A joint NGO statement to the High Level Forum on Health MDGs

October 2005

The third High Level Forum (HLF) on Millennium Development Goals (MDGs) on health is taking place on 14 and 15 November in Paris. We, civil society organisations from different countries working on health in developing countries, want to take the opportunity to share our views with the delegates to this important meeting.

The latest WHO report on Health and the Millennium Development Goals made a strong call for fully functioning and equitable health systems as a prerequisite for reaching the health MDGs. We strongly support this call. In the countries we work, we see sick people who are not able to pay for transport to the nearest health centre, children dying as a result of user fees for health services, nurses that are expected to run several uncoordinated health programmes without adequate support.

We fully subscribe to the rationale of the WHO when it states that integrated health systems that are adequately financed and staffed are urgently needed to attain the MDGs and achieve access for all. At the same time, all stakeholders should jointly contribute to address the root causes of ill-health. We aim to help realise the right to health for all and we see the MDGs as a powerful tool to raise awareness and mobilise support for what needs to be done.

In this statement, we want to raise your attention to some important issues that are related to two items on the agenda of the High Level Forum: *(1) financial sustainability and fiscal space* and *(2) global health partnerships and aid effectiveness.* Related to the issue of financial sustainability and fiscal space the undersigning organisations argue that macroeconomic policies need to be revised, in order to promote expansionary public expenditure. The ultimate goal of macroeconomic targets should be human development rather than just macroeconomic stability. Related to the issue of global health partnerships we argue that global partnerships will only contribute to the achievement of the MDGs when there is a long term commitment to address the root causes of ill health, to align with national priorities and plans and to contribute to strengthening health systems and poverty reduction.

Fiscal space and macroeconomic stability

Health systems in many countries are chronically under-funded, and health budgets remain far below what is seen as minimal spending. To achieve the health MDGs, health expenditure needs to be scaled up dramatically. Tight spending limits included in International Monetary Fund (IMF) conditions, have been criticised for inhibited increasing health expenditure. In response, the IMF claims that it is not against increased spending and is willing to accommodate higher aid levels. Instead, unpredictable and unsustainable aid flows create problems for financial planners and therefore for achieving macroeconomic targets.

While we acknowledge that increased, sustained, predictable and harmonised aid flows are of crucial importance, this is only part of the solution.

a. Creating real space

First of all, the IMF's position on fiscal space does not engage with the need to revise the macroeconomic targets in IMF programmes. Increased spending is accepted, but only as long as macroeconomic stability is not put at risk. While nobody would want to destabilise the economy, the IMF does not explain, or discuss, how exactly they define macroeconomic (in)stability. The IMF tends to stay on the safe side, with low single digit targets for inflation and budget deficits. This is mirrored by the view of ministries of finance and central banks, in which there are only two options: the cautious targets, or hyperinflation. There seems to be only one sound model – the one advocated by the IMF.

However, macroeconomic studies do show contradictory results. There is no agreement on evidence for what constitutes 'sound' macroeconomic targets. For example there is no consensus on the level of inflation that would endanger economic growth or poverty reduction. In a recent paper, United Nations Development Programme (UNDP)[1] provides evidence that increasing public expenditure is necessary for both economic and social development. Where the IMF usually calls for reallocation within the existing budget to make expenditure more pro-poor, the UNDP study shows this is not enough and argues for monetary and fiscal policies that allow for expansionary public expenditure. Estimates of the loss of economic growth due to malaria or aids also clearly show that investing in health is a wise economic decision.

Therefore, we call upon the HLF to emphasise that a shift in priorities is needed if we are serious about the MDGs. Governments should weigh the tradeoffs between prudent macroeconomic targets and large-scale long-term investments in people and development, instead of simply taking low single digit macroeconomic targets as the overriding objective. The IMF should loosen its belt-tightening prescription, open up to discussion of alternative policy options and play a much more pro-active role in helping countries to mobilise resources. World Bank, donors and WHO could assist in assessing the development impact of alternative macroeconomic options.

b. From paper commitments to daily practice

The papers on fiscal space published by the IMF over the past year, indicate that the IMF should help countries accommodate higher aid levels and mitigate macroeconomic effects. It is not evident whether this policy position is reflected in IMF programme guidelines and mission briefs. Moreover, it is unclear what happens in practice. For example, the Independent Evaluation Office (IEO) of the IMF found in evaluations of the Poverty Reduction Strategy Papers (PRSP) approach that the briefings for IMF staff missions regularly indicated the need to carry out impact assessments of proposed reforms. In practice, however, these assessments were hardly carried out. The IEO did not find evidence that governments were presented with the 'menu of options' which the IMF has officially committed itself to formulating. Negotiations on macroeconomic policies and targets take place behind closed doors. Line ministries, parliaments and other stakeholders have no say,

[1] Making Fiscal Policy Work for the Poor, Rathin Roy and John Weeks , UNDP

although these targets determine the policy space for the different sectors. Representatives of central banks and ministries of finance, interviewed in recent studies by Action Aid International and Wemos[2] admitted the absence of debate with other stakeholders, let alone analysis of different macroeconomic policy options.

We urge the HLF to come up with suggestions to open up the debate on macroeconomic framework and policy options at country level, and ensure an effective involvement of health and other line ministries. It is of great importance for health ministries to strengthen their negotiating position. We feel there is a crucial role to play for donors, World Bank and WHO country and regional offices to provide assistance with independent analysis and strategic support. Macroeconomic enabling policies are pivotal for governments to be able to improve their population's health and well-being.

c. Prevent adverse side-effects of general conditions

Several IMF programmes contain spending limits on the public wage bill, such as in Kenya and Zambia. In Kenya, the government was asked to downsize the public sector to 8.2% GDP. The IMF argued that the Kenyan public sector was too large compared to that of neighbouring countries. Yet, between 1991 and 2003, the government reduced its work force by 30%. The government's civil service retrenchment plan (2000-2002) envisaged a net reduction of 5.300 health staff. The health sector currently experiences a staff shortage of about 10.000 health workers. Officially, the ministries of health and education are exempted from the recruitment freeze once extra resources become available or if they reallocate the budget. In practice this means that the ministry of health can not recruit the staff that is needed. Newly graduated health professionals remain jobless – or migrate. In Zambia, current staff levels in health centres are about one fourth of what WHO recommends as minimum staffing levels. The ministry of health is not allowed to increase spending on wages to recruit and retain staff, because of the ceiling on the wage bill. But if donor contributions are included in the government health budget, the share of wages is only 31%, which is clearly insufficient to solve the human resource crisis in the health sector.

In our view, overall budget ceilings on the wage bill are highly problematic for the health sector. We feel it is not within the IMF mandate to say that the public sector of a country should be leaner, just because its neighbours spend less. Decisions on the size and composition of the public sector (related to its tasks) are the government's responsibility. Secondly, if the sectoral implications of such a generic prescription are not taken into account before the targets are being set, then who is responsible for adverse side-effects in the health sector?

We ask the HLF to find solutions for the impact of setting overall wage bill ceilings for the health sector. We feel that the IMF should refrain from setting arbitrary limits on the wage bill. The public sector has a large responsibility in realising the MDGs and civil service reforms should therefore aim to strengthen the sector and its outputs. We urge donors to support efforts to improve the composition and capacity of the civil service.

[2] Changing Course, Alternative Approaches to Achieve the Millennium Development Goals and Fight HIV/AIDS, Action Aid International USA, September 2005. Budget Ceilings and Health: The Kenya Case Study (draft), Wemos, ALMACO Management Consultants Ltd and AMREF Kenya, September 2005

Global health partnerships and aid effectiveness

Global health partnerships are viewed as an important tool to address health problems in developing countries and as such contribute to the achievement of the health MDGs. We are glad that global health partnerships are on the agenda of the third HLF. During the second High Level Forum in Abuja in December 2004 several challenges were identified such as the need for increased health systems investment, national ownership and harmonisation and alignment.
Wemos and nine partner organisations carried out several case studies to gain insight into the functioning of four global partnerships and their effects on national health systems[3]. These case studies confirm the challenges mentioned above.

a. Partnerships and the social determinants of health

Partnerships are initiated to fight diseases of poverty. However, the (poverty-related) social determinants of health, such as adequate income, food and clean water are hardly addressed by global health partners. Instead a predominantly curative medical approach is followed by many global partnerships. It is crucial to assess how partnerships contribute to the reduction of poverty and inequity. Currently partnerships are hardly investing in strengthening health systems. A well functioning health system is a prerequisite for partnerships to fully achieve their goals and for sustainable health improvement of the population. This can only be achieved through long term commitments of donors, including partnerships. How can partnerships contribute to MDGs and poverty reduction if neither the poverty-related root causes of ill health nor strengthening of health systems is addressed?

We therefore ask the HLF to acknowledge the necessity for partnerships to address the social determinants of health and health systems strengthening in order to effectively contribute to the achievement of the MDGs. Furthermore, we wish to stress that all partnerships should align their activities with national and global strategies for poverty eradication.

b. Governance

Governance is an important issue that was already touched upon during the second HLF. Transparency is a point of concern especially related to disclosure of information concerning financial decision-making. The case studies mentioned above show that the accountability of partnerships is rather limited as very little information concerning the partnerships is communicated in the field, not even to the functionaries and the health workers who run the programme. Many partnerships do not have clearly defined accountability and transparency mechanisms which is remarkable as they are partly funded with public money and dealing with public health issues. Moreover, at field level partnerships often do not promote approaches that allow national stakeholders and target groups to participate in decision-making and financial management. Instead top-down mechanisms are used leading to a lack of knowledge of the realities at field level jeopardising ownership of the programme and missing opportunities for capacity building.

[3] Risky Remedies for the Health of the Poor, Global Public-Private Initiatives in Health, Wemos, Prepare, West Bengal Voluntary Health Association, Consumers Information Network Kenya, People's Health Movement East Africa, Ifakara, Joint Medical Store, Chessore, Health Systems Trust, Community Health Cell. May 2005

***Global partnerships should develop clearly defined mechanisms to ensure transparency and accountability. At country level partnerships should promote participative mechanisms for defining priorities and plans aimed at responding to the needs of the target groups. We urge the HLF to continue the debate on this topic as interventions can only be effective if they are based on national needs and priorities*.**

c. Harmonisation

Often various global partnerships operate in one and the same country without coordinating or integrating their activities. This often results in duplication of activities. Even more worrisome is the fact that partnerships are each imposing different strategies and reporting demands on district and national health staff leading to a deteriorating public health sector as the health staff is overburdened and insufficient time remains to perform their regular duties.

The WHO plays a pivotal role in many health partnerships. We call upon the WHO to take active steps to coordinate the programmes of different GPPPs at global level and to promote a 'code of practice' which would outline ways in which partnerships programmes can be integrated with the national health systems.[4] Recipient countries should play a leading role in the national coordination and alignment of the activities of the different partnerships in order to ensure their effective contribution to local needs and priorities.

Finally, we wish to make an urgent call to the HLF and governments of developing and developed countries, and international agencies to put their MDG commitments into harmonised action and to agree on the roles and responsibilities of each actor involved while taking into account the above mentioned points of concern.

This statement is supported by the following organisations:

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[4] Unger JP et al. (2003). "A code of best practice for disease control programmes to avoid damaging health care services in developing countries. " International Journal for Health Planning and Management 2003; 18: S27-S39

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