Global Health History Seminar 11 May 2011

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one perspective from WHO

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Overview

1) Policy perspective
2) Monitoring and analyses
3) Connecting to other determinants
WHO Constitution (1948) defined health as physical, social & mental; downplayed during 1950s era of disease campaigns.

Broad social and economic dimensions re-emerge under Health for All agenda (1970s), yet action falters in 1980s.

1990s: paradigm of health as "private" "market" approach dominants; some exceptions.

2000s: "pendulum swing" and new action involving multiple partners and stakeholders, including 2005 launch of PMNCH

2010: Universal coverage based on sustainable financing

2008 Commission on Social Determinants of Health, re-emergence of PHC
<table>
<thead>
<tr>
<th>Goal and Targets</th>
<th>Indicators to monitor progress</th>
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<tbody>
<tr>
<td><strong>5.A:</strong> Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio</td>
<td><strong>5.1</strong> Maternal mortality ratio</td>
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<td><strong>5.2</strong> Proportion of births attended by skilled health personnel</td>
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<td><strong>5.B:</strong> Achieve, by 2015, universal access to reproductive health</td>
<td><strong>5.3</strong> Contraceptive prevalence rate</td>
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<td><strong>5.4</strong> Adolescent birth rate</td>
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<td><strong>5.5</strong> Antenatal care coverage (at least one visit and at least four visits)</td>
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<td><strong>5.6</strong> Unmet need for family planning</td>
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Global, regional and national agenda

5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

5.B: Achieve, by 2015, universal access to reproductive health

Implications - What can the health sector do?

Implications - What can government do? What can others do?
<table>
<thead>
<tr>
<th>Typical constraints</th>
<th>Health system response</th>
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</thead>
<tbody>
<tr>
<td>Financial inaccessibility, inability to pay, informal fees</td>
<td>Develop risk pooling strategies</td>
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<tr>
<td>Physical inaccessibility, distance to facility</td>
<td>Reconsideration of long term plan for capital investment and location of facilities</td>
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<tr>
<td>Inappropriately skilled staff</td>
<td>Review of basic medical and nursing training curricula to ensure appropriate skills</td>
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<td>Poorly motivated staff</td>
<td>Performance review systems, greater clarity of roles and expectations, review of salary structures and promotions</td>
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<td>Weak planning and management</td>
<td>Restructuring of MoH, recruitment and development of cadre of dedicated managers</td>
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<td>Lack of intersectoral action and partnerships</td>
<td>Building system of local government incorporating representatives from across sectors, promote accountability to people</td>
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<tr>
<td>Poor quality of care amongst private sector providers</td>
<td>Development of accreditation and regulation systems</td>
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</tbody>
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Source: Travis et al., 2004, *Lancet*
Overview

2) Monitoring and analyses
Effectiveness Coverage: effective services to all in need – universal coverage

Contact Coverage
Acceptability Coverage
Accessibility Coverage
Availability Coverage

A model of service access

Tanahashi 1978

Total or Target Population
Yet usually measure availability or accessibility coverage

The proportion of the population in need of an intervention who have received an effective intervention -- effectiveness coverage

The key to measurement of effective coverage is to determine what constitutes an effective intervention.

The measurement of effective coverage, as an intermediate goal, is expected to link health system performance measurement more directly to managerial practices and decision-making process at local, regional and national levels.
Income per capita and life-expectancy: most countries

Patterns of access to health services by household wealth

1: Mass Deprivation
2: Queuing
3: Marginal Exclusion
From massive deprivation to marginal exclusion:
moving up the coverage ladder

World Health Report, 2005
WHO Advisory Committee on Health Monitoring and Statistics

December 2006

"Recommend that a small set of priority indicators which should be disaggregated by equity measures within countries when appropriate"
Skilled birth attendance, 20 countries, African Region (AFRO, 2010)

Change in difference between the lowest and the highest wealth quintiles (%)

Decrease in average
Decrease in inequity

Increase in average
Increase in inequity

Change in average (%)

Decrease in average
Increase in inequity
### Changes in Kenya, DHS data 1998 and 2003

<table>
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<tr>
<th>Relative gap</th>
<th>Narrowing</th>
<th>Widening/status quo</th>
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</table>
| **Population Average** | **Improving** | A. **Best outcome**  
- Use of modern contraception for women with expressed need  
- Stunting in Children | B.  
- DPT3 coverage |
|               | **Worsening/status quo** | C.  
- Infant mortality rate  
- Under-five mortality rate  
- Prevalence of overweight among women | D. **Worst outcome**  
- Delivery by skilled attendants  
- Prevalence of underweight among women |
Modern contraceptive use, 20 countries, African Region (AFRO, 2010)
Anti-malarial drugs during pregnancy, selected African Countries

![Bar graph showing percentage of anti-malarial drugs used during pregnancy in selected African countries. The x-axis represents countries, and the y-axis represents percentage. The graph includes data for countries such as Burkina Faso, Chad, Zimbabwe, Zambia, Cameroon, Ghana, Mali, Nigeria, Rwanda, Uganda, Congo, Ethiopia, Guinea, Benin, Kenya, Senegal, Madagascar, Tanzania, and Malawi. The graph uses different symbols to indicate least poor, poorest, and average categories.](image-url)
Counselling of HIV during antenatal care, selected African Countries

![Diagram showing the percentage of HIV counselling during antenatal care in selected African countries. The countries included are Senegal, Guinea, Nigeria, Tanzania, Kenya, Cameroon, Ghana, and Mozambique. The x-axis represents the countries, and the y-axis represents the percentage. The diagram includes markers for the least poor, poorest, and average categories.]
Prevalence of maternal underweight, four South East Asian countries (year indicated)

- **BGD-97**: 33% Richest, 65% Poorest, 46% Average
- **BGD-04**: 17% Richest, 46% Poorest, 27% Average
- **NPL-96**: 15% Richest, 21% Poorest, 26% Average
- **NPL-01**: 15% Richest, 15% Poorest, 27% Average
- **IND-98**: 15% Richest, 15% Poorest, 50% Average
- **LKA-00**: 10% Richest, 37% Poorest, 40% Average
Inequalities in skilled birth attendance, six South East Asian countries (year indicated)
% Population In Lowest Wealth Quintile Across Different States of India (2005-2006)
Trend of Institutional Delivery (1992-2006)

Percentage

Tamil Nadu 79.3 87.3
Karnataka 51.1 64.7
Maharashtra 43.9 52.6
Gujarat 46.3 52.7
All India 33.6 38.7

Universal coverage, as defined by WHO Member States, requires all people to have access to needed health services - prevention, promotion, treatment and rehabilitation - without the risk of financial hardship associated with accessing services.

World Health Report 2010 raises basic questions:

-- Who is covered?
-- Which services are covered?
-- What proportion of the costs are covered?

Cervical Cancer Screening, by global wealth deciles, 57 countries, WHS 2002

Source: Gakidou, Nordhagen, Obermeyer (2008)
Universal Coverage without financial hardship

Financial barriers should not prevent people receiving needed services – payments at the point of service should be as low as possible.

Contributions to the health system should be in relation to their capacity to pay.

A substantial part of funds for health should be pooled to allow risk pooling – e.g. the sick should not bear the full costs of their illness.

Services should be received according to need.
Number of People Suffering Financial Catastrophe and Impoverishment Due to Health Spending

David Evans, Department of Health Systems Financing, WHO
Overview

3) Connecting to other determinants
Causes of the Causes of Health inequities

- Where do health differences among social groups originate, if we trace them back to their deepest roots?

- What pathways lead from root causes to the stark differences in health status observed at the population level?

- Where and how should we intervene to reduce health inequities?
Determinants of skilled birth attendance

- Health systems factors
- Intermediary determinants
- Socioeconomic position
- Socioeconomic political context

BANGLADESH (2004)
INDIA (1999)
INDONESIA (2003)
NEPAL (2001)
Spousal Violence and Utilization of Maternal Healthcare, India

Source: NFHS-3
Thank you!