Strengthening Health Systems to Reach the Poor

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Edited Transcript – Lynn Freedman

I should just keep this slide up. Well, good afternoon, everyone. And many thanks to Geoff, and the Woodrow Wilson Center, and to our friends in USAID for helping make this event happen. And it's always a great pleasure to be with Cesar, and have the chance to discuss with him, and interact, and I hope with all of you, too.

If you came here expecting some kind of debate between the two of us, I have to say that I'm sorry to disappoint, because for the most part I actually agree with virtually everything Cesar said. And so, rather than repeat many of the same things, I thought I would try to show you in a way why I think public health is really a very rich field that can and should entertain many different perspectives for coming at the same problems. So even though I am a professor of public health, and I very often do use slides, and do use many, even some of the same slides Cesar was using, I decided today that I would play the lawyer human rights advocate to Cesar's epidemiologist. And in the world today, that often means that you don't use slides. So I decided not to. So for the people online, apologies.

But I thought I would speak today from fundamentally a human rights perspective. And I don't mean the chapter and verse of different treaties, but basically speak from a perspective about values, and so addressing this question of strengthening health systems to reach the poor, and to have as the kind of fundamental starting point the basic human rights values of individual dignity, structural equality, equity, and the whole dynamic of accountability, the dynamic of obligation, and entitlement. So Cesar outlined some of the key policy priorities that the evidence shows a ministry of health can and should think about and incorporate in their planning, implementation, and monitoring. But here's the question. How do we make those policy priorities actually work?

I think, in fact, the field is littered in a way with good ideas and good intentions that look good on paper. And maybe they've even worked in a country, and there's been an impact evaluation, and we have good data that they work, but they don't necessarily work in the next

place that tries to import it. Why not? Why is it that we can't just take one country, prove that something works, and have a formula for doing it in the next country?

Well, some of it Cesar showed you, such as the different patterns of inequality, what I think WHO has called the massive deprivation versus the marginal exclusion patterns. So that's part of the reason. But I also think we should ask, "What about the ways we actually understand poverty and what it is, the ways we understand what a health system actually is, and how it works? What about those ways of understanding and thinking enables us to implement these kinds of interventions that Cesar showed you so that they do, in fact, reach the poor and not just reach the poor but address poverty?"

So we have some quite traditional ways to think about the relationship between poverty and health. The usual ways include, for example, the capabilities approach of [unintelligible], that the reverse of poverty, health, is intrinsically valuable. Good health is intrinsically valuable, and that's part of what poverty reduction is about. It's not just about your economic position. It's about good health, education, and the ability to reach your capabilities. And so, that's an intrinsic value. We often talk about the instrumental value of poverty reduction, so, for example, the big problem of catastrophic health care costs. I mean, at different times, WHO has estimated that something like 100 million people a year are pushed below the poverty line by catastrophic health care costs. So that's a very important connection between poverty and health.

I want to focus on actually a somewhat different way of thinking about it, that I think of as being at fundamentally the way we in both human rights and public health should be approaching this question of how to strengthen health systems to reach the poor. So first, how do we understand poverty? I would argue that poverty is not just about deficit. It's not just about what you don't have: you don't have money; you don't have food; you don't have education, even -- but that poverty is fundamentally relational. It's about interactions with structures of power.

I think that we do have data such as the Voices of the Poor Studies that the World Bank did in the year 2000, which really showed when they asked people about what it means to be poor, what really came through is it's not just what you don't have, but rather things like neglect, abuse, voicelessness, exclusion. These are all part of the very experience of what it means to be poor today. And that's not just in poor countries. I mean, certainly, if we think

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about what it means to be poor in America today, it includes things about these interactions with different structures of power, not least of which, of course, is the health system.

But if we think about poverty in these kinds of power relations terms, we see immediately why, for example, Cesar's very first point is really critical. And that is the point about what we sometimes call intersectionality, that it's never just about not having money. It's always some kind of intersection that includes things like gender, race, and other aspects of social disadvantage. So when we think about poverty, we need to think about those things. And I think we need to think critically about this question of interaction with structures of power.

And then how do we think about health systems? What are health systems? Well, I would argue that a health system is not just a mechanical delivery system for delivering interventions the way a post office delivers a letter, right, the government system for doing that, but rather a health system is part of the very fabric of social and civil life. The health system, the way it operates with the population, actually transmits the state's values, whether we're talking about the public health system or the private health system, when we talk about exclusion from that system, it transmits the values of the state.

And so, I often argue that health systems are actually core social institutions. And I often say when I speak to public human rights groups, just like a judicial system, or a police system, or a prison system is a key social institution in the country that you're concerned about, if we think about the way most people deal with life and death, the health system is a key social institution and, by human rights people, as well as public health people, should be addressed that way. And, therefore, if we put these two together, this view of poverty and this view of health systems, I think we can say that neglect, and abuse, and voicelessness in the health system is part of the very experience of being poor today, again, in this country, as well as in poor countries.

But I think the converse is also true. The health system can neglect, abuse, and make people poor in this sense, but I also believe that the health system is a key place for asserting citizenship rights. And, therefore, the health claims, the ability to make a claim for care and have it addressed, have it met, the kinds of claims Cesar was talking about and many more, that, that itself is an asset of citizenship in a democratic society, the ability to make a health claim and have it met. And so, we should think of health systems in that sense, as a building block of a democratic society.

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So what does it mean then, to take the question of the day, of the afternoon, of the two hours, what does it mean to strengthen a health system to deal with these kinds of power relationships that I would argue to find poverty, is one definition of poverty? And I'm going to just use one example -- and make sure we leave time for questions here -- from the maternal health field. And I think it's important that in addition to speaking about child health, we also talk about maternal health and, specifically, maternal mortality because in a way this is where the question of strengthening health systems is really very challenging.

And in that sense it's different, I think, from a vaccine program or even community-based programs like some of what Cesar showed you here. When we speak about maternal mortality, and I'm going to take that piece of maternal health, maternal mortality. I really think we have to think of the health system as a whole, as the home to hospital continuum of care, often what we're talking about, a district-level, local health system.

And I'll make one little digression to say that tonight on PBS on Wide Angle at 9:00, tune in, there's going to be a special called "Birth of a Surgeon," and we can come back to this, which is about a program in Mozambique to train midwives to do Caesarian sections. And it's on tonight on PBS. And following the show, there is an interview with Margaret Chan. And we just did a premiere of this yesterday at Columbia, so I happened to see it yesterday, and encourage everyone to watch it tonight.

So Margaret Chan is the Director-General of WHO. And in it she says very explicitly what many people agree, that maternal mortality is actually a surrogate for a functioning health system. So she says, you know, if you follow maternal mortality, in many ways you're following what happens with a health system. And if it can work for women for that purpose, it can work for men, she says. But I think this is right. And this is a reason why it's, I think, helpful to bring maternal mortality here.

So what does it mean to strengthen a health system? Well, I would certainly agree there's a technical challenge. All the technical pieces of a health system needs to be in place. And sometimes I have this argument with human rights people, that rights are great and talking about accountability is great. But we need always to have the technical pieces in place. And that, itself, is a human right. So I would say we can take something like the WHO's new framework for strengthening health systems, and just to give you a sense of what I'm talking about, I mean things like health services, these are the building blocks of the WHO health system strengthening framework, health services, the health workforce, health information

system, medical products, vaccines, technologies, health financing, leadership, and governance. Those are the different building blocks that WHO is now using as its framework for action for strengthening health systems.

One of the interesting things about them is that they are devoid, in a way, of values. They're neutral in a sense. They are building blocks of the health system. And what I would argue is that they have to be underlined by values. So what does it mean to have leadership or governance? You can have good governance in a system that's totally inequitable, I mean, in a technical sense. I would argue it's bad governance if it doesn't improve equity. And that's what I mean by putting a value to it.

So let me take one example that I think is now really critical from the maternal mortality field, and put it out there and ask the question of whether this example strengthens health systems to reach the poor. There's a lot of interest in the world these days in cash transfers to strengthen health systems, and in demand-side financing, results-based financing. There are different kind of pieces of this general approach of using money and the way it flows to try to improve the functioning of the health system. So I want to just take an example from India that's, I think, being used a lot or talked about a lot in global circles today, that I think challenges us on this issue.

So India has a big new program, I think it launched in 2005, called the National Rural Health Mission. And the NRHM is really an attempt to address rural poverty in rural areas with the health system. And as part of this, a centerpiece is what is called the JSY scheme, Janani Surakha Yojana, JSY scheme. And the JSY scheme is supposed to address the basic problem, in India as in most countries you have inequity in maternal mortality. And there's higher maternal mortality amongst the poor and marginalized. Amongst the poor and marginalized, there's very low utilization of services, and there's also a very high level of home deliveries.

So the JSY scheme is a key part of the National Rural Health Mission. And what the JSY does is it recognizes that for low utilization, money is one of the barriers, perhaps not the only barrier but one of the barriers. So the JSY scheme is pretty simple. It pays a poor woman a small amount of money, which is actually a lot of money in India, about 700 rupees. It varies in different states but about 700 rupees, about $12 or so these days, to a woman who goes to an institution to deliver. And it pays about 600 rupees to the new community health workers in -- there are actually volunteers in India -- so it pays this

community worker about 600 rupees, about $10, for bringing the woman to the facility to have an institutional delivery.

So this program, how is it working? What are the early results? This has had an incredible impact on institutional delivery. Almost overnight in public health terms, so in the space of a year, a year and a half in many states institutional delivery rates have skyrocketed. They've come close to doubling in some places. The states are delighted. I think people are reporting this as a huge success. And I've heard it talked about in different parts of Africa as a really model program for demand-side financing. It's clearly reaching the poor. You have literally hundreds of thousands more people who are reached by this program. But is it addressing poverty? And that's the question I put out to you. Is it strengthening the health system as a core social institution in addressing poverty?

I think it's also important to ask, is it improving safe delivery because really the question is one about health systems, about not just demand, not just reaching the poor and changing demand, but we also need to be looking at supply, how is this system functioning to provide services for people? And I would say the anecdotal evidence early on is that it's a very mixed bag. Let me put out some of the kinds of things we've been hearing about how this is going.

So one, there's some level of corruption. And I'm not even going to speak much about that because I think in any new program that can happen. And it needs to be addressed. And problems with the money not being paid, and so on, to different individuals is something that, you know, a new program needs to look at. And I think the Indian government is trying to look at it. But I think there are bigger kinds of problems.

So what does it mean to just increase institutional delivery? This is the kind of anecdotal evidence -- I was recently in India with the U.N. Special Rapporteur on the Right to Health. And we heard these kinds of anecdotal stories about what's going on, so people below the poverty line can be paid about $10, a lot of money in India, to go to an institution to deliver. So I heard stories from rural Maharashtra, for example, that a woman would go into labor, where this is a place where people almost always deliver at home. So a woman goes into labor, and her husband wants to get the payment from the JSY scheme. So when she goes into labor, she walks two hours to the nearest health facility. In many cases, this is just a couple rooms without a skilled attendant or any other ability to treat complications of

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pregnancy. She gives birth. She receives the payment. And two hours later, bleeding, she walks home two hours, and the husband gets the money.

So this is an example of some of what's happening. In other cases, the scheme may be working very well. And people are going to facilities that can actually treat complications and perhaps address maternal death. But I think this is an example of where a very specific scheme has narrowed its attention to one issue, in this case institutional delivery, in a system that has not actually addressed the supply side. So it has not actually dealt with the whole range of power and other problems that make it so that in many parts of India, there are no institutional delivery services. There are no skilled birth attendants in the facilities. There is no capacity at the place where women are being asked to deliver to address the complications that could kill her.

And this is where all the kinds of issues like the power of the professional societies to prevent other people, other levels of health workers from being trained to provide life-saving care, this is where these issues come in, issues like absenteeism. In parts of India, something like 40 percent of health care workers are simply not there in the health facilities. So there's a whole -- where they are posted and where they are supposed to be, so all of these kinds of power issues are out there.

Well, this JSY scheme is being talked about as a way of reaching the poor as a huge success because it's getting poor women into institutions for delivery. But the problem is we're not looking at either -- we're just looking at institutional delivery. And we're not looking at the whole range of dynamics that makes a health system function. In the case of India, and in the case of this National Rural Health Mission, I'm actually optimistic because I think what we are seeing in India is a program like this that starts in one way. There's also a whole structure to engage people and civil society groups in ways of trying to monitor and hold the program accountable.

So where did we hear these stories? We didn't hear these stories just from women. We heard stories about the way the program is functioning from civil society groups, from groups who are actually working with the Ministry of Health, with Commissions on Women's Affairs, and so on, to hold public hearings, to in other ways begin to monitor and address these programs. So I think when we are talking about strengthening the health system to reach the poor, we're talking not just about what the Ministry can do, although that's critical, but we're talking importantly about what civil society can do, what people can

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do to hold the system accountable for actually doing more than simply reaching the poor, but actually addressing these kinds of underlying dynamics of poverty.

And that, I think, is what we mean when we talk about strengthening health systems to reach the poor, not just reaching them but addressing poverty. And that, I think, is the fundamental challenge that we have today. So I'm going to end there, give us time for questions.

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