Mobilizing resources

when

developing countries adopt the MDGs - and when rich countries pledge to support them - all need to be clear about the resource implications. Although the amounts of money needed are relatively small in global terms, they are significantly higher than current levels of investment in the health sector.

Resources will also need to come from the governments of low-income countries themselves; even the poorest countries have some scope to increase domestic health spending. But this will not be enough. Reaching the health goals will require a dramatic increase in *aid for health*. As discussed earlier, developing countries will need to improve the quality of their health plans and strategies, and strengthen their health systems, if they are to attract these resources.

This chapter looks at *what it will cost* to achieve the health MDGs, and addresses the arguments against increasing aid. Chapter 6 looks at the issues of aid effectiveness, i.e. ensuring that aid is delivered to countries in the most useful and efficient form.

Monitoring Goal 8

Achievement of Millennium Development Goals 1 to 7 will depend largely on the actions of developing countries. Complementing these are actions outlined in Goal 8 which identify what rich countries must do to provide the necessary support. While Goal 8 identifies key elements for a genuine global partnership for development - mainly aid, trade, and debt relief - it does not set specific quantified targets to measure donor countries' efforts. The lack of specific targets for actions by rich countries is regarded as a major weakness of the MDGs, not least by developing countries. In response, some donor countries have produced their own MDG reports - complementing the MDG reports produced by developing countries - that focus on aspects of the quality and quantity of their aid, and their role in and views on global trade, debt relief, technology transfers and the overall coherence of government policies. These donors include Denmark, the European Commission, Finland, Ireland, the Netherlands, Norway, Sweden and the United Kingdom. Other reports have already been announced for 2005, including a joint report by the countries of the European Union.

Debt

For those countries classified as "heavily indebted", debt relief is potentially a more significant source of funding than conventional aid. In Malawi and Mozambique, 100% debt cancellation would immediately release US$ 600 million in additional resources per country over the period 2000-2015. In Uganda it could release up to US$ 1 billion, and in Tanzania US$ 700 million. Even after maximum debt relief under the 'Enhanced HIPC' (Highly Indebted Poor Countries) initiative, these countries would pay US$ 3 billion in debt service payments between 2000 and 2015; this figure excludes payments on more recently contracted debts (6). In addition to the volume of resources released, debt cancellation is, potentially, an effective means of delivering resources: it releases funds to the general budget, and is a sustained source of income - allowing governments to plan the use of additional resources over a long-term period. Efforts are therefore needed to expand and extend debt relief, including to those countries which do not qualify for relief under current schemes. The announcement by G8 countries in July 2005 that they would "cancel 100% of outstanding debts of the eligible HIPCs to the IMF, IDA and African Development Fund" is a welcome step in this regard.

Goal 8

The eighth goal of the MDGs is to "Develop a Global Partnership for Development". This is the goal that makes the MDGs unique, marking them as a compact between rich and poor countries, and making explicit that progress in poor countries will depend on the actions of rich ones. Goal 8 (see opposite) represents the donors' side of the MDG bargain and is a reminder that global security and prosperity depend on the creation of a more equitable world for *all*.

The content of the "Global Partnership" has been elaborated in various ways. The Monterrey Consensus - the outcome of the International Conference on Financing for Development in 2002 - is seen to lay out the key elements. These include trade liberalization, private financial flows, debt (see opposite), domestic resource mobilization, and development assistance (aid).

Clearly, all these aspects have an important impact on the capacity of countries to achieve the first seven MDGs. Aid is particularly important to the health sector (as it is to other social sectors) because health receives a significant share of its resources from the public purse - resources which, given the non-profit-making nature of public health investments, cannot be replaced through private investment. *Aid is thus often the only reliable alternative when public funds for health run short.*

What will it cost to achieve the health MDGs?

Development assistance for health (DAH) was estimated at US$ 8.1 billion (€6.3 billion) in 2002, the most recent year for which figures are available[i] (1). This represents a significant rise - up from an average of US$ 6.4 billion between 1997 and 1999 - and reflects an upward trend in overall aid levels. Total aid from OECD members rose by 7% in real terms between 2001 and 2002, and by a further 3.9% in 2003 (2, 3). Much of the increase between 2002 and 2003 was due to the start of reconstruction aid flows to Iraq, while much of the increase in aid for health was due to new funds committed to the Global Fund to Fight AIDS, Tuberculosis and Malaria, the majority of which have been committed to sub-Saharan Africa.

While these increases are welcome, they remain far short of the amounts that are needed. The Millennium Project recently estimated that meeting *all* the MDGs would require an estimated US$ 135 billion of Official Development Assistance (ODA) in 2006, rising to US$ 195 billion by 2015. Importantly, the Millennium Project notes that these increases remain well within the target adopted by the United Nations General Assembly in 1970 and recently renewed at Monterrey, that rich countries should allocate 0.7% of their GNP as development aid: US$ 135 billion is equivalent to 0.44% of rich countries' GNP.

Within health, there have been a number of studies on the need to increase spending. In 2001, the Commission on Macroeconomics and Health estimated that a minimally adequate set of interventions - and the infrastructure needed to deliver them - would cost in the region of US$ 30 to US$ 40 per capita[ii] (4). Other estimates suggest that as much as US$ 60 per capita is needed (5). While these figures differ markedly, the overriding message is clear: in the poorest countries, health spending needs to be of a different order of magnitude compared to its current level of just US$ 8-10 per capita.

Global figures now need to be matched by country-specific estimates on the cost of scaling up. Costing the expansion of specific disease-control programmes is useful for advocacy purposes, but should be complemented by estimates which take into account the financial implications of expanding and strengthening the sector as a whole.

i This includes contributions from bilateral and multilateral agencies, the UN and the World Bank, the Bill and Melinda Gates Foundation and the Global Fund to Fight AIDS, Tuberculosis and Malaria.
ii This figure does not include family planning, tertiary hospitals, and emergencies.

Done in this way, costing exercises will help make the case for larger health budgets.

The economic impact of scaling-up

Attention is now turning from costing exercises to the difficult question of how to mobilize support for long-term investment in health. Here a debate arises concerning the possible macroeconomic impact of rapidly scaling up aid flows to poor countries. Arguments against rapid increases include the observation that when aid is used to pay for local goods and services (salaries, construction materials, etc.) the result may be to push up the prices of these resources without increasing the supply (7). This issue affects the health sector, where local costs are typically 70-75% of total spending (8) and where the number of skilled staff cannot be increased quickly. Other concerns include:

- when aid is in the form of loans, it will increase the debt burden and may threaten debt sustainability;

- aid flows are typically volatile, which may increase macroeconomic instability and affect the sustainability of increases in recurrent costs such as salaries, in turn raising concerns about medium-term fiscal sustainability;

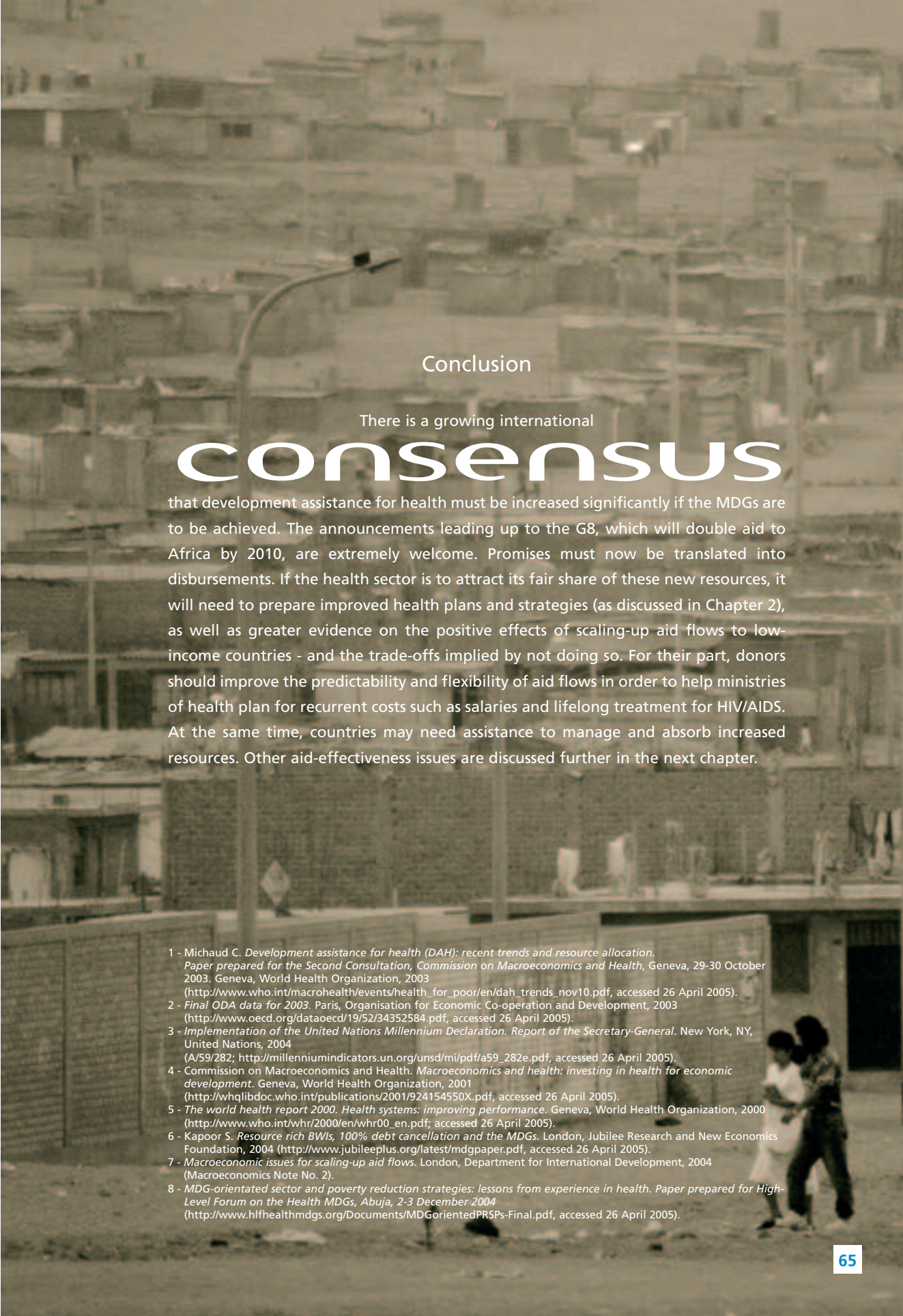
- increased aid flows may create short-run volatility in the exchange rate and interest rates, both of which can damage private-sector investment.

However, much of the evidence on which these concerns are based is inconclusive, or was gathered in the 1980s and 1990s and may no longer be applicable in countries that have undertaken macroeconomic and public expenditure reforms. Further, many of the concerns refer to the way in which aid is delivered - predictability is a particularly important issue, as is timing of disbursements to match national budget cycles. Thus, there is not necessarily a problem with high levels of aid per se. Aid inflows that are reasonably predictable and persistent are neither intrinsically inflationary nor do they necessarily generate macroeconomic instability.

Most important of all, the potential disadvantages of increasing aid need to be weighed against the likely advantages, and the costs of inaction. In poor countries where there is both some record of success in improving health and a measure of economic stability, and where governments are willing to embark on a process of scaling up, the international community should provide support. Financial ceilings and expenditure management norms may need to be stretched, and close monitoring by the international financial institutions will be essential. But this will provide evidence of the approaches that work, as well as lessons for future engagement.

Exactly how much aid could be usefully absorbed, and where it should be directed, depends on countries themselves. In some places, expenditure can be immediately increased in sectors such as road construction and sanitation (which can have a positive impact on health when well targeted) while the health sector develops the basic systems to take on more resources. The key is to ensure that scaled-up investments support equitable progress towards all the MDGs, recognizing the synergistic nature of the goals.

WHO's experience working with ministries of health suggests that many countries receive conflicting advice about the potential macroeconomic impacts of increasing aid. Donors (and in particular the international financial institutions) should work together to avoid this inconsistency, and where necessary encourage countries to seek independent advice. WHO will work with partners to develop an economically-robust case for increasing aid in order to encourage a much more ambitious approach to raising both the level and the predictability of resource flows to poor countries, including fragile states and countries in crisis.



Conclusion

There is a growing international

consensus

that development assistance for health must be increased significantly if the MDGs are to be achieved. The announcements leading up to the G8, which will double aid to Africa by 2010, are extremely welcome. Promises must now be translated into disbursements. If the health sector is to attract its fair share of these new resources, it will need to prepare improved health plans and strategies (as discussed in Chapter 2), as well as greater evidence on the positive effects of scaling-up aid flows to low-income countries - and the trade-offs implied by not doing so. For their part, donors should improve the predictability and flexibility of aid flows in order to help ministries of health plan for recurrent costs such as salaries and lifelong treatment for HIV/AIDS. At the same time, countries may need assistance to manage and absorb increased resources. Other aid-effectiveness issues are discussed further in the next chapter.

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2 - *Final ODA data for 2003.* Paris, Organisation for Economic Co-operation and Development, 2003 (http://www.oecd.org/dataoecd/19/52/34352584.pdf, accessed 26 April 2005).

3 - *Implementation of the United Nations Millennium Declaration. Report of the Secretary-General*. New York, NY, United Nations, 2004 (A/59/282; http://millenniumindicators.un.org/unsd/mi/pdf/a59_282e.pdf, accessed 26 April 2005).

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7 - *Macroeconomic issues for scaling-up aid flows.* London, Department for International Development, 2004 (Macroeconomics Note No. 2).

8 - *MDG-orientated sector and poverty reduction strategies: lessons from experience in health. Paper prepared for High-Level Forum on the Health MDGs, Abuja, 2-3 December 2004* (http://www.hlfhealthmdgs.org/Documents/MDGorientedPRSPs-Final.pdf, accessed 26 April 2005).