EDUCATION FOR HEALTH

COMMENTARY

Controlling Diseases, Securing Access to Health Care, Strengthening Health Systems...Squaring the Circle?

JP Unger, P De Paepe

Institute of Tropical Medicine - Department of Public Health, Antwerp, Belgium

Published: *28 August 2007*

Unger JP, De Paepe P

Controlling Diseases, Securing Access to Health Care, Strengthening Health Systems...Squaring the Circle?
***Education for Health*, Volume 20, issue 2, 2007**

Available from: http://www.educationforhealth.net/

Up to 50% of people are barred from access to care and essential drugs. Despite an unprecedented increase in external financing, disease control - the paradigm of international aid - is in total disarray in low and middle-income countries (Table 1). AIDS kills more than 8,000 people everyday (of which more than 6,000 are in sub-Saharan Africa) and malaria, up to three million every year (one million twenty years ago).

One may ask if international aid policy, as defined for the health sector of Low Income Countries (LIC) and Middle Income Countries (MIC), shares a responsibility for such failure. This policy allocates health care and disease control to different providers (De Paepe, In press): while disease control would remain public-hosted, industrialized countries have been promoting and sometimes enforcing a market approach of health care delivery for over a decade. Substandard detection and follow-up rates were related to a true catch-22: disease control interventions were ineffective because health facilities were lacking patients, while disease control programmes were straining health care delivery in publicly-oriented health centres and dispensaries. This occurred by pressure exerted by disease control managers, by multiplication of disease-specific divisions in (inter)national administrations, by ill-defined priority setting, unrealistic costing, inadequate budgets, and mobilisation of the best human resources (Kelly, 1999).

There are reasons to believe that this flawed managerial strategy together with the use of TRIP- (Trade-Related Aspects of Intellectual Property Rights) protected ART (Anti-Retroviral Treatment) drugs were responsible for the evident inefficiency of the approach. Indeed, in 2004, 21% of all health aid was allocated to HIV (8% in 2000). Total funding for HIV/AIDS programmes in

low and middle-income countries reached 8.3 billion USD during 2005. Realising the extent of the waste, The Financial Times requested that less money be spent on AIDS – instead of proposing to correct the causes of programme's inefficiency (England, 2006).

Table 1: The state of the millennium development goals (MDG) - September 2005 (from l'Atlas du Monde Diplomatique, 2006, UN data)

MDG Region	Maternal mortality	AIDS	Malaria	TB
Latin America				
Subsaharan Africa				
South Asia				
South East Asia				

No improvement or deterioration
Unattainable objectives

The late WHO Director Lee advocated strengthening health systems while controlling diseases in developing countries (Jong-Wook, 2003). However, directors of disease control programmes across the world could easily claim that this is precisely what they have been doing during the last 15 years. Training Ministry of Health staff in seminars taking up to 50% of their time (and paying them to stop working instead of paying them to work)? An investment to strengthen health systems. Providing cars for parallel mobile teams? Another such investment. Multiplying authority lines? A way to strengthen systems. Focusing skilled labour on the control of three diseases, kindly requesting doctors to forget their medical knowledge and training? A way to make them more effective. In short, the concept of "systems strengthening" is so vague that virtually any initiative fits in this category.

What about the concept of "health care accessibility"? In 2002, subverting the old WHO slogan "Health for all by the year 2000", the Antwerp Institute of Tropical Medicine started promoting "Health Care for All", a motto soon taken over by many Belgian cooperation organisations. The move was relevant from an ethical standpoint and from a managerial one - since utilisation of curative care conditions the success of disease control initiatives. It has been shown, for instance, that if malaria patients are to be detected, treated and followed up, basic health services delivering malaria treatment need to be attended by an adequate pool of users (Unger et al., 2006).

To the contrary, international health policies recommend marketing of curative care together with prioritisation of disease control within the public sector (Kelly, 1999). The General Agreement on Trade in Services (GATS) article 1.3.c. makes this recommendation compulsory: "a service supplied in the exercise of governmental authority means any service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers". Subsidies to publicly-oriented services owned by ministries of health, city councils, and non-governmental organisations could be barred on the ground of GATS article 1.3.c. Politicians who endorse it, thus, carry a heavy moral responsibility.

Rather, a sound strategy to strengthen health systems is badly needed to improve both disease control and access to decent health care. More specifically, those health services delivering disease control interventions should be strengthened in a way that permits attracting patients.

Clearly, such services need to be publicly-oriented. To our knowledge, the successful initiatives to externalise disease control at a national level are just two, which were achieved in very specific conditions: Public-Private Mix for Directly Observed Treatment; Short Course for tuberculosis control in India and the Philippines (WHO, 2006). Consequently, publicly-oriented services must remain in charge of disease control programmes, which is what international agencies advocate. If these programmes are to be integrated with health care delivery, publicly-oriented services also need to remain in charge of the latter, which is precisely what international organisations reject.

Furthermore, the failure of developing countries' governments and administrations to control and regulate their private-for-profit sector must be taken into account while designing strategies to "strengthen health systems". Indeed, after 15 years of health care privatisation, there is not yet one single success story on the record of this policy. The rare countries such as Colombia, Chile and Lebanon which managed to find funds to finance health care privatisation increased dramatically their health expenditures without improving access to care. Instead, those with an unorthodox approach such as Costa Rica, which boasts universal coverage of social health insurance, do better than the USA in terms of life expectancy, access to care and disease control while spending nine times less per capita.

What went wrong with orthodox international policies? First, they aimed at maximising the production of Coca Cola cans (standard treatments, vaccinations, etc.) without having built the plant – the health services. Secondly, the plant must produce not only disease control, but also health care in an integrated way, as discussed above. Neither mere programmes coordination nor financing for institutional building such as the otherwise well-intentioned "ten-by-ten" WONCA initiative will do the job. [Aimed at obliging disease control programmes to devote 10% of their budget to strengthening health systems by 2010.]

In fact, international agencies and industrialised countries can square the circle, improve access to care and control disease while building the health factory in developing countries. The strategy is straightforward. Instead of financing solely disease control programmes, international aid agencies should finance and contract in non-for-profit, publicly-oriented health facilities. Ad hoc contracts and technical supervision could secure their social mission. The technology and managerial know-how are available, but not the policy will. This is precisely the political potential of the Network: "Towards *Unity* for Health" and other such organisations.

References

DE PAEPE, P., SOORS, W., UNGER, J.-P. International Aid Policy: Public Disease Control and Private Curative Care? *Cadernos de Saude Publica* (in press).

ENGLAND, R. (2006). We are spending too much on AIDS. *The Financial Times*, August 15, 2006.

JONG-WOOK, L. (2003). Global health improvement and WHO: shaping the future. *Lancet* 362, 2083-2088.

KELLY, M. (1999). A donor's perspective on tuberculosis in international health *Lancet,* 353, 1006.

UNGER, J.-P, D'ALESSANDRO, U., DE PAEPE, P., GREEN, A. (2006). Can malaria be controlled where basic health services are not used? *Tropical Medicine & International Health* 11, 314-322.

WORLD HEALTH ORGANIZATION (2006). WHO Engaging all Health Care Providers in TB Control. Guidance on Implementing Public-Private Mix Approaches, WHO/HTM/TB/2006.360.