Strengthening health systems to meet MDGs

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Introduction

The UNDP report on the Millennium Development Goals, or MDGs (UNDP 2005), cautions that the Goals will not be met by 2015 in the most needy countries, and, in fact, warns that the situation in Africa may actually worsen. What can be done to secure some measure of success in the health-MDGs effort? Should strengthening health systems be regarded a ‘first-order’ goal within ‘higher-order’ MDGs to secure at least the institutional and system prerequisites of better health for all in the future, perhaps after 2015 – a ‘second-best’ result in the absence of a ‘first best’ MDG outcome?

What is the underlying reorientation in health policy that could result in faster progress towards the MDGs for the poor?

The importance of emphasizing disaggregation of ‘progress’ towards the health-MDGs, to ensure national averages do not conceal little or no change for the poor, is argued by some, for example Gwatkin (2005); the better-off are easier to reach with scaling-up efforts and when targets are defined as population averages, these provide ‘quick results’ for managers. This, suggests Gwatkin, is the likely, though not inevitable, outcome without fundamental policy reorientation.

Table 1 captures Gwatkin’s main observations based on a 42-country study for MDG4: reduce child mortality. It may be used to infer the need for both absolute and relative progress among the poor in a policy that aims at full achievement of the health-MDGs: (1) current indicator levels for the poor are so far below the baseline that reaching the average MDG target would necessitate perceivable absolute progress for the poor; and (2) the rate ratio, which measures inequality between those below and above the poverty line, is widely dispersed indicating that attainment of the MDG may require some relative gains for the poor as well. Absolute and relative health gains in health outcomes for the poor, in turn, imply substantial and disproportionate focus in policy on this target group.

Inevitable exclusion of the poor from progress towards the MDGs?

Figure 1 is taken from the World Health Report 2005 (WHO 2005) and examines evidence on MDG5: reduce maternal mortality, Indicator 17, proportion of births attended by skilled personnel. It is presented to illustrate that the implications of ‘targeting the poor’ may be beyond the scope of countries with populations most in need and why, in these cases, (much) slower progress among those below the poverty line may be the inevitable outcome.

In the Dominican Republic, a small and clearly identifiable population group is significantly deprived of facility care. Also, such marginal exclusion implies an adequately functioning overall health system. ‘Quick wins’ (Millennium Project 2005; United Nations 2005) could conceivably be successfully implemented here with substantial and disproportionate focus on the lowest quintile through a service expansion/outreach strategy. And these absolute gains would, of course, also be relative to the other quintiles (for whom there are no, or very marginal, further improvements that can be made).

Two sets of data are presented for Cote d’Ivoire: ‘before and after’ intervention. In 1994 there appears to be a ‘natural’ and gradual increase in facility utilization; successive worse-off populations appear to ‘queue’ for progressive improvements in their status. ‘Quick results’ vis-à-vis improvements in national level indicators seem to have been gained by extending coverage to the relatively better-off (quintiles 3 and some in quintile 2). The poor, even with absolute gains, continue to be relatively worse off. The MDGs, on average, could be achieved if equal progress is made among all income quintiles (the fitted line in Figure 1 moves upward in a parallel movement) or with slower progress among the poor (the fitted line has a steeper slope) – some absolute but no relative gains for the lowest quintile. Better progress for the poorest could perhaps be achieved by ‘fast tracking’ (Millennium Project 2005)2 the country through increased international support for ‘quick wins’ here too. But, for such ‘quick wins’ to be more than ‘quick results’ – to secure sustainable improvements in health for the poorest – effective fast-tracking would need the prerequisite of minimal health systems, and further, the fast-tracking itself would need to be towards both achieving MDGs health outcomes and strengthening health systems.

Chad and Bangladesh are more typical of developing countries at the centre of current international focus on the MDGs. The levels of poverty and ill-health constitute mass deprivation, implying that targeting the poor would be attempting to cover almost the entire population.
Health systems are so weak that neither substantial nor disproportionate focus on the health needs of the poor is feasible. MDG-initiated efforts are most likely to be preempted by the higher income quintiles, with absolute and relative gains for the rich and much slower progress, if any at all, for the poor (even steeper slope for the left-hand tail of the fitted line). Any ‘quick wins’ are unlikely to be more than ‘quick results’, though with such mass deprivation the MDG target is unlikely to be achieved even at national level. But it is critical that the opportunity provided by the MDGs is not lost and at least a ‘second-best’ outcome is secured. In these countries, developing and strengthening health systems must be regarded as the ‘first-order’, immediate/medium-term goal to create the necessary enabling institutional and systemic environment to achieve and sustain ‘higher-order’ MDGs in the long(er) run.

Strengthening health systems: a ‘first-order’ strategy goal for a pro-poor policy within ‘higher-order’ MDGs?

Examining country situations in depth indicates that policy reorientation to secure the health-MDGs for the poor may not be feasible in implementation by 2015. This is not to excuse a lack of ambition in policy and countries

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**Table 1. Population, poverty and under-5 mortality in 42 developing countries**

<table>
<thead>
<tr>
<th>Region</th>
<th>Population of countries covereda</th>
<th>% population below US$1/dayb</th>
<th>Under-5 mortality (deaths per 1000 livebirths)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Millions</td>
<td>% of region</td>
<td>In countries covered</td>
</tr>
<tr>
<td>Latin America and the Caribbeand</td>
<td>293.4</td>
<td>55.9</td>
<td>10.6</td>
</tr>
<tr>
<td>Middle East and North Africae</td>
<td>119.8</td>
<td>39.2</td>
<td>4.3</td>
</tr>
<tr>
<td>South and South East Asia</td>
<td>1737.8</td>
<td>88.7</td>
<td>28</td>
</tr>
<tr>
<td>Sub-Saharan Africag</td>
<td>494.5</td>
<td>71.8</td>
<td>41.1</td>
</tr>
<tr>
<td>Total or average</td>
<td>2645.5</td>
<td>76</td>
<td>27.4</td>
</tr>
</tbody>
</table>


bData for population below the poverty line in entire region refer to 1998 and are from the World Bank’s *World Development Report 2000/01* (World Bank 2001, p.23). Data for countries covered are drawn from the 2004 edition of the World Bank’s *World Development Indicators* (World Bank 2004, p.54–56). The reference year varies from country to country depending on the date of the survey from which the data were derived – 34 of the 42 surveys were between 1995 and 2000, two were more recent, six less recent.

calculated from the Demographic and Household Survey (DHS) data. The reference year varies from country to country, depending on the date of the most recent DHS survey – 34 of the 42 surveys were between 1995 and 2000, three were more recent, five less recent.

Bolivia, Brazil, Colombia, Dominican republic, Guatemala, Haiti, Nicaragua, Paraguay.

Egypt, Jordan, Morocco, Yemen.

Bangladesh, Cambodia, India, Indonesia, Nepal, Pakistan, Philippines, Vietnam.


Source: Gwatkin (2005).
must indeed aim to make rapid progress towards alleviating poverty as encapsulated in the MDGs. It is, rather, to caution against unrealistic aspirations in the absence of the necessary institutional and systemic requirements on which this success is conditional. The suggestion here is that a pro-poor policy orientation to secure the health-MDGs for lower quintiles must be accompanied by a strategy to strengthen health systems. And, for this, the opportunity provided by the global momentum around the MDGs needs to be seized to strengthen systems as a ‘first-order’ goal within the framework of the ‘higher-order’ MDGs – a ‘second-best’ outcome, perhaps, but one which is a necessary condition for putting all countries on-track to achieve and sustain the ‘first-best’ MDGs outcomes for all, albeit that this can be realistically attained only after 2015.

Endnotes

1 Unlike MDG1 (Eradicate extreme poverty and hunger) that specifies a population target (Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day), the health MDGs refer to only population averages (Goal 4: a two-thirds reduction in child mortality; Goal 5: reducing maternal mortality by three-quarters; and Goal 6: halting and reversing HIV and AIDS, TB and malaria).

2 The example used here, Cote d’Ivoire, in fact does not satisfy the Millennium Project’s suggested prerequisite condition for fast tracking – stable governance (underlining the critical need for protecting health in fragile states).

References


Disclaimer: The views presented here are those of the author and do not in any way reflected the views of the World Health Organization.

Biography

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