending 15% of their budgets on health. However, few do so. And 15% of very little is … very little, certainly not enough to get anywhere near the $35 per capita target in most low income countries, even when private expenditure on health is included. This is shown very clearly in figure 5, which adds the current per capita spend on health to the increase in spend per capita that would result of all African countries meeting the 15% Abuja target, and private spending per capita on health.

Figure 5: Expenditure on health compared to CMH target - Would meeting the Abuja targets make much difference?



Looking at this the other way round, meeting the $35 per capita CMH target for reaching the MDGs in the context of existing government budgets would involve huge and unrealistic reallocations towards the health sector. For example, even if Ethiopia allocated its whole government budget to health it would still not meet the CMH target.

What about reallocating the existing health budgets?

Focusing only on the $35 spending target ignores the fact that relatively little current public and private spending is actually devoted to items within the CMH “package” of essential services. For example, analysis of donor project spend in Uganda for 2004/05 revealed that 56% of spend was on items not prioritised within the Health Sector Strategic Plan (designed to help meet the MDGs).

Estimates also assume that services are provided efficiently. But this is often not the case, as many of the poorest countries suffer from additional problems with service delivery, including low levels of productivity, high absenteeism and pervasive corruption. In practice, it may take a lot more than $35 per capita to provide a CMH package.

B. Increased donor support for health

Donors made extremely generous commitments at the Gleneagles G8 summit in 2005, including a target of doubling aid to sub-Saharan Africa by 2010. It can therefore be assumed that within this increased package, more resources from development partners will be available for the health sector.

However, the harmonisation agenda also means that donor funding for health is increasingly likely to be provided indirectly through general budget support in future. If this is the case, it will only end up in the health sector if finance ministries choose to allocate the additional resources in this way. This could have serious implications for spending on health, including no increase in overall spend on health, or even reductions in spending. This could happen for a number of reasons. Countries could place less importance on health than donors have in the past, civil servants in the health sector may not argue as strongly for resources as other sectors, or politicians may exert undue pressure on finance ministries to divert resources to other "vote-winning" areas.

There are also debates going on within parts of the donor community as to whether the current emphasis on the social sectors should continue, and there is significant pressure to invest more in infrastructure. It is far from clear, therefore, that either governments or donors would be willing to reallocate resources towards health and away from other sectors.

The financing gap is going to be significant. Based on relatively optimistic assumptions about future prospects for public spending from both domestic and external sources, it has been estimated that there is still likely to be a financing gap of as much as $35 billion by 2015 (against the $35 per capita target set by the CMH in 2001).[8]

Despite this, it is still important to consider what impact any potential increases in resources may have on countries.

5. Possible impact of increased donor support

Before substantially increasing aid to a country, and to the health sector in particular, there are a number of issues that development partners should consider.

Ability of countries to absorb increased spending

A rapid scale up of health spending raises a number of important issues with regards to the capacity of the country to absorb and use such resources effectively. First, it is necessary for donors to consider whether countries have the human resources to cope, as demands on personnel increase while the number of staff in the system is drained by migration and HIV. Donors should also consider whether the process of recruiting more of the educated workforce into the health sector will adversely affect other areas of economic development in the country.

Increased aid dependence

Aid dependence is an ongoing concern. It is already very high, (especially in East and West Africa) and is expected to increase significantly if the aid flows promised at the 2005 Gleneagles G8 meeting are realised. This raises serious questions of sustainability for countries. Donor support can be volatile, against a need for continued and predictable support over what is likely to be a considerable period of time – certainly well beyond 2015.

Macroeconomic impacts of extra donor funding

Substantial donor funding may also have negative macroeconomic effects. The mechanism through which this *might* occur has been termed "Dutch Disease". Dutch Disease is the macroeconomic instability caused by increased public spending, when extra demand competes to purchase a limited supply of goods and services thus bidding up the price and causing inflation.

[8] More detail on this can be found in: Mark Pearson, *Funding flows for health: what might the future hold?* HLSP Institute, April 2007. http://www.hlspinstitute.org/projects/?mode=type&id=144019

This is a major concern as inflation disproportionately affects the poor and causes appreciation of the exchange rate. The disruption of macroeconomic stability is also a concern because it is well recognised that stability is a key determinant of sustained economic growth, which, in turn, is accepted as perhaps the key factor behind improvements in health outcomes. It is therefore important to consider the potential impact on macroeconomic stability of any extra health spending, particularly as an increase in development assistance does not automatically cause Dutch Disease.

First, extra development assistance does not automatically result in additional public spending − aid may be retained to increase foreign exchange reserves or to reduce borrowing. It may also be used to purchase goods which cannot be produced locally (for example imported drugs).

Even when extra donor resources result in extra public spending, this does not automatically result in Dutch Disease. This is because the extra demand may generate new inputs (a supply side response), particularly if the economy is operating below its full capacity. The problems only arise when extra resources are used to purchase scarce domestic resources and non-tradeable goods such as staff. And in fact, this is how much of the additional resources are expected to be spent: the CMH envisages a doubling in health worker salaries.

Most evidence, however, suggests that the macroeconomic impacts of extra spending are manageable if the money is well spent and public financial management is sound. In general, the quality of financial management in low income countries is improving (albeit relatively slowly) and the levels of aid are, at least for now, not significantly higher than those experienced in the early 1990s (although this may not be the case in the future). The current consensus therefore seems to be that the benefits of extra aid are likely to outweigh any macroeconomic costs, although this may not still apply at the higher levels of aid dependence implied by the target to reach the MDGs.

6. Good donor practice in increasing health sector support

Balancing increased aid and macroeconomic stability

In a bid to maintain a balance between increasing aid in order to reach the MDGs and maintaining macroeconomic stability, it has been suggested that organisations such as the IMF are being too conservative. It may indeed make sense to err on the side of caution as once lost, macroeconomic stability can be difficult and painful to regain.

A number of criticisms can be levelled at the IMF.[9] For instance, their models seem to offer the same prescription for countries with hugely different levels of public spending on health (% GDP). There is also little justification for any proposed pace of fiscal adjustments. Debate on the issue has often been stifled by concerns about commercial sensitivity; this has meant that macroeconomic issues are not always fully integrated into poverty reduction processes. But those working in the health sector must also share some responsibility. They have failed to ensure that the significant amounts of money which have been channelled into the sector do more to improve health outcomes and boost economic capacity.

There are some specific features of the health sector which are particularly relevant to the debate. For example, although the sector is extremely labour intensive, a large and probably increasing share of aid goes towards purchasing drugs (for which local production is probably not going to be an option for most countries in the near future). In these cases it can be argued that such aid will not have negative macroeconomic effects, as the extra money is not competing for an existing supply of inputs. This suggests that certain types of investment in the health sector might be favoured if macroeconomic concerns are pressing and that *how much* you spend is less important than *on what* you spend it.

Aid delivery

In order to maximise the benefits of increased donor support to the health sector, it is essential that development assistance is provided in a *predictable* manner, as it is the volatility, not the level of resources that causes the major problems. The 2004/05 Uganda Health Sector Performance Report shows that donors not only often fail to honour existing commitments (for whatever reason), but also provide significant resources that were not anticipated during the budget process.

[9] See for example: M. Foster, *MDG oriented sector and poverty reduction strategies: lessons from experience in health*. World Bank 2005.

Table 2: Unpredictability of donor support to Uganda
Donor project expenditure 2004/05[10]

Donor /Initiative	Budget (MoFPED) shs '000	Expenditure Ug. Shs '000	Expenditure as % of budget
UNICEF**	11,183,201	1,921,515	17%
USAID	39,940	104,996,060	262884%
DfID	998,500	2,223,853	223%
EU *	1,498,801	3,033,672	202%
DCI		735,764	
WHO	19,970,000	5,069,149	25%
Italian coop	9,785,300	14,051,036	144%
Germany	2,569,100		0%
JICA	599,100	0	
China	79,880		
World Bank		22,286,109	
UNFPA	1,797,300	2,691,345	150%
DANIDA	19,970,000	16,725,562	84%
SWEDEN	399,400	9,194,387	2302%
Spain	12,962,600		
Netherlands	3,275,080		
AfDB		21,619,935	
GAVI		3,782,000	
Global fund	68,635,000	46,516,271	68%
Overall	**85,128,202**	**254,846,658**	**299%**

A country with good management of its public finances can take steps to manage fluctuations in aid flows. For instance, issuing treasury bills to absorb some of the liquidity introduced by extra aid, and in doing so reducing domestic demand and the likelihood of inflationary pressures. However, it is difficult for government to manage liquidity without a clear picture of how much will introduced into the system and when. In Rwanda, which is seen as a good performer, most of the aid support to the health sector is provided "off-budget" which is extremely difficult to manage and plan for. This is exacerbated in cases where public financial management is weak.

The use of aid

Not all forms of increased expenditure will have the same impact, in terms of value for money, or otherwise, and this needs to be carefully considered before increased funds are made available to the health sector. For example, spending on productive sectors might be expected to have a more immediate supply side effect. Simulations in Zambia carried out by the IMF[11] assume that spending on essential infrastructure is likely to have an impact within two years, while improvements in human capital are not expected to feed through for five to ten years. However, as is the case for all public investment the key criteria is that it should achieve good socio-economic returns over its lifetime.

The timing of the returns is an important, but secondary issue. Investment in adult health through investment in antiretroviral therapy, for example, might be expected to have a more immediate impact than investment in child health which will lead to few, if any, immediate productivity gains. This does not necessarily mean that investment in adult health should be favoured over child health. Rather, it means that those who invest in child health may need longer term support to promote growth and development

[10] Reproduced from the Annual Health Sector Performance Report, FY 2004/05, October 2005. Table 4.1, p. 68. http://www.health.go.ug/mohreports.htm
[11] Zambia: selected issues and statistical appendix. IMF Country Report No. 06/118, March 2006.

– until such time as the socio-economic benefits do finally arrive. For this reason, mechanisms such as the new International Finance Facility for Immunisation may be particularly suitable for health as a whole (and not just for the introduction of new technologies and products).

The bottom line in all of this is that resources, from whatever source, must be put to their best use. If spending on roads offers higher social returns than spending on health, then that is where the extra aid should go. If spending on health offers higher returns, funds should flow there.

Sustainability

Additional aid will create longer term liabilities. This is particularly the case in the health sector, and more so when extra aid is used to pay salaries of health workers who are highly unionised, often more radical than other public sector workers, and are often seen as "vote banks" rather than public servants who deliver services. In such circumstances it can be extremely difficult from a political perspective to shed such obligations afterwards. Donors need to be aware of these issues.

Some forms of health expenditure are also unusual in that preserving *existing* benefits may require continued provision. For example, with antiretroviral therapy drugs need to be taken for life (as opposed to immunisation, which is one-off). As health systems evolve and basic health coverage improves, it will become more likely for aid funds to be increasingly devoted to the treatment of chronic conditions. This can create strong incentives for some donors to expand programmes safe in the knowledge that once in place it would be extremely difficult to scale them back, but it can lead to extremely inefficient investments which pre-empt the limited fiscal space that may be available to government.

Sustainability therefore needs to be considered more closely *before* programmes are developed and expanded, rather than *afterwards* when it is too late − as unfortunately occurs too often.

Wider development impact

Another concern is that increased spending will be channelled into higher salaries for the health labour force (with relatively few prospects to expand supply in the short term) but with little in return in terms of extra productivity. In the longer term higher salaries may encourage school leavers to seek careers in the health sector, which is, of course, good news for the health sector. However, the rest of the economy may well suffer, as it will still need teachers, lawyers, accountants and businessmen. These broader development considerations need to be borne in mind.

7. Conclusions

In conclusion, more spending – a lot more spending – is undoubtedly needed if progress towards the MDGs is to be accelerated. There are a number of ways of achieving this, with potential pitfalls. Those working to achieve the health MDGs cannot ignore the macroeconomic implications of what they do. Economic growth is important, and macroeconomic stability, which contributes to it, is likely to make a major contribution to achieving the health MDGs. However, increased spending can have a detrimental impact on the macroeconomic stability of the economy. Achieving a balance between increasing health expenditure and macroeconomic stability is vital.

There should also be some scope for increasing the share of domestic funding allocated to health, in addition to increasing the resources coming from development partners. The share of GDP allocated towards health remains much lower in sub-Saharan Africa than in other parts of the world. This may require more systematic efforts to provide evidence and strong arguments to ministries of finance that improving health is not just a good thing to do – it is also good economics.

Experience has shown that some types of spending/donor behaviour have more of an impact than others on enhancing macroeconomic stability and improving the health sector, including:

- Improving the predictability of aid flows to the health sector by supporting the development of medium term expenditure frameworks and designing health programmes in ways which promote a reliable transfer of funds (e.g. not too many conditions).

- Ensuring health programmes deliver high returns. There will be an ongoing need to ensure that health programmes represent good value for money, which requires continued emphasis on strategic planning processes and monitoring and evaluation activities.
- Better prioritisation of existing health expenditure: promoting the development of well thought out, costed programmes which ensure health resources are put to their best use.
- Encouraging countries to fund increases for health spending out of the existing government budget wherever possible; and encouraging countries to meet existing international obligations such as the Abuja Declaration (with donors also holding to theirs).
- Supporting governments to increase their revenue mobilisation efforts, ensuring that it is done in ways which are consistent with efforts to reduce poverty.
- More awareness of the broader issues related to the scaling up debate – the need to improve domestic resource mobilisation, the importance of macroeconomic stability and greater predictability in aid.

This is not an issue that is going to go away. Indeed it will become more important as the funding promised at Gleneagles (hopefully) begins to materialise in an attempt to reach the MDGs by 2015. This money is vitally important, particularly for the poorest countries, but it can come with risks.

Efficient and effective health programmes that focus on priorities and maximise health outcomes will help to ensure that additional resources are re-allocated by governments and development partners to the health sector, and hence help the move towards the health MDGs. However, the importance of sound public finances and macroeconomic management, and the risk of extra resources adversely affecting macroeconomic stability cannot be underestimated. It is simply not tenable to advocate for additional resources for the health sector without considering the wider context in which this takes place.

Further Reading

E. Cavagnero et al, *Development assistance for health: should policy-makers worry about its macroeconomic impact?* WHO Bulletin, November 2008, 86(11) 864–870.

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The HLSP institute aims to inform debate and policy on global health issues and national health systems in order to reduce inequalities in health