Trans. Nat. Acad. Sci. & Tech. (Philippines) 32 (2010)
ISSN 0115-8848

HEALTH MDGS: THE KEY TO ACHIEVING UNIVERSAL HEALTH CARE

Alberto Romualdez, M.D.

1. Introduction

The Millenium Development Goals are derived from the eight chapters of the United Nations Millenium Declaration of the year 2000, an agreement signed by all of the world's leaders who met at the UN Summit in New York in September of that year. Three of the goals are considered as directly health-related: Goal No. 4 on the reduction of child mortality rate, Goal No. 5 on the improvement of maternal health, and Goal No. 6 on combating HIV/AIDS, malaria and other infectious diseases.

Globally, progress towards achievement of the goals has varied from country to country. Some countries, notably large ones like China and India, are making rapid progress and are likely to achieve them at a national level by the target date of 2015. A number, such as those in sub-Saharan Africa, are having considerable overall difficulties and will probably miss most of the targets and goals (UNICEF, 2007). Many countries, such as the Philippines, are making uneven progress, even at national level – with a high probability of attaining some goals but with less likelihood of reaching others.

To assist countries in difficulties, global financial support programs have been organized, notably after the G8 finance ministers meeting in London in 2005 where support was pledged through various financial and technical assistance institutions. Packages such as the Multilateral Debt Relief Initiative (MDRI) and others involving financing bodies (such as World Bank, IMF, and the regional development banks) have helped many poor countries to begin to move towards attaining the MDGs. However, as the target year of 2015 approaches, some developments – like the recent international financial crisis, the multiple challenges of climate change, – are likely to have adverse effects on individual country efforts but others – such as the recent successful elections in this country- may have more positive consequences. For these reasons, it would be appropriate for global funding bodies to revisit their MDG support programs to include countries like the Philippines which normally would not qualify under existing arrangements for extraordinary financing.

As countries implement specific programs to address individual MDG issues, it is becoming apparent that all the MDGs are inter-related and that their attainment requires the collaborative effort of all sectors. Moreover, it

is unlikely that achieving the MDGs in any one sector can have long-lasting and broadly-based beneficial effects if any of the MDGs in the other sectors are not attained.

Thus, for example, permanent reduction of child mortality (MDG 4) is not possible for as long as a significant proportion of the population lives in poverty and experiences hunger (MDG 1). As well, eliminating preventable women's deaths from child-bearing related causes and providing reproductive health services to all families (MDG 5) is not possible without a firm policy commitment and significant action to promote gender equity and empowering women in all sectors (MDG 3). Additionally, combating HIV/AIDS, malaria, and other diseases like tuberculosis (MDG 6) will be most important components of efforts to attain the other two health-related MDGs and also requires success in improving education universally (MDG 2). Mitigating the effects of environmental degradation (MDG 7) and improved global cooperation (MDG 8) are in fact requirements to ensuring the attainment of all the other MDG goals.

2. Status of MDGs 4 and 5 in the Philippines

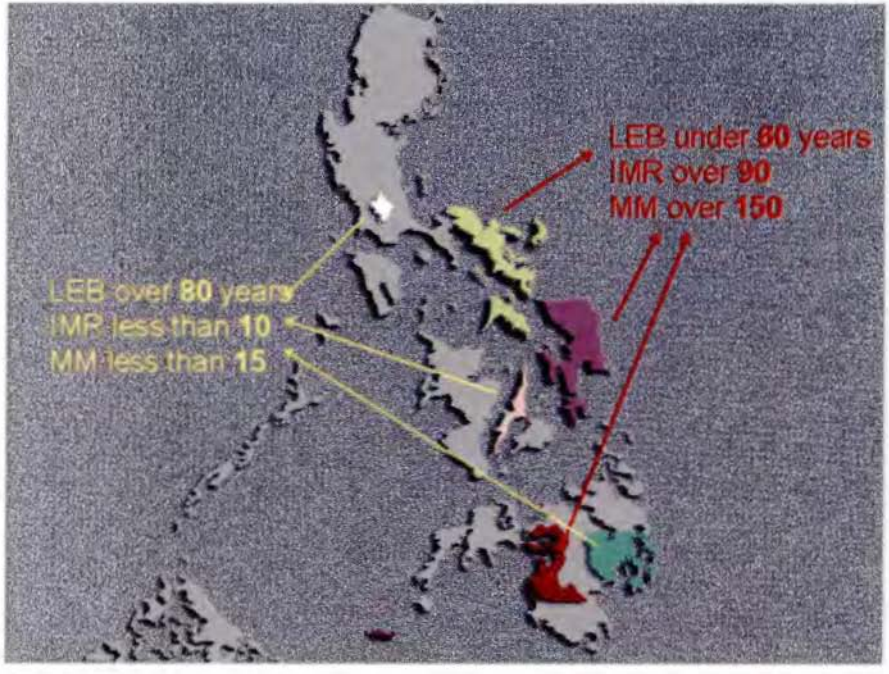
In the Philippines, there seems to be a general consensus that the MDG 4 goal to reduce childhood mortality by two-thirds from the level in 1990 is likely to be reached while achievement of the MDG 5 goal of reducing maternal mortality by three quarters from the 1990 level is unlikely to be reached (UNDP, n.d.).

2.1. MDG 4 – Reduction of Childhood Deaths

For childhood mortality, the optimism concerning MDG 4 is based on the encouraging trend seen in the decline of the different measures of childhood death such as infant and under-five mortality rates. Nevertheless, close examination of the data, especially disaggregation by population groups and provinces, should temper this expectation of success with caution and alert the health sector to the need to avoid complacency. Such an examination would reveal a number of disturbing points.

First, the most recent figures reveal that the rate of reduction of childhood deaths appears to be levelling off (NDHS, 2008: Table 8.1) with a small chance that the target level may be missed if the slowing trend continues. There should be particular concern for the fact that the trends for neonatal deaths, for example, have actually levelled off – emphasizing the fact that the care of newborns is very closely related to the care of mothers at or around the period of childbirth.

Second, there are gross disparities in the rates of childhood deaths among population groups. For example, childhood deaths (neonatal, post-neonatal, infant and under-five mortality rates) are much higher for children of women with little or no education as compared to those of college graduates (NDHS, 2008: Fig.8.1). Also, the offspring of poor women are more likely to die in childhood than those of families in the highest income quintiles. Moreover, there are provinces and regions where the MDG 4 targets may in fact not be reached (NDHS 2008: Table 8.2) – these provinces, depicted in red on this map of the Philippines, are concentrated in depressed regions such as Mimaropa, Bicol, Eastern and Western Visayas, and Mindanao, especially ARMM.



The 2008 National Demographic and Health Survey (NDHS) data indicate that inequity in access to services accounts for most of these disparities. For example, the survey indicates that children in the lowest income quintiles are less likely to receive child health interventions such as nutritional supplements and vaccinations than those in the highest income quintiles (NDHS, 2008: 133).

2.2. MDG 5 – Reduction of Maternal Deaths and Access to FP services

If the current trend continues, overall maternal mortality ratio in the Philippines (presently estimated at 162 by the 2006 Family Planning Survey

at the NSO) (Romualdez, 2008) is forecast to be 140 maternal deaths per 100,000 live births by 2015. This is 2.7 times the target of 52 (one fourth the 1990 level). Contraceptive prevalence rate (CPR), as a measure of access to reproductive health services, is projected to increase from the present 50.7 percent in 2008 (U.N. Millennium Development Goals Indicators, n.d.) – far below the MDG target of 80 percent. Thus, without extraordinary effort in the health sector, attaining MDG 5 is virtually impossible.

The inequalities in outcomes between population groups and among regions seen for child health care are even more dramatic for maternal health indicators. Maternal mortality ratios in economically advantaged large metropolitan areas and among higher income groups approximate those of developed countries while ratios in depressed areas and among the poor, generally above the national average of 162, are similar to those of least developed countries.

It is estimated that about one-third of all pregnancies among Filipino women is unwanted or unplanned (Guttmacher Institue, 2009). Based on the fact that rich women, on the average, achieve their family size goal of two children while poor women have twice the number of desired children, it is evident that family planning information and services are not equally available to the two population groups. This also means that most unwanted pregnancies (including the more than half a million abortions that are estimated as a result each year) occur among the poor. Such pregnancies would be avoided, and the corresponding number of maternal deaths prevented, if reproductive health information and services were more adequately available to all regardless of socio-economic status.

More than 90 percent of childbirths in the highest income quintile are attended by skilled or professionally trained birth attendants while only one-fourth of deliveries in the lowest quintile benefit from such attendance (NDHS, 2008: Fig. 9.6). Studies (including data from the Field Health Information System or FHSIS surveys and others) have repeatedly shown the strong inverse correlation that exists between the presence of skilled birth attendants and the number of maternal deaths (DOH-National Epidemiology Center, 2005).

The internationally accepted standard for the rate of Caesarean sections in an adequately served population is 15 percent. Recent NDHS data show that, with a rate of almost 30 percent, high income Filipino women may often have unnecessary surgery. On the other hand, with a rate of about 1 percent, low income Filipinas are unlikely to have surgery even when they urgently need the intervention (NDHS, 2008: Fig. 9.6). Such a disparity in service access almost certainly accounts for at least part of the disparity in outcomes.

3. Health Inequity and MDGs 4 and 5

This presentation so far has provided evidence that unfair and unjust inequality in access to health information and services or health inequity is a major factor that hinders progress towards the attainment of the Millenium Development Goals related to the health of mothers and their children. It seems logical, therefore, that the different efforts to improve the Philippine performance in these two important areas should converge on significantly reducing, if not eliminating, these inequalities – precisely, the objective of universal health care.

Universal health care can be achieved by a strong commitment from the health sector in coordination with all other social sectors to removing all economic and geographical barriers that hinder access to high quality and effective health services by all Filipinos. Meaningful health sector reforms that specifically target the inequities that impede progress in attaining MDGs 4 and 5 will have a two-pronged effect: 1) they will accelerate improvements in the relevant health indicators (namely, maternal mortality ratios and neonatal mortality rates), and 2) they will lay the groundwork for reducing inequities in the rest of the health sector.

This can be done by introducing reforms that specifically address deficiencies in each of the six building blocks (or components) of the national health system.

The first component is health service delivery which mainly suffers from severe fragmentation and compartmentalization that hinder the development of an effective two-way, referral system. A well-integrated maternal care system will establish strong and effective links between different levels of care from homes to Basic Emergency Obstetric and Neonatal Care units (BEMONCs) to the more sophisticated Comprehensive Emergency Obstretric and Neonatal Care (CEMONCs) facilities and even upwards to the most sophisticated tertiary institutions of the country. This will not only be a major step towards reducing mortality and morbidity from obstetrical complications but will also provide a working model for reducing or eliminating fragmentation in the rest of the health service delivery system especially by similarly integrating child care services.

One of the weakest components of the present health system is its information infrastructure. True integration of health service delivery with a functional referral system can be effected only if modern information and communications technology is applied optimally in the decision-making processes for maternal and child health at each of the health care levels but

most especially the level of the family and the community. Such a system will ensure that possible complications are detected, prepared for, and attended to early by the appropriate level of care. This will also be the template on which will be based the manner in which health information is collected, collated, and utilized throughout the rest of the health system.

Health goods and materials as well as appropriate technology for maternal services at various levels are often unavailable or inaccessible either for geographic or economic reasons. Reforms must include installing mechanisms for timely and adequate procurement and distribution of these goods and technologies. Passage of a reproductive health bill that assures availability of family planning supplies is one such mechanism. As well, the same mechanisms can be applied to child care and other services.

Making sure of the availability of appropriate, capable, and motivated health personnel at all service levels will necessitate putting in place a new paradigm for assigning roles to the different kinds of health human resources involved in maternal and child care. Such a paradigm should include organizing doctors (including specialists), nurses, and midwives into tightly-knit teams that coordinate all aspects of maternal and child care and share functions according to the needs of specific sites for delivery from the home to the highest level facility.

To assure that all these elements are in place sustainably over the long-term, health financing packages must be specifically designed to cover all aspects of the care of mothers and children. All current modes of financing maternal and child care must be thoroughly reviewed with a view to effective coordination of tax-based spending (national and local) and funding through the social health insurance scheme (Philhealth). Out-of-pocket payments should be drastically reduced, if not eliminated altogether, specially at the point of service.

Finally, a system of governance must be instituted that secures not only the technical and administrative integrity of the delivery system but will also guarantee the meaningful participation of individuals, families, and communities in the decision and policy-making processes for managing maternal and child health programs (including inputs for managing facilities and agencies involved). This should be designed so as to ensure that various sectors and levels of society can influence the decisions of health providers, health institutions and policy-makers. Such a system of governance would take into account the interconnections, earlier mentioned, between all the MDGs as well as address issues, such as the social determinants of health, that are not usually the concerns of the health sector as we know it. This is in fact in the spirit of the old Alma Ata vision of primary health care.

4. Summary and Conclusion

To summarize, the application of universal health care principles to the national efforts to achieve the Millennium Development Goals pertaining to the health of women and children will not only accelerate progress towards those goals. It will also initiate the transformation of the Philippine health system into one that provides truly equitable health care for all Filipinos - the essence of universal health care.

References

UNICEF. *Progress for Children: A World Fit for Children Statistical Review.* 2007. <http://www.unicef.org/progressforchildren/2007n6/index_41401.htm> accessed

United Nations Development Programme - Philippines. *MDGs in the Philippines.* <http://www.undp.org.ph/?link=mdg_ph> accessed

NDHS 2008. Table 8.1 Early Childhood Mortaity Rates. 96p. National Statistics Office (NSO) [Philippines], and ICF Macro. 2009. *National Demographic and Health Survey 2008.* Calverton, Maryland: National Statistics Office and ICF Macro.

NDHS 2008. Figure 8.1 Under-Five Mortality Rates by Background Characteristics. 99p. National Statistics Office (NSO) [Philippines], and ICF Macro. 2009. *National Demographic and Health Survey 2008.* Calverton, Maryland: National Statistics Office and ICF Macro.

NDHS 2008. Table 8.2 Early childhood mortality rates by socioeconomic characterics. 98p. National Statistics Office (NSO) [Philippines], and ICF Macro. 2009. *National Demographic and Health Survey 2008.* Calverton, Maryland: National Statistics Office and ICF Macro.

NDHS 2008. Nutrition of Children and Women. 133p. National Statistics Office (NSO) [Philippines], and ICF Macro. 2009. *National Demographic and Health Survey 2008.* Calverton, Maryland: National Statistics Office and ICF Macro.

UP Centennial Lecture 2008 – Dr. Alberto Romualdez

UN Millennium Development Goals Indicators. Contraceptive Prevalence Rate metadata. <http://unstats.un.org/unsd/mdg/Data.aspx> accessed

Guttmacher Institute. *Meeting Women's Contraceptive Needs in the Philippines*. New York, 2009.

NDHS 2008. Figure 9.6. Assistance during delivery. 113p. National Statistics Office (NSO) [Philippines], and ICF Macro. 2009. National *Demographic and Health Survey 2008.* Calverton, Maryland: National Statistics Office and ICF Macro.

Department of Health National Epidemiology Center. 2005. Field Health *Service Information System 2005.*
<http://www2.doh.gov.ph/nec/FHSIS.htm> accessed