

## Editorial: A framework for analysing the relationship between disease control programmes and basic health care

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**Summary** In this paper, we present a framework for analysing the complex relationship between disease control programmes and basic health care systems. Many of the ideas and concepts presented in this paper were developed by the staff of the Public Health Department of the Antwerp Institute of Tropical Medicine (ITM) over the last 20 years. They are thus the product of the reflection of an entire team.

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### **The difficult relationship between (vertical) disease control programmes and (horizontal) basic health care services: an unfulfilled potential?**

The relationship between disease control programmes and basic health care systems has always been, and still is, a problematic and even tempestuous one. One of the reasons for this state of affairs lies in the fact that in the past, too often, protagonists of both approaches took rigid ideological viewpoints and dug themselves in, each in their own trenches. Managers of basic health care systems looked at disease control programmes as a threat to the values and principles underlying primary health care. And disease control programme managers considered the defenders of basic health care systems as dreamers who had forgotten about the need for effectiveness and impact.

The lack of dialogue, and even respect, between the so-called 'verticalists' and 'horizontalists' has blurred judgement. It is our conviction that this has been a hindrance to a fruitful collaboration in the interest of patients and populations whose health would benefit from a more open relationship and from more exchange. Hence the need to clarify the terms of the debate.

### **What is a disease control programme?**

A programme can be defined in two ways, which are not mutually exclusive. The first and rather classical way of defining a programme is to describe it as a coherent set of activities conceived to control, possibly eliminate, a given disease (Cairncross 1997). The identification of this set is, in principle, the intellectual product of scientific research and rational planning.

A second way is to consider a programme as an institution, with a specific administration, scientific and technical staff, and logistical and financial resources – the core business of which it is to control one particular health problem. Such an institution generally has access to more resources – often earmarked – than is the case for other departments or sections in the Ministry of Health. A programme thus represents an important resource and opportunity to reduce the burden caused by a given disease.

But it also is, by the very force of its resources, a powerful player in national and local health systems (Gish 1992). It has considerable weight on (inter)national and local decision-making processes, which can then be – more or less easily – biased in favour of the control of one particular disease.

### **Why a programme?**

A programme is launched when a health problem is considered sufficiently important to warrant specific attention and means to combat it. This decision is taken on the basis of two types of criteria: on the one hand, objective and explicit criteria, mainly the importance – its frequency and severity, and the vulnerability of the disease – i.e. the availability of an effective treatment. On the other hand, it is based upon more subjective and implicit criteria related to the way the disease is 'perceived'. The social perception of a disease is in fact a complex issue. It is shaped by a variety of actors: patient organizations, lobbyists from a variety of backgrounds (including the pharmaceutical industry), health care providers, research institutions, politicians, non governmental organisations, media, etc. The decision to launch a specific programme is, naturally,

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influenced by prevailing international, political, economic and cultural power relations between the North and the South.

**What is integration about?**

In the case of health care, integration usually means that general health services take the responsibility to operate specific activities designed to control a health problem. These services thus become one of several channels for the programme to implement its activities, which then become part of the broader package of activities delivered by these multipurpose general health services (Criel *et al.* 1997).

It is important to point out that this definition and many of the other concepts handled when analysing the issue of integration into general health services also apply to other sectors than health care. Indeed, a disease control programme may collaborate with a variety of partners. For instance, a schoolteacher can speak in his classes about the prevention of HIV infection; an environmental health worker can mention the use of bednets in the prevention of malaria; and a field agricultural worker can highlight the need for children to have a balanced diet. Finally, let us not forget that when we talk about integration, the issue is not integrating (or not) programmes in their totality; the issue is integrating or not (some) activities of a programme.

**The logic of disease control programmes and basic health care: a field of tension**

Table 1 summarizes the main differences in logic between disease control programmes and basic health care systems. A limit of this comparison is that it probably presents things in an overly simplifying way, as if in reality there were no situations in between – which of course there are; or as if the opposition in logic would be absolute – which

of course it is not. We nevertheless think that the comparison is useful.

Disease control is disease-centred, a population dimension prevails, and the basis for the planning of interventions is need. Basic health care on the other hand is patient-centred, favours an individual dimension, and plans its activities starting from the community's felt needs. The basis for decision-making in disease control is epidemiologic evidence, but it is much more complex in the case of basic health care systems, where the health worker, ideally, needs to contextualize his decisions so that the specific and unique character of every single patient is taken into consideration.

The terms of reference for the evaluation of disease control activities are straightforward: they focus on the coverage of the programme and on its epidemiological impact. The objectives of disease control are relatively easy to quantify. This is not so in the case of basic health care. In the latter, the question to be addressed, ultimately, is to assess whether the health care delivery system is capable to help patients, cured or not, to cope with their health problem and to carry on with their lives in a way that is acceptable to them. Finally, the nature and qualification of the health workers distinguish disease control from basic health care: in the former specialists are more prominent, in the latter versatile health workers constitute the main workforce.

**Integrate or not? Guiding rules for decision-making**

To help answer the question whether disease control activities should be integrated in basic health care services or not, we wish to present a simple set of guiding rules. It consists of three straightforward questions. The first question is whether integration is *desirable*. Is there an added value in asking general health services to incorporate a given disease control activity, or several activities, in their basic package? In some cases integration is not a

	Disease control programmes	Basic health care systems
The object	A disease	The patient
The main dimension	Populational	Individual
The basis for planning	Need	Overlap of demand and need
The principal basis for decision-making	Evidence	Mix of evidence, patients' preferences and constraints, and local context
The terms of reference for evaluation	Programme coverage and impact on frequency and severity of disease	Is the patient able to carry on with his life in a way that is acceptable to him?
The staff	Specialists	Versatile health workers

**Table 1** Disease control programmes *vs.* basic health care systems

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desirable option (Mills 1983). For instance, there is a strong case for integrating BCG vaccination in general health care services, but far less so for integrating active case-finding of African trypanosomiasis (De Brouwere & Pangu 1989; Kegels 1995).

A second question is whether integration is *possible*: can a generalist perform the tasks properly? A certain degree of standardization of the task at hand is needed if it is to be delegated to non-specialists. For instance, passive case-finding and diagnosis of sputum-positive open pulmonary TB are tasks that can, relatively easily, be standardized. The diagnosis of leprosy, on the other hand, would be an example of a task where integration is much more difficult, especially in low-prevalence situations.

A third question is whether it is *opportune* to integrate. Can the general services cope with the additional workload? Are the general health services functioning sufficiently well to host the related new activities (one cannot integrate activities in something that does not work)? Or does the policy of integration constitute a genuine opportunity to strengthen the functioning and credibility of the general health services?

What transpires from this simple set of guiding rules is that the answer to the question 'integrate or not?' must necessarily be a contextual one: the answer may differ from one country to the other, even from one district to the other. We should thus avoid blanket solutions.

### The challenge: optimize the articulation between the two systems

The challenge ahead is to optimize the articulation between the two systems. Integration presents opportunities and threats for both disease control and basic health care (Table 2). The challenge is to reach an organizational set-up where the threats and dangers of integration are minimized, and where the opportunities and strengths are maximized.

For disease control, a powerful opportunity is to extend the coverage of its programme activities; for basic health care, the opportunity created by a policy of integration lies

**Table 2** Effects of integration

	Opportunities of integration	Threats of integration
For the disease control system	Extension in coverage of programme activities	The disease loses its privileged status
For the basic health care system	Increased capacity to respond to people's felt needs	Imbalance in the offer of care

in the possibilities it creates to improve the general health services' capacity to respond to people's felt needs (Loretto 1989; Criel 1992). When it comes to the threats, the case is clear for disease control: integration means that the disease will lose its privileged status and become 'a disease like any other'. In the case of basic health care, a major threat is that the integration of disease control activities will lead to an imbalance in the offer of care, with a shift of attention and resources, within the general services themselves, towards the control of one particular disease. The opportunity cost would soon become detrimental.

### Conclusion: Proposals for a fruitful interaction between disease control systems and basic health care systems

If we wish to move in the direction of an optimal relationship between disease control and basic health care, four general proposals could be kept in mind. A first one would be to leave the dogmatic discourse behind and to drop the simplistic (and counter productive) dichotomous classification of 'us' and 'them'... A second suggestion is for the people in charge of disease control and basic health care to recognize the respective strengths and weaknesses of either approach, and also to acknowledge the intrinsic field of tension that exists between both systems. The third suggestion is to accept the need for contextualised solutions when it comes to integrating some activities of disease control in basic health care. And finally, a fourth proposal is for all to accept that basic health care is a human right and that this right is in agreement with the existence of disease control programmes *together with, not instead of*, general health services.

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