

Achieving the MDGs: Health systems as core social institutions

LYNN P. FREEDMAN

E-mail: lpf1@columbia.edu

ABSTRACT Lynn Freedman argues that strategies for meeting the MDGs should be premised on an understanding of health systems as core social institutions that help define the very experience of poverty and citizenship. MDG 5 on maternal mortality provides a strategic entry point for addressing health systems.

KEYWORDS maternal mortality; emergency obstetric care (EmOC); AMDD; health policy; equity

Introduction

When it comes to the Millennium Development Goals (MDGs) and health, everybody – from grassroots activists to the World Bank – agrees on one thing: ‘business as usual’ is a recipe for failure. But what has to change? Clearly, achieving the MDGs will require massive new investment in the health sector: domestic budget allocations and official development aid on a whole new scale. But the answer is not just money; it is the entire way in which we think about the connection between health and development – and the priority actions that result.

The MDGs have been criticized for their conventional approach to health. The goals and quantitative targets, all pegged to the year 2015, are disease-specific or condition-specific:

- reduce child mortality by two-thirds (MDG 4);
- reduce maternal mortality by three-quarters (MDG 5);
- halt and begin to reverse the spread of HIV/AIDS (MDG 6);
- halt and begin to reverse the incidence of malaria and other major diseases (MDG 6).

This way of framing goals and targets invites a technocratic, largely top-down approach with a familiar sequence of steps: determine the primary causes of the MDG diseases/conditions; measure the incidence and prevalence; identify the medical interventions to prevent or treat these causes; determine the most cost-effective delivery systems for those interventions; calculate the cost; advocate for ‘political will’ to get the job done.

Of course few serious analyses of the MDGs are so mechanistic and linear. There is increasing attention to health inequity, particularly the widening gaps between rich and poor both within and between countries (Gwatkin et al., 2004). There is a push to address so-called ‘demand side’ factors that constrain individual utilization of health services (Standing, 2004). There is increasing recognition that scaling up coverage of health interventions depends on strengthening of the overall health system, including the serious

problem of human resources (Wagstaff and Claeson, 2004; Travis et al., 2004; Joint Learning Initiative, 2004).

These important trends in health policy analysis will be even more powerful in changing the course of 'business as usual' if they are embedded in a renewed conception of health and health systems as part of overall poverty reduction. This is the hidden opportunity of the MDGs: With health recognized as a central part of a wider development agenda we have a chance to push past the conventional target-based public health approach and to re-ground health policy in the most critical debates of the day, including globalization, human security, equity, human rights, and poverty reduction. From that vantage point, health is not just a residual category where the side effects of development policy play themselves out for better or for worse. Instead, health policy and the health sector can be a leading wedge in forging the kind of equitable and democratic society imagined in the loftiest passages of the Millennium Declaration.

Rethinking the link between health and development

The relationship between health and development or health and poverty-reduction is usually explained with two rationales:

First, health is intrinsically valuable. Health is often cited as one of the social dimensions of poverty using the 'capabilities' approach to development articulated most famously by Amartya Sen: good health enables each person to achieve the true end goal of development, i.e., to 'lead the kind of life he or she has reason to value' (Sen, 2001). A similar concept can be found in human rights documents codifying the rights to health and health care (Committee on Economic Social and Cultural Rights, 2000). The underlying assumption is that good health and the conditions that make it possible are part of the very essence of a life with dignity.

Second, health is instrumentally valuable. Economists have argued persuasively that good health of a country's population is an essential pre-condition for its economic growth (World Bank, 1993; Commission on Macroeconomics and Health, 2001). At the individual level, poor health can initiate a spiral into deeper poverty as illness prevents an individual from working to earn the money needed to survive, and as the financial costs of preventing or treating disease can have catastrophic impact on individuals and families (Xu *et al.*, 2003).

Both rationales have been used to argue for increased investments in health.

I believe that a third rationale focused on health systems as core social institutions that help define the experience of poverty, must now be given equal weight in health policy. Poverty is not just a state of being. Poverty is also fundamentally *relational*. It concerns the interaction between individuals/communities and structures of power. This is the overriding lesson of many participatory poverty assessments, including the large 60-country qualitative research project undertaken by the World Bank and reported in *Voices of the Poor* (Narayan, 2000; WHO and World Bank, 2002). The experience of poverty goes beyond the lack of material goods or the state of poor physical health. Rather the

experience of poverty is profoundly marked by exclusion, marginalization, neglect, and voicelessness. These dynamics in themselves must be understood as critical dimensions of poverty.

If poverty is fundamentally relational, then it is important to understand the social norms and institutions that structure those relationships. Human rights activists have long understood the political arms of the state -- prisons, judicial systems and police forces -- to have the power to exclude, abuse and silence. But rarely are social and economic rights and the social institutions on which they depend approached with the same understanding. This must change. Health systems are part of the very fabric of social and civic life. A new respect for the role of health systems in creating or reinforcing poverty and, conversely, in building a democratic society should be the foundation for policies to achieve the health MDGs.

Health Systems as Core Social Institutions

WHO defines a health system as ‘all the activities whose primary purpose is to promote, restore, or maintain health’ (WHO, 2001). This includes the facility-based system, interventions at the household and community levels, as well as broader public health interventions such as food fortification or anti-smoking campaigns. It includes all categories of providers: public and private, formal and informal, for-profit and not-for-profit, allopathic and indigenous. It also includes mechanisms, such as insurance, by which the system is financed as well as the various regulatory authorities and professional bodies who are meant to be the ‘stewards’ of the system.

But the health system is not simply a mechanical structure to deliver technical interventions the way a post office delivers a letter. Rather, health systems are core social institutions. They function at the interface between people and the structures of power that shape their broader society. Neglect, abuse and exclusion by the health system is part of the very experience of being poor. Conversely, health claims, legitimate claims of entitlement to the services and other conditions necessary to promote health, are assets of citizens in a democratic society (Mackintosh, 2001). Health actions, the choices and means that enable individuals and communities to control their health, to participate as agents – not victims – in shaping their own life circumstances are important for individual capabilities and the enjoyment of individual rights.

Health systems ‘are not only producers of health and health care, but they are also purveyors of a wider set of societal norms and values’ (Gilson, 2003). People’s interaction with that system thus defines in critical ways their experience of the state and of their place in the broader society.

Health systems communicate and enforce values and norms through many different aspects of their operation. Perhaps the most obvious is the way providers treat patients. In many parts of the world, poor people experience appalling abuse in health facilities (Jewkes *et al.*, 1998, Miller *et al.*, 2002). As reported from the *Voices of the Poor* studies:

Rude, humiliating and inappropriate treatment are common complaints. A man from Tanzania says: 'We would rather treat ourselves than go to the hospital where an angry nurse might inject us with the wrong drug.' Elsewhere in Tanzania, men, women and young people say over and over again that they are treated 'worse than dogs'. Before they have a chance to describe their symptoms, they 'are yelled at, told they smell bad, and [that they are] lazy and good-for-nothing . . .' (WHO and World Bank, 2002).

The ways in which health providers are themselves treated by the system sends equally powerful messages about societal norms and values, and no doubt influences their treatment of patients as well (Mumtaz *et al.*, 2003). Sometimes those who struggle in the most challenging conditions to provide ethical, compassionate, high-quality care find themselves unrewarded – or even punished – for taking initiative, while those who exploit a poorly functioning, ill-supervised system to shirk their responsibility or enrich themselves, do so with impunity. Yet in other settings, the system is organized to pay serious attention to accountability and to communicate the importance it places on responsible provider behaviour (Tendler and Freedheim, 1994).

Societal values and norms are signaled and enforced not only through inter-personal relationships, but also in the very structure of a health system. In many countries of Sub-Saharan Africa and Asia, universal access to health care was a commitment that governments made to their people at the time of independence, regarding it as an essential part of nation-building (Bloom and Standing, 2001). But few countries came even close to achieving these aspirations. Indeed, by the 1980s, most poor countries found themselves in the grip of deep economic crisis, characterized by overwhelming international debt obligations and by failing public services, such as health care, that could not be maintained on domestic revenue alone.

Health sectors thus became prime targets for reform, often as part of broader structural adjustment programs aggressively promoted by the World Bank and other donors. The prescriptions for reform built on the ideological assumption that commercial markets were the most efficient way to produce and distribute health care. To transform the health sector into a market-based system, the standard package of health sector reform entailed (1) converting health care into a marketable commodity, i.e., into a product or service to be bought and sold; (2) encouraging a private sector to deliver health care on a for-profit basis; (3) shrinking the state to the role of 'gap-filler', to provide a minimum set of essential services to the poorest while all others purchased their health care in the private sector (Koivusalo and Mackintosh, 2004). Formal user fees were routinely instituted in public facilities; but exemption schemes intended to protect the poor rarely proved effective. In practice, whether services were officially public or private, whether users could afford it or not, all health care now required cash, with the poorest often simply priced out of the market, even for emergency life-saving services (Bloom and Standing; Afsana 2004).

Health sector reform typically treated health systems as a technocratic challenge, almost as a mechanical puzzle in which adjustment of one piece was expected to have standard,

measurable consequences for another, with increases in efficiency and equity as the stated goal. But if we regard health systems as more fundamentally social, culturally embedded, politically-contingent institutions, then we need to ask what values and norms does the state signal with this kind of reform? Most importantly for the MDGs, what does it communicate about the poor and poverty, about equity, about entitlement and obligation?

When access to health care depends on the ability to mobilize cash resources, then it explicitly legitimates exclusion of the poor (Mackintosh, 2001). Moreover, a policy that intentionally segments health care into one system for those who can pay and a separate system for those who cannot, exposes any mechanisms for cross-subsidization. As Mackintosh and colleagues have convincingly argued, in circumstances where subsidization of the poor by the better-off is exposed and constructed as an 'unrequited gift,' it becomes exceedingly difficult to maintain (Mackintosh and Gilson, 2002; Mackintosh and Tibandebage, 2002). By contrast, a system which constructs access to health care as a universal entitlement, as a human right, commits itself in principle to redistribution, to 'social processes that create increasingly inclusive or egalitarian access to resources' (Mackintosh and Tibandebage, 2002). Such a system signals the values and norms on which to begin to build the kind of trust on which quality health care so heavily depends (Gilson, 2003).

MDG 5 on Maternal Mortality: A good place to start

These abstract ideas about the nature of the health system can find immediate application in the strategies adopted to achieve the MDGs. MDG5 with its target on maternal mortality reduction is a good place to start.

To many health policymakers, the health system seems forbiddingly complex, like a spider's web that will lure in, tangle up and paralyze even the best-intentioned initiatives. This wariness has contributed to the tendency, especially among donors, to favor initiatives that can go around the facility-based public health system and deliver services in vertical programs deploying their own insulated infrastructure and resources. Many family planning and immunization programs, for example, are designed this way. Such programs have often yielded relatively rapid success for the targeted outcome, although their sustainability is less clear and their long-term impact on the health system questionable.

In the maternal mortality field, however, attempts to go around the facility-based system by relying solely on community-based interventions such as training traditional birth attendants, or ante-natal nutrition programs, or educating women about warning signs of complications, have all failed to yield any meaningful reduction in maternal deaths. Although there are techniques that may improve women's experience of normal childbirth or even avert some proportion of post-partum hemorrhage, the great majority of obstetric complications that kill cannot be predicted or prevented. But they can be treated with relatively simple, well-known interventions, collectively known as emergency obstetric care (EmOC), delivered at the health center or district hospital level

(Maine, 1991). Thus maternal mortality reduction to meet the MDG depends fundamentally on having a functioning district-level health system that can provide EmOC when women experience life-threatening complications (Freedman *et al.*, 2004; Wagstaff and Claeson, 2004).

EmOC is a focused, *but not a narrow*, intervention. Experience in a 51-country program, the Averting Maternal Death and Disability (AMDD) program (1), has demonstrated that interventions addressing simultaneously the technical, management and human rights issues within health facilities, with special attention to EmOC, can '[break] through the conceptual barrier against dealing with the health system' and initiate a process of broader, systemic change that goes well beyond the specific requirements of EmOC (Caro *et al.*, 2004).

The entire health system may not be transformed in one grand intervention. But focused, do-able action such as the provision of EmOC, which is necessarily located in a facility-based system provides a strategic starting point (Freedman, 2003). By bringing together our growing understanding of health systems as core social institutions with our knowledge and experience of the concrete steps needed to make health facilities function, we have the foundation for addressing poverty as it experienced: Not only as deficit and want, but as exclusion and voicelessness, as marginalization from the very institutions and processes through which democracy and development find their most powerful expressions.

There is a long way to go. In the maternal mortality field, equity remains among the biggest, largely unaddressed challenges. But the MDGs put the issues on the table. It will take a concerted, politically conscious effort, both inside and outside the health sector, to make sure we do not let this opportunity pass.

Note

(1) The Averting Maternal Death and Disability (AMDD) Network is coordinated by the Mailman School of Public Health at Columbia University. AMDD works with field-based partners -- including UNICEF, UNFPA, CARE, Save the Children, The Reproductive Health Response in Conflict Consortium, and the Regional Prevention of Maternal Mortality Network -- and their government counterparts to improve availability and utilization of EmOC. AMDD is funded by The Bill and Melinda Gates Foundation.

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