

The Challenge to Improve Global Health Financing the Millennium Development Goals

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IT IS NOT OFTEN THAT A MINISTER OF FINANCE OF A RICH country proposes a doubling of the aid budget for poor countries. But over the past year and a half, the British Chancellor of the Exchequer Gordon Brown has spearheaded an initiative for a major increase in resources for the developing world. Brown's proposal for an International Finance Facility (IFF) calls on the richest countries to increase their long-term donor commitments and then to use these commitments to leverage additional money from the international capital markets. First announced for debate in January 2003, the IFF is intended to provide a framework to increase aid from just over \$50 billion annually in 2001¹ to \$100 billion annually in the years leading up to 2015.²

The immediate focus of the proposed IFF is to provide funds needed to meet the Millennium Development Goals (MDGs).³ The goals were agreed to in 2000 by 189 countries of the United Nations, with the support of the International Monetary Fund (IMF), World Bank, Organisation for Economic Co-operation and Development, and the G7 and G20 countries. There are 8 goals, which range from eradicating extreme poverty and hunger to establishing partnerships for development. Each goal has a number of targets and indicators by which achievements can be assessed. Three of the 8 goals, 8 of the 18 targets, and 18 of the 48 indicators relate directly to health. The targets include halving the proportion of people living on less than US \$1 per day, reducing by two thirds the mortality rate for children younger than 5 years of age, reducing the maternal mortality rate by three quarters, and halving the proportion of people without access to sanitation and safe drinking water.³

However, the MDGs are not above criticism. For example, they omit specific reference to noncommunicable diseases and injuries, both major contributors to disease burden in many low- and middle-income countries. Ongoing policy debates about who should be responsible for achieving the goals, given the proliferation of global health actors since the 1990s, also remain unresolved. Nonetheless, the MDGs deserve the support of the public health community because they represent an unprecedented global compact

to reduce unacceptable inequalities in health between rich and poor nations.

Taking stock of progress so far, it is now clear that, based on current forecasts, the goals will not be met. For example, it is projected that targets to reduce child mortality in sub-Saharan Africa will be achieved, not by 2015, but perhaps by 2165. It is also predicted that sub-Saharan Africa, the Middle East, North Africa, Latin America, the Caribbean, and the transition economies of Europe and Central Asia will all fail to see a halving of poverty by 2015.^{4,5} The reasons for the expected shortfalls are complex—many countries continue to struggle with political and economic transition, conflict situations, lack of access to technical expertise, and many other hurdles. Yet the most enduring problem remains a stark shortfall in financial resources.

Although now apparently halted,¹ the decline in levels of development aid since 1993 attests to the fact that rich countries, according to Chancellor Brown, “simply don't care enough.” The long-standing United Nations target of raising total official development aid to 0.7% of the gross national income of donor countries remains a distant goal and, despite modest improvements in recent years, remains around 0.25% on average.¹ In comparison, estimates by the World Health Organization Commission on Macroeconomics and Health of the costs of scaling up priority interventions in the health sector call for substantially increased expenditures by donor and low-income country governments of \$22 billion and \$35 billion per year, respectively, by 2007.⁶ Attempts to raise aid funds through initiatives such as the Tobin tax (a tax on cross-border currency transactions), an arms tax, and special drawing rights issued by the IMF to help respond to the financial development needs of poor countries have not to date been successful, partly because they demand the cooperation of a large number of countries. Moreover, aid continues to be viewed as charity rather than an investment in the world's future, an afterthought only when crises such as famine reach our television screens.

So what makes the proposal for an IFF different? The plea is for a shift in mind-set and to see today's challenges in historical terms. The Marshall Plan of 1948 led the United States to transfer 1% of its national income for 4 years (\$75 bil-

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lion in today's terms) to rebuild postwar Europe. This was done out of recognition that peace and prosperity were indivisible. In today's world, riven by economic and cultural differences, an increasing number of governments are once again making linkages between national security and development assistance.⁷ If globalization is to work, its costs and benefits need to be shared more equitably throughout the world.

To meet health development needs, in particular, a highly welcome flow of resources has been directed recently to prevention, treatment, and research of selected diseases. Commitments through the Global Fund to Fight AIDS, Tuberculosis and Malaria to mid 2004 total \$2 billion, with \$0.5 billion disbursed so far.⁸ In 2001-2002, the Bill and Melinda Gates Foundation spent about \$1.4 billion on global health programs.⁹ President Bush's Emergency Plan for AIDS Relief, announced in January 2003, is a 5-year initiative with a proposed budget of \$15 billion, including \$1 billion going to the Global Fund annually.¹⁰ Yet the sums are still far from adequate to meet the health-related MDGs or the priority interventions that can do most for the poorest of the world as identified by the Commission on Macroeconomics and Health. Additional funds could be used to effectively support a wide range of proven health interventions. Around two thirds of preventable childhood deaths occurring worldwide could be averted by using effective low-cost interventions, including, for example, vitamin A supplementation, insecticide-treated nets, and oral rehydration solutions.¹¹ Similarly, effective medicines exist to prevent the near 2 million deaths each year from tuberculosis and more than 1 million from malaria.⁶

Of course, increased funding alone is not the answer. The question of whether poor countries have the capacity to put additional resources to effective use remains an important concern. Killick¹² cites IMF reports of a rising proportion of country programs during the past 2 decades where actual disbursements have been less than half the agreed amounts. Insufficient attention continues to be given to strategies and resources that support and strengthen health infrastructures and human resources. Chad, for example, has only 185 physicians for a population of 7.5 million.¹³ Major increases in the numbers of available physicians and nurses, but also health workers such as clinical assistants and other primary care workers, are needed. Without addressing deficiencies in health systems, it will not be possible to actually deliver available interventions.

In addition, debates continue about the long-standing issue of conditionality. The IFF proposal makes it clear that there are strings attached to the receipt of funding. It is unclear the extent to which low-income countries will be able to exercise a genuine voice in how aid funds are used. The IFF's focus on the MDGs provides specific, measurable targets to direct use of these funds. Furthermore, each country drawing on the IFF "will have to show the commitment to reform necessary to ensure that money

will achieve the results intended."² This is supported by a recent World Bank report demonstrating how international aid is more effective in those countries where good governance functions.¹⁴ The IFF proposal thus underlines the importance of including anticorruption and pro-stability policies, a positive environment for investment and private sector-led growth, and an effective poverty reduction strategy in such commitments.

The current challenge for the United Kingdom is to bring on board the governments of other rich countries. Much will depend on whether industrialized countries can reform their attitudes to development aid as an investment in sustainable globalization, not as a handout. Part of the shift in mindset demands an informed and public debate. Moving from rhetoric to action, to improve the quantity, quality, and fairness of aid, will only occur if taxpayers generate public interest in making this a priority issue. But opinion polls suggest that citizens are often mistaken about existing aid levels. The US public, for instance, believes that 20% of federal funds go to international aid, when the figure is actually 0.13% of gross national income.¹⁵

High-level political support will also be needed. The British government assumes the helm of the G7 and European Union during 2005 when it will push the IFF agenda. Chancellor Brown will have to convince world leaders to do the unusual—make a 10-year binding pledge of funding to the IFF. On the basis of these long-term pledges, the IFF would issue bonds in its own name, turning the long-term income stream from donors into capital available for immediate disbursement to poor countries. So far the US government has been skeptical about the value of the IFF proposal.¹⁶ Germany has also been indifferent toward the idea given concerns about its already overstretched public deficit. France has come out in favor, and Nordic countries may still add their support following discussion of the IFF at a meeting of the joint IMF and World Bank development committee held in September 2003. China, India, Brazil, and many African countries have all expressed strong support.¹⁶

The amounts to be raised by the IFF appear substantial at first glance. Yet a doubling of total development aid to \$100 billion sits modestly beside the \$1 trillion spent globally on military expenditure, and \$300 billion in agricultural subsidies paid each year by rich countries.¹⁷ Put in the context of the vast inequalities that scar current forms of globalization, the choices become clear.

The challenge for the global health community is to engage with this critical debate, beginning with support for actions to ensure that the MDGs are achieved. As Chancellor Brown warned, "If we let things slip, the Millennium Goals will become just another dream we once had, and we will indeed be sitting back on our sofas and switching on our TVs and . . . watching people die on our screens for the rest of our lives. We will be the generation that betrayed its own heart."¹⁸ The global health community has much to con-

tribute. Decades of experience in the developing world predict that the attainment of the MDGs will be heavily predicated on investing in and strengthening weak health systems and building human resource capacity.⁵ Research has already revealed many effective low-cost interventions. Such efforts need to be expanded and complemented by research on how to ensure that health systems can deliver such interventions. If this opportunity is seized, the IFF could contribute to the \$34 per person needed each year for meeting essential health needs of disadvantaged populations.⁶

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