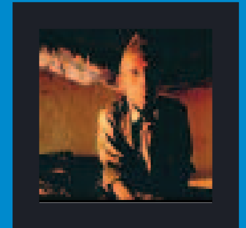
Health and the Millennium Development Goals

Fully functioning and equitable health systems: a prerequisite for reaching the health MDGs



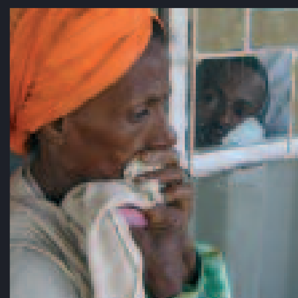
health outcomes are unacceptably low across much of the developing world. Chapter 1 shows that sub-Saharan Africa is worst affected, but there are extreme and acute pockets of ill-health in all regions. At the centre of this human crisis is the failure of health systems, which have both failed to protect the poor from the consequences of ill-health and in some cases contributed to more widespread social breakdown.

Much of the burden of disease can be prevented or cured with known and affordable technologies. The problem is in getting staff, medicines, vaccines, and information - on time, reliably, and in sufficient, sustained and affordable quantities - to those who need them. In too many countries, the health systems needed to achieve these objectives either do not exist or are on the point of collapse. We have examples of successful delivery strategies for single diseases, which have worked on a large scale in low- and middle-income countries (see box). The difficulty has been in achieving similar results for all causes of disease and disability.

Synergies in strengthening systems and public health outcomes: some examples from TB control

In countries where the private sector dominates in providing health care, expanding public-private collaboration in TB control offers a chance to increase access to quality care. It can also reduce dangerous practices that fuel the spread of drug-resistant disease.

In many countries, particularly in Asia, cost-effective public-private mix TB service approaches are expanding. In India, national authorities have set TB service contracting standards for collaborating with the private sector. In Indonesia, DOTS[i] expansion is accelerating: partnerships within the public sector, between TB programmes and large public hospitals, are yielding faster patient recruitment. This approach demands more investment in service supervision as well as the fostering of support from local leaders.



In the Philippines, strengthening of TB services within primary care systems is part of the health reform programme, including decentralization, community engagement and new insurance schemes. In Pakistan, the Lady Health Worker programme provides one platform, and private providers another, for expanding DOTS coverage and treatment follow-up.

Among village workers, hospitals, and provinces in China, financial disincentives to TB control are being overcome through offering compensation to those curing free-care TB patients, as well as through increased central Government subsidies for disease control overall.

In the countries of the former Soviet Union, linkages are being strengthened across the health services of the ministries of health and justice. Prisons have been an epicentre of the resurgence of TB - due to the underlying health status of inmates, overcrowding, and previously poor drug supply. Larger reforms are needed to reduce such underlying risks and to enable more community-based care.

In Bolivia, Ministry of Health outreach teams for poor indigenous communities provide a platform for social mobilization, active TB case-finding, and early treatment among those at risk. Kenya and Malawi have also developed strategies to extend access by the very poor - for example by offering TB treatment at remote health posts and even from shops. In the United Republic of Tanzania, TB control is now financed from the health budget, after a decade of full external dependence.

i - DOTS is the WHO recommended strategy to control TB.

National health systems worldwide have evolved in response to changing historical, economic, and social circumstances. It is therefore not surprising that health systems often mirror the problems that beset societies more broadly, as for example in relation to governance, management, financing, or inclusiveness. The converse is also true: in countries where health systems are at risk of collapse, the causes - such as chronic underinvestment or the impact of HIV/AIDS - do not affect the health sector alone. The starting point for addressing the effectiveness of health systems is therefore to define the elements of a clear and actionable agenda which recognizes and responds to underperformance in the sector itself but which also acknowledges that success depends on a range of factors in wider society.

A health systems action agenda

The creation of strong health systems is not an end in itself - it is a means to achieve better health outcomes. Effective and equitable health systems are an absolute requirement for achieving the MDGs as well as other health goals, such as those related to reproductive health and immunization. It has been estimated that universal access to broad-based health services could meet 60-70% of the child mortality and 70-80% of the maternal mortality MDGs (1). Furthermore, strengthening health systems is essential if the current increase in aid for health (see Chapter 5) is to be well spent now and sustained in the future.

The first challenge is to define clear priorities for improving the functioning of the health system, while at the same time recognizing that its essential elements are - as those of any other system - interdependent. A change in financing strategy which, for instance, makes clinics more dependent for their income on user fees, will inevitably influence provider behaviour, the balance between curative and preventive care, client demand, and so forth. Removing charges, on the other hand, may increase utilization among poorer groups while having unexpected

Figure 1: Human resources for health, by WHO region, 1995-2004

Source: WHO

consequences in terms of demand for commodities, health worker motivation, and quality of care. Accordingly, strengthening of health systems needs to be seen as an integral part of national health policy. Actions to strengthen health systems will draw from a common menu, but specific priorities and sequencing will be determined by national circumstances.

A general point to make is that there are many ways to reflect the relationship between goals, functions, and components of the health system - one approach was articulated in *The world health report 2000* (2). This chapter is not a contribution to that debate. Rather, it aims to highlight the importance of strong health systems to the achievement of the MDGs, to identify some of the factors that affect overall performance, and to emphasize the need for change on a national scale.

Human resources for health

In many countries, particularly in Africa, the shortage of health service staff has become one of the most serious constraints to scaling up the response to HIV/AIDS and the achievement of the other health MDGs. Health workers are dying; they are leaving public service because the conditions are bad and getting worse - in many countries, health workers themselves live below the poverty line; they are moving from rural to urban areas, migrating to countries that pay them better, or leaving health care altogether. As Figure 1 shows, almost 90% of the population in Africa lives in areas where there are less than five doctors per 10 000 people, and more than 60% have less than five nurses or midwives per 10 000 population.

The action agenda is clear. Addressing the human resources challenge will require work to improve pay, supplements, and incentives for those working in poorer areas; efforts to upgrade the skill-mix of health workers - in particular, to strengthen essential emergency and surgical skills and knowledge of primary health care; and better partnerships with private providers, nongovernmental organizations (NGOs), and community partners.

This agenda will in turn require a reassessment of tasks and responsibilities and a review of job descriptions to ensure the appropriate allocation of tasks to various categories of health workers at various levels of the system - from community health centre to district hospital. In most parts of the world, the key issue is that of shortages of personnel. However, even in those countries of eastern Europe and central Asia where this is not the case, efforts are required on several fronts to increase efficiency and effectiveness.

Particularly in Africa, it is essential to take action to prevent deaths of health personnel from HIV/AIDS. Where migration is stripping health systems of vital personnel, efforts are required - both within and among countries - to manage mobility without infringing upon individual rights. The key point is that the crisis demands political as well as technical solutions because it is deeply associated with national priority setting (for example, why should health workers get special treatment, compared to other public sector workers?) and because it often involves overcoming conflicting interests at the core of national and international political processes (3, 4, 5, 6).

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In the countries most affected by the human resources crisis, national as well as global approaches are needed. Also needed is the cooperation of multiple actors both within and across countries. International institutions - including those dealing with trade and immigration, and employment policy bodies and regulatory regimes - must be part of the response. WHO is working with others to draw attention to the challenges and advocate for increased action on the human resources crisis. WHO also assists ministries of health to expand and improve their health workforce, and works to promote policy coherence on human resources issues throughout governments and with development partners.

Fair and sustainable financing

There are reasonably robust estimates of what constitutes an adequate level of investment in health systems, but few developing countries reach anything like this level of spending (see Chapter 5). Beyond level of spending, the key questions concern *how* the health system is financed and what proportion of contributions comes from users themselves - either in the form of out-of-pocket contributions (common in most poor countries) or through insurance payments.

This chapter does not discuss the merits and problems associated with various approaches, such as cost-sharing, cost-recovery, user fees, and private and community-based insurance. Rather, it promotes the principle that whatever system of financing a country adopts, that system should not deter people from seeking and using services. In most cases, this will mean that payments at the point of service will need to be eliminated - or at least related to ability to pay. The financing system should also - as a minimum - protect people from catastrophic expenditure if they become ill, promote treatment according to need, and encourage providers to offer an effective mix of curative and preventive services.

Given these policy objectives, the choice of strategy - between purely tax-based financing and various forms of social insurance, for example - will be determined by a variety of factors. Success will depend upon not just the technical merits of the argument for and against a particular strategy, but will also require careful marshalling of political support and a sober assessment of managerial and administrative capacity.

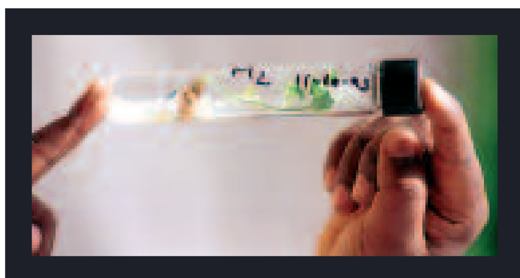
For example, experience suggests that scaling up small-scale community-based insurance schemes often falters when coverage expands. Similarly, establishing a sustainable nationwide health insurance system is a complex task for under-resourced health systems, requiring active political support from legislators, ministries of finance and labour, employers, and unions - as well as reliable systems for managing contributions and payments.

Drugs, diagnostics, and the basic infrastructure needed to deliver services

The provision of health services relies on the availability of regular supplies of medicines and equipment, as well as appropriate infrastructure at facility level. Facilities without safe water and electricity, with non-functioning equipment, and with infrequent or inadequate deliveries of drugs, diagnostics, and other supplies, are all too common in many developing countries.

The provision of drugs and vaccines alone cannot build systems nor ensure quality of care, but without the facilities and materials to do their job, health professionals cannot function. When the health care system cannot deliver, it loses credibility and people turn elsewhere. In many cases, they turn to unqualified health workers, which may worsen their chances of being treated effectively. A poor system of medical supplies can also create problems of drug resistance.

Basic life-saving commodities are in short supply in most low-income health systems. In part, this is a result of resource shortages, but even when substantial increases in funding are available (as is now the case with monies from the Global Fund to Fight AIDS, Tuberculosis and Malaria), problems still remain. Building effective and accountable national procurement and drug management systems is an increasingly prominent component of the health systems action agenda[ii].



After staff shortages, slow and dysfunctional procurement systems can be the most serious constraint to scaling-up. The ideal approach is to build and strengthen national systems, rather than to bypass them or use offshore mechanisms, as is the current practice of some donor agencies. Building the requisite systems that are capable of reliable purchase and distribution of medicines - and which can overcome corruption where it exists - involves addressing a combination of administrative, managerial, and political issues.

Assessing progress and tracking results

Successful scaling-up and maintenance of health care services depend on the generation and use of sound data on health system inputs, processes, outputs, and outcomes. While, at first glance, information does not appear to be an inherently politicized issue, it becomes so when linked to accountability and transparency (particularly of resource allocation). The general public wants reassurance that public policy in health is based on sound evidence of approaches that work, and that the distribution of energies and resources is effective, efficient, and equitable. Reliable health data also provide important information on broader social and developmental progress, as maternal and child mortality indicators are often used as indicators of poverty.

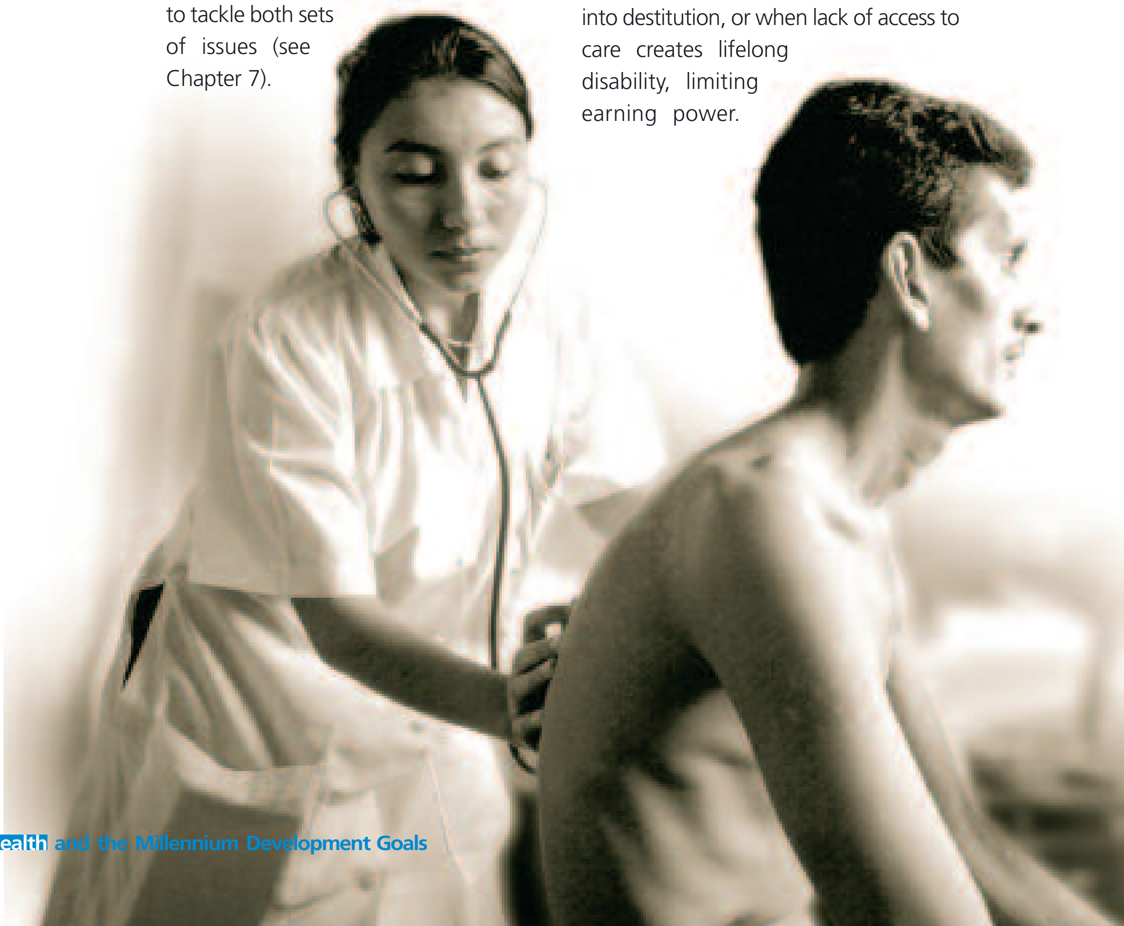
Functional health information systems are needed to deliver that reassurance. Yet, the vast majority of the world's poorest countries cannot even count their dead. In sub-Saharan Africa, fewer than 10 countries have vital registration systems that produce viable data. In many poor countries, patient records - the 'building blocks' of information systems - are so poorly completed and maintained that they become obstacles to better clinical care and improved information systems. Generation of disaggregated data - while challenging - is vital to provide information for the development of health policy targeted at those in need.

ii - See WHO Essential drugs and medicines policy for more detail (http://www.who.int/medicines/, accessed 28 April 2005).

Addressing these issues requires action on two fronts. First, a massive effort is needed to strengthen health information systems, and - crucially - to link data to decision-making and accountability. One of the reasons that health information systems remain underfunded and dysfunctional is that decision-makers are not interested in, nor do they rely on, the outputs of those systems. This is both because data are of poor quality and incomplete, and because they are not summarized in a way that makes sense to decision-makers. Second, work is needed to build international consensus on *what* needs to be monitored, particularly in terms of what constitutes the most appropriate set of indicators for measuring performance of health systems. The Health Metrics Network, based at WHO, has been established to tackle both sets of issues (see Chapter 7).

Organizing health services: towards a more equitable and pro-poor approach

Actions to strengthen health systems need to be grounded within an overarching health strategy which aims, in particular, to improve the health of the poor and vulnerable. The problem of inequitable health outcomes between rich and poor is an issue in all countries, although it is usually worst in the poorest countries (see Chapter 4). Limited health resources are typically spent in urban areas, providing health centres to serve relatively better-off and more vocal populations, while the rural poor and slum dwellers are more likely to seek care from expensive private providers. As a result, the health system can itself contribute to poverty, when health-care payments push the poor or near-poor into destitution, or when lack of access to care creates lifelong disability, limiting earning power.



Much of the debate around provision of health services has tended to focus on public sector primary care. A more comprehensive action agenda must take into account the health system as a whole - recognizing the role of private providers and the contribution of community-based organizations, NGOs, and home-based care. In practice, ambulatory care in many low-income countries is provided by a wide range of private, voluntary, traditional, and community providers.

Getting such a variety of providers to work together to provide consistent and quality services is a key priority. Franchising and other forms of 'managed networks' - in which private businesses such as drug shops undertake to deliver public health interventions in accordance with guidelines set by the franchiser - work well for some specific services, including family planning, treatment of sexually-transmitted diseases, and TB. However, this approach works less well for general care.

In many countries, creating a 'pro-poor' system is likely to require either an increase or a reallocation of resources to primary level and outreach services. However, access to hospital treatment is also critical for obstetric emergencies and for injuries and accidents. In countries in crisis, hospitals can be one of the few places of refuge for those caught up in fighting. In addition to being accessible, hospitals must be affordable; the costs associated with hospital treatment may force poor families to sell the few assets they have, deepening their poverty.

In many countries, administrative decentralization aims to bring health-service management closer to the people. Experience suggests, however, that governments need to consider carefully how financial and other incentives can be used to ensure both that national priorities (for example, in relation to services such as immunization) are maintained, and that locally-run services are genuinely more efficient and responsive - particularly to the needs of the poor. Ensuring quality of care is an important issue in this regard, and can be a problem even in relatively well-resourced countries such as the eastern European countries of the former Soviet Union. Quality and responsiveness are key elements in increasing demand for services. For poor people in particular, a visit to a health clinic can be a demeaning and humiliating experience. Introducing incentives for providers to deliver better quality care must therefore be part of broader efforts to strengthen the health system. Differences between poor men and women also need to be taken into account. Women and men are exposed to poverty differently, and respond in different ways. For example, women are more likely to be subject to violence, be denied property rights, and experience occupational segregation - all of which impact on their health and the health of their families.

A related but sometimes forgotten point is that services in poor areas are often costly to provide. Infrastructure may need to be re-established and staff paid incentives to work in remote locations. That said, these costs need to be compared with the price of providing tertiary care to the urban middle class - which, as mentioned above, often captures a disproportionate share of health budgets in poor countries.

In summary, a ‘pro-poor’ approach does not imply establishing separate health services for the poor - although targeted outreach services can often be a useful tool for reaching poor communities. Rather, it means addressing the inequitable allocation of staff and funds by shifting resources towards services and activities which benefit the poor and the marginalized. For many countries, the essence of a pro-poor approach is to renew or reinvigorate the primary health care strategy through investments in quality public health and personal care services, and improved access to hospitals. Ensuring equitable financing mechanisms and forming links with other sectors which influence health outcomes - such as education, water, and the environment - are also essential.

Defining the rules of engagement: stewardship and the role of the state

Stewardship refers to the oversight role of the state in shaping, regulating, and managing health systems. Governments are expected to provide public and private health system actors with overall policy direction; to create conditions that allow them to do their jobs; to ensure oversight across the whole system with particular attention to equity concerns; and to reconcile competing demands for resources. The growing share of external funding channelled through disease-specific initiatives poses a particular challenge to the government oversight function (see Chapter 6).

‘Stewardship’ is often used as a shorthand term to describe the more political functions of the state in relation to health systems, with the implicit assumption that the other components are largely technical issues. As the discussion above shows, this is not the case. The stewardship function itself includes several important managerial functions (for example, regulation of insurance markets, setting and maintenance of professional standards, and facility management and logistics).

In addition, stewardship also covers key areas which are influenced by overall government policy, and are thus subject to the differing views of competing groups. These include oversight of human resources for health, the way in which financing is organized, the relationship with the private sector and with voluntary organizations, and - not least - strategies for addressing inclusion and equity. Although increasingly decentralized, these functions remain well within the public sector and are as subject to the political economy as any other component of the health system. Capacity needs to be built within ministries of health to manage these issues and to ensure the best possible results according to available resources.

Conclusion

health systems are the means of achieving better health outcomes, including the health MDGs. Efforts to combat communicable disease, to reduce child and maternal mortality, and to increase access to HIV/AIDS treatment all face the same constraint - provision of quality services cannot be scaled up while the health system remains fragile, fragmented, and inequitable. Achievement of other MDGs is, in turn, dependent on the capacity of the health sector to deliver. Therefore, strong and sustainable health systems are central to overall MDG efforts.

While stronger health systems are recognized as a prerequisite for achieving the MDGs, neither health donors nor national health planners have paid sufficient attention to systems strengthening. The drive to produce results for the MDGs has led many stakeholders to focus first on their own disease priority, with an implicit assumption that through the implementation of specific interventions the broader system will benefit (7). If aid for health is to be well spent and deliver equitable health outcomes, stronger health systems are needed. This in turn will require looking beyond technical solutions for specific interventions and addressing political, organizational, and managerial constraints.

The fact that health systems' constraints are shared across health priorities creates some opportunities for designing responses that exploit potential synergies, for minimizing duplication, and for maximizing economies of scope and scale. Although constraints vary greatly from one place to another, it is clear that - in every setting - achieving the MDGs requires building systems that are relevant to the social, economic, cultural, and political realities of poor people and low-income countries.

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2 - *The world health report 2000. Health systems: improving performance.* Geneva, World Health Organization, 2000 (http://www.who.int/whr/2000/en/whr00_en.pdf, accessed 28 April 2005)
3 - *Addressing Africa's health workforce crisis: an avenue for action. Paper prepared for High-Level Forum on the Health MDGs, Abuja, 2-3 December 2004* (http://www.hlfhealthmdgs.org/Documents/AfricasWorkforce-Final.pdf, accessed 28 April 2005).
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7 - Travis P et al. Overcoming the health-systems constraints to achieve the Millennium Development Goals. *Lancet*, 2004, 364:900-906.