Debate Overview

"Millennium Development Goals – What Factors Impact Achievement?

How Best to Impact Global Poverty?"

30 September 2010
Bad Homburg, Germany

Background

On 30 September 2010, EPOS Health Management marked its 25th Anniversary by holding a public debate before an invited audience at its headquarters in Bad Homburg. A panel of distinguished experts discussed how better progress could be made on achieving the Millennium Development Goals (MDGs). All panel members and all audience members were actively engaged in different aspects of international health care development.

With such a variety of experts and experience represented on the panel, and within the audience which also contributed, there was unlikely to be complete unanimity on what are the main barriers for MDG implementation, or on the right solutions for progress. However, there was a high degree of consensus around a number of themes, and this overview seeks to capture the main areas of agreement.

The debate tended to fall around four key issues: (i) the relationship between health, wealth and poverty; (iii) the role of politics, and the need for better governance within and between governments and international agencies; (iii) the need for better public – private – civil society partnerships; and (iv) the need to look beyond the traditional health sector to improve the health of populations.

1. **Health, wealth and poverty.**

All panel members agreed that the relationship between health and wealth is fundamental, but that absolute poverty in developing countries was not the full story. Mobilisation of wealth

for development purposes is also vital, and many countries are failing to exploit domestic resources effectively. It was recognised that international trading relationships are often disadvantageous to poor countries. UN estimates of unfair trading between the developed and under-developed world swamp aid budgets, and it is essential developed countries avoid using their power to maintain such inequitable relationships or denude developing countries of scarce health care workers. However, several of the least developed countries are exporters of oil, most developing countries exercise poor tax collection, and their financial systems fail to support entrepreneurial activity. Waste is also widespread.

It was noted that around three quarters of the World's poor now live in middle income countries, and it was suggested that there are two kinds of poverty: (i) absolute poverty with communities lacking basic food, water and shelter need for survival; (ii) the poverty of exclusion from social life and opportunity which is encouraging a growing gap between rich and poor in many countries. Development aid needs to find a balance of investments to address both types of poverty, not merely the more immediate and heart-rending needs. "Global social protection" to protect the very poor in every society is required.

Changes to funding arrangements were likely to be the main incentive for changing both health seeking behaviour, and health provider behaviour in terms of better quality and responsiveness. Pouring money into the health system did not work because much of funding failed to trickle down to where it could be used effectively. Neither provision of free health care nor cost sharing was the single answer, but a balance is needed. Charging at the point of use is a deterrent to the poor seeking health care, and free health care is an unnecessary subsidy for those who could contribute more, so new approaches are needed. The use of vouchers was identified as a way forward which in some areas is already changing the basic relationship between providers and the public, promoting better access and quality of services. Social insurance systems are another example.

2. Politics and governance.

There was a consensus that achieving the MDGs is not a technical issue, but a political one. Politics is about balancing different interests in society, including the production and distribution of wealth. Trying to differentiate between "politics" and "people" is not a helpful distinction as governments represent their people. Consequently, international agencies could not avoid having to deal with and through governments, although it was noted that governments are not homogenous, and have competing interests and changing agendas which undermine ownership and sustained support. There was agreement that serious problems with governance lead to misuse of resources and poor implementation. The obvious example is widespread corruption, but also the short term-ism within governments

and aid agencies which leads to vertical programmes and projects which are prematurely closed down. International agencies need to avoid on the one hand competing with each other, and on the other hand forming clubs which can be threatening to the recipient government. More attention is needed to build effective governance capacity at all levels to improve programme design and local implementation. Wider use of output based aid would is also desirable.

3. Better partnerships.

Among the panel there was consensus that governments cannot achieve the MDGs on their own and that more effective partnerships are required. Attempts to improve health service quality are hampered by system failures yet governments show reluctance to change their ways of working, or to recognise where people want less government interference in their lives. Government, the commercial private sector, and NGOs all have competitive advantages as well as limits on what they can achieve. Identifying and exploiting those advantages and harnessing them in effective partnerships are essential if MDGs are to be achieved. Better differentiation is required between goods, services and “public goods” and which parts of society are best able to provide them.

Governments are best placed to regulate health services rather than directly provide them, and should focus on issues such as accreditation, surveillance, and quality assurance. Managing complex social institutions such as modern hospitals is best achieved if governments allow them some degree of autonomy, with funding arrangements that enable their sustainability and systems to assure quality. Civil society, as represented by religious organisations or NGOs, has a vital role to play in encouraging behaviour change, provision of services and mobilising resources. There are excellent examples of governments using NGOs for wide-scale service provision, but experience shows the importance of ensuring that the rules of engagement are clear and that governments deliver on their part of the arrangement, such as timely funding.

It was recognised that there is a growing appreciation of the role the private sector can play in delivering “public goods” such as health care. It was also noted that the use of new technologies such as mobile phones had exploded because they represent good value for money, and serve real needs. More effort was needed to ensure that health services similarly address people’s needs and offer good value: available, accessible, affordable and of reliable quality. If health care staff are to be motivated to deliver such services they must be sure of sustainable funding mechanisms and new technologies must be simpler to learn and use. To achieve the MDGs better use must be made of the private sector’s capacity for innovation, marketing, logistics and efficiency. Internationally, commercial interests could

share technology and even raw materials, to improve the quality of locally produced medicines, for example, rather than engaging in practices which encourage counterfeiting or sub-standard products.

4. **Beyond the health sector.**

There was consensus that better health of populations is not just about health workers providing better quality health care. Achieving the health related MDGs and improving the health of populations requires much broader approaches than can be undertaken by health ministry's or even development ministries. Wider approaches are required which embrace other sectors such as energy, education, housing, transport, security, food production and finance. Currently, new international relationships are being forged between India and both the EU and USA, and such discussions should be opportunities to include pro-poor policies.

Debate Panel members:

- Dr. Renée Ernst, German Coordinator of the United Nations Millennium Campaign

- Mr. Bruno Wenn, Chairman of DEG's Board of Management, Deutsche Investitions- und Entwicklungsgesellschaft GmbH (DEG)

- Dr. Michael Rabbow, Corporate Affairs, Boehringer Ingelheim GmbH

- Dr. Franz von Roenne, Head of Health Section, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH

- Prof. Richard O. Muga, Chairman of the National Hospital Insurance Fund in Kenya

- Ms. Rose Kumwenda, Acting Executive Director of Christian Health Association of Malawi (CHAM)

- Dr. Michael Niechzial, Managing Director, EPOS Health Management

- Moderator: Dr. Christopher Potter, Director of Public Health Powys Health Board, Wales

Debate summary provided by Dr. Christopher Potter, Director of Public Health Powys Health Board, Wales, and debate moderator.