International Health and Aid Policies

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Preface

This book explores health policies through examining patterns of commercialization that have underpinned the vast majority of these policies in different regions of the world, at the same time providing the reader with both concepts in public health and techniques to develop health services with a social mission. The chapters in the book include case studies and an extensive review of the literature.

We began this task with one main purpose: to explore the extent to which donors and international agencies have, over the past two decades, shared the same underlying motivation: that is to primarily commercialize the health sector of low-income countries (LIC) and middle-income countries (MIC), despite the stated aim of improving access to health care and addressing issues of poverty and exclusion. In this book, we provide evidence showing the contradictions between access to care and strengthening health systems on the one hand and increased commercialization on the other.

The ideas and evidence presented in this book thus call for an exploration of the contradictions of commercialized health care delivery under the guise of maintaining public provision. The book challenges the discourse and status quo among national bodies, in global policy circles, among donors and northern governments. It argues for

- the creation of health care services that have a social rather than a commercial motivation, and
- delivery of publicly oriented health care based on (professionally defined) 'needs' and on the (population) 'demand' to access quality, polyvalent health care, rather than on health interventions efficiency only.

Biographies

Authors

Jean-Pierre Unger (MD 1979 and PhD 1991, Free University of Brussels; DTM&H 1980, ITM Antwerp; MPH 1983, Harvard School of Public Health) is senior lecturer at the Institute of Tropical Medicine, Antwerp. He started his career in 1981, as a doctor, in the ITM Kasongo project, Congo, then gained experience in health systems and academic development mainly in Africa (in the 1980s and early 1990s) and in Latin America thereafter. He researched strategies to develop publicly oriented health care services (in Africa, Latin America, Asia, Middle East, and Europe), and, since 2000, studies international health policies.

Pierre De Paepe (MD 1977, Antwerp; MPH 1985, Buenos Aires; certificate in health economics 2005, York) spent 25 years in Latin America (Haiti, Peru, Argentina and Ecuador) and has worked at the ITM since 2003 at the Public Policy and Management Unit. His professional experience focused on the implementation of primary health care programmes, health systems analysis, the documentation of country case studies of Latin America, health systems funding, and financing. He is currently studying Colombian and Brazilian health policies.

Kasturi Sen (Dip Soc. Pol, PhD) is a social scientist who has worked on issues of public health and development for the past 25 years. She helped set up a network of seven countries to monitor the public health implications of health reforms in the late 1990s in India and also worked with statisticians, economists and epidemiologists to collect one of the largest data sets on household level impact of changes in the organization of health services in three states of India, on safety nets, on quality and on access to care. Kasturi has taught in public health departments at London (1991–1995), Cambridge (1996–2004) and at Oxford (2005–2008) where she helped establish a course on public health and development. She is working on a collaborative project on global health policies at ITM.

Werner Soors was born in 1955 in Antwerp (MD 1986, University of Antwerp, DTM&H) and worked in Nicaragua up until 2003, with a strong focus on public health care and community participation. Back in Antwerp, he attained his MPH and has been with ITM since 2004. He works in ITM's Department of Public Health on health systems and reform analysis (Public Policy and Management Unit) and on social protection in health (Health Policy and Financing Unit).

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Patrick Van Dessel was born in 1964 in Antwerp, MD 1991, Ghent, Belgium, DTM&H 1992, and MPH 1997, ITM Antwerp, worked for more than a decade in Africa (Malawi, Rwanda) and Latin America (Bolivia) with a main interest in integrated health system organization and primary health care. He has experience with epidemiology and health care accessibility in neglected urban areas in Belgium (2004–2008) and has been working with ITM's Public Policy and Management Unit since 2008. His current focus in Antwerp is on health system research, public institutional capacity building and teaching public health in a globalized context.

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Notices

The majority of the papers in this collection have been published already. However, the interest they created inspired us to combine them into one volume aimed at students and public health professionals.

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This book would not have been possible without the efforts of several people within our unit and outside. First, Patrick Van Dessel, in addition to being co-author of several of the chapters, has been instrumental in the completion of this project, contributing to the edition and the bibliographic research. Indranil Mukhopadhyay, from the Centre of Social Medicine and Community Health (CSMCH) of the Jawaharlal Nehru University, New Delhi, India, undertook the edit of a first draft, working closely with Jean-Pierre Unger and Kasturi Sen. We have also had invaluable help from medical student, Casper Van der Veer, who managed with great skill all the technical aspects of the manuscript from the illustrations to formatting and referencing. His efforts especially during the final stages have been integral to the completion of this project. His work has been supported and complemented by our highly skilled secretary Linde De Kinder. The contractual negotiations were also managed, with care and attention, by the legal advisor to the Institute, Jef Van Lint. The task of seeing this through various committees and Cambridge in-house rules was carefully and consistently undertaken by series editor Richard Marley aided by Editorial Assistant, Rachael Lazenby, and Jane Seakins, Publishing Assistant, Medicine. All of the editors of this text have worked hard to complete this marathon project in a short time. The views expressed in the articles and chapters are the authors' own and do not reflect those of the Institute of Tropical Medicine (ITM) or that of the publisher, Cambridge University Press.

Professor Em. Pierre Mercenier and Professor Harrie Van Baelen, physicians and professors of public health at the Institute of Tropical Medicine, Antwerp (ITM), pioneered numerous concepts formulated in this book (e.g., holistic, continuous and integrated care; integrated health services and systems). Our intellectual debt to them is immense.

Finally, we are indebted to the Belgian Directorate-General of Development Cooperation for the funding of several research endeavours presented in this book.

List of Abbreviations

ACT	Artemesinine Combination Therapy
ADB	Asian Development Bank
AHDR	Arab Human Development Report
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ASeMeCo	Asociación de Servicios Médicos Costarricense (Costa Rican Association of Medical Services)
BI	Bamako Initiative
CAFTA	Central American Free Market Agreement
CCSS	Caja Costarricense de Seguro Social (Costa Rica, Social Security Administration; see SSAC)
CHC	Comprehensive Health Care
CHW	Community Health Worker
CMH	Commission on Macroeconomics and Health (WHO)
CMP	Common Minimum Programme (India)
(N)CMS	(New) Cooperative Medical System (China)
COMAC-HSR	(European) 'Concerted action' on Health Services Research
CPHC	Comprehensive Primary Health Care
CSC	Civil Service Cooperative (Lebanon)
CSDH	Commission on Social Determinants of Health (WHO)
CSMCH	Centre of Social Medicine and Community Health of the Jawaharlal Nehru University, New Delhi, India
CT (Scan)	Computed Tomography (Scan)
CUP	Cambridge University Press
DAC	Development Assistance Committee (OECD)
DALY	Disability-Adjusted life year
DANIDA	Danish International Development Agency
DCP(s)	Disease-Control Programme(s)
DFID	Department for International Development
DGDC	(Belgian) Directorate-General for Development Cooperation
DOTS	Directly Observed Treatment Short Course
DPH	Department of Public Health at the Prince Leopold Institute of Tropical Medicine Antwerp
DSP(s)	Disease-specific Programme(s)
EBAIS	Equipos Básicos de Atención Integral en Salud (Costa Rica; primary health care clinics)
ECP	Essential Clinical Package
EPI	Extended Programme on Immunisation (WHO)
ESAFs	Enhanced Structural Adjustment Facilities (International Monetary Fund)
ESE	Empresas Sociales del Estado (Colombia; Public Hospital and Health Centres)

EU	European Union
FDI	Foreign Direct Investment
FMP/A	Fund for Military Personnel / Army (Lebanon)
FONASA	Fondo Nacional de Salud (Chile; National Health Fund)
FWP	Family Welfare Programme (India)
GATS	General Agreement on Trade in Services
GCI	Global Competitiveness Index (World Economic Forum, 2006)
GDP	Gross Domestic Product
G.E.R.M.	Groupe d'Etude pour une Réforme de la Médecine
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative (or Global Health Partnership)
GHP	Global Health Programme
GMR	Global Monitoring Report (World Bank)
GNP	Gross National Product
GOBI	Growth monitoring of young children, Oral rehydration therapy, promotion of Breast-feeding, and Immunisation programme (UNICEF)
GP	General practitioner
GPPP(s)	Global Public–Private Partnership(s)
GSF	General Security Forces (Lebanon)
HCDI	Health care Delivery Institutions (Colombia; Instituciones Prestadores de Servicios de Salud, IPS)
HDR	Human Development Report (WHO, 2003)
HFLC	High Frequency Low Cost
HIC	High-Income Country
HIV/AIDS	Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome
HMO	Health Maintenance Organization
HPE	Health Promoting Enterprises (Colombia; Empresas Promotores de Salud, EPS)
HSR	Health Services Research / Health Service Region / Health Sector Reform
IDP(s)	Internally displaced person(s)
IDWSSD	International Drinking Water Supply and Sanitation Decade
IFI(s)	International Financing Institution(s)
IFPA	Interface Flow Process Audit
IHP	International Health Partnership
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPPI	Intensified Pulse Polio Immunization
ISAPRES	Private insurers (Chile)
ISF	International Security Forces (Lebanon)
ITM	(Prince Leopold) Institute of Tropical Medicine Antwerp
LA	Latin America(n)
LDC	Less-Developed Country
LFHC	Low Frequency High Cost
LIC	Low-Income Country

LMIC	Low- and Middle-Income Country
lpcd	liters per capita per day
MAP	Minimum Activities Package
MDG(s)	Millennium Development Goal(s)
MHO(s)	Mutual Health Organization(s)
MIC	Middle-Income Country
MMR	Maternal Mortality Rate
MNC(s)	Multinational Corporation(s)
MNP	Minimum Needs Programme (India)
MoH	Ministry of Health
MOPH	Ministry of Public Health (Lebanon)
MRI	Magnetic Resonance Imaging
NCAER	National Council of Applied Economic Research
NCD(s)	Non-Communicable Disease(s)
NCMS	New Cooperative Medical System
NFHS	National Family Health Surveys
NGO(s)	Non-governmental organization(s)
NHA	National Health Accounts (Lebanon)
NHES	National Household Expenditure Survey (Lebanon, 2000)
NHHEUS	National Household Health Expenditures and Utilisation Survey (Lebanon, 2000)
NHP	National Health Policy (India)
NHS	National Health System / National Health Service (Great Britain) / National Household Survey (Colombia, 1992; Encuesta Nacional de Hogares, ENH)
NQLS	National Quality of Life Survey (Colombia, 1997)
NRHM	National Rural Health Mission
NSS	National Sample Survey (Kerala, India)
NSSF	National Social Security Fund (Lebanon)
NTP(s)	National Tuberculosis Programme(s)
ODA	Official Development Assistance / Official Donor Assistance
OECD	Organization for Economic Co-operation and Development
OHP	Obligatory Health Plan (Colombia)
OR	Odds Ratio
PAHO / OPS	Pan American Health Organization / Organización Panamericana de la Salud
PDS	Public Distribution System
PFI	Private Finance Initiative
PHC	Primary Health Care
PHS	Population and Housing Survey (Lebanon)
PP(s)	Private provider(s)/practitioner(s)
PPM-DOTS	Public-Private Mix for Directly Observed Treatment, Short Course
PPMU	Public Policy and Management Unit (ITM Antwerp)
PPP(s)	Public–Private Partnership(s)
PPS	Pre-payment System

PRSP	Poverty Reduction Strategy Paper/Program Requirements Support Plan
QALY	Quality-Adjusted Life Year
RMB	Chinese Renminbi (People's Republic of China currency)
SAPs	Structural Adjustment Programmes (World Bank)
SARS	Severe Acute Respiratory Syndrome
SDC	Swiss agency for Development and Cooperation
SIDA	Swedish International Development Cooperation Agency
SPHC	Selective Primary Health Care
SSA	Subsidised System Administrators (Colombia; Administradores de Regimen Subsidiado, ARS)
SSAC	Social Security Administration of Costa Rica (see CCSS)
SSF	State Security Forces (Lebanon)
TBHBC	Tuberculosis High Burden Countries
TNC(s)	Transnational Corporation(s)
TPDS	Targeted Public Distribution System
TRIPS	Trade Related Intellectual Property Rights
UN	United Nations
UNAIDS	(Joint) United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNRISD	United Nations Research Institute for Social Development
WB	World Bank
WDR	World Development Report
WHA	World Health Assembly
WHO/OMS	World Health Organization / Organización Mundial de la Salud
WONCA	World Organization of Family Doctors
WTO	World Trade Organization

Reviews

International Health and Aid Policies: The Need for Alternatives, represents an important and comprehensive effort in gathering the evidence of the grave consequences on developing countries' health systems of some international health and aid policies that promote excessive reliance on disease-specific programmes and commercialized care. The book proposes alternative policy scenarios to begin reverting the for-profit on self-sustained and fragmented health care systems, and highlights the key role of health system researchers in influencing the development of pro-equity international health policies and the evaluation of their impact. The thorough review of historic data and trend analysis will serve scholars and decision makers alike.

Dr. Mirta Roses
Director
Pan American Health Organization
Regional Office of the World Health Organization

Timing is everything in comedy and in scholarship. One cannot imagine a better timing for this book's publication.

The title of the book promises to make a call for health services with a clear social mission; and this it fully delivers. Here is a book that paves the way in a direction using the right political analyses. It tells us that it has been donors who have pushed the patterns of commercialization of health in poor countries; and that aid policies share a large responsibility for the breakdown of the health systems of many of the poor countries we currently see. It highlights the contradictions of public provision under the guise of commercialized health care looking at two decades of neoliberal policy that has systematically undermined access to quality health care services for a majority of the world population. This, it rightly claims, receives far too little attention in the literature.

The book is clear about the need for a policy shift that re-establishes the right to access to quality health care. It proposes a health policy based on a political philosophy in an attempt to reconcile professional, cultural and political ethics. It clearly states that health policy is political in the sense that it refers to actions (deeds) meant to challenge the structures of power and social organization from an ethical perspective.

For all these reasons, the People's Health Movement feels the principles of its People's Charter for Health are here represented; our worldwide membership would want to read it.

Bridget Lloyd
People's Health Movement Co-ordinating Commission

This important book challenges the dominant discourse on global health and the growing commoditization of health care to the detriment of poor people all over the world. The serious and evidence-based questions and facts raised by the authors on the relentless promotion of private sector growth in health must now be answered.

Ann Marriott
Development Finance and Public Services Team
Oxfam GB

This book comes at a time of a highly needed reform in the Global Health Governance and the International Health Aid Architecture. The attention to health has been enhanced in global fora and health aid has tripled in the last decade. We all share responsibility and the challenge to address the highly fragmented health landscape. The EU is developing a new policy framework aimed at greater equity and coherence in the EU role in global health. The agreed global commitment to universal coverage rescuing the Alma Ata principles and applying the principles of partnership and ownership to health in development aid are clear opportunities. The reflections of this book will be a valuable reference for our debate and the enhanced EU role in the global health challenges.

Juan Garay
Public Health Physician
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Introduction – Overview and purpose

> Confident in the infinity of time, a certain conception of history discerns only the rhythm, faster or slower, at which men and times move along the path of progress.
>
> Walter Benjamin, 1915. La vie des étudiants. In: W. Benjamin, Œuvres I, Folio Essais, Editions Gallimard, 2000, p. 125.

> Plato was the first to discern between those who know without acting and those who act without knowing while in the past, action was divided in enterprise and achievement: the result was that the knowledge of action to accomplish and its implementation became two radically different concepts.
>
> H. Arendt. Condition de l'homme moderne. Calmann Levy Ed., Paris, 1983, p. 286.

After 15 years of neoliberal international health policy, data from 26 sub-Saharan countries reveals that more than 50% of the poorest children receive no health care when sick (Marek et al., 2005). Data from 44 low- to middle-income countries (LMICs) suggest that the greater the participation of the private sector in primary health care (PHC), the higher the exclusion from treatment and care (Macintosh & Koivusalo, 2005) across sectors.

This is a textbook about public health with a difference. Firstly, it addresses policies relating to the delivery of health care – while the study of public health has historically evolved around issues of disease control. This book makes a case for alternative policies that could shape the structure and provision of universally accessible, polyvalent, discretionary health care, rather than making it work through its commodification[1] and the priorities of cost-effective interventions in public services. Secondly, the articles we have included are critical of the debates over the political and technical paradigms of such discussion, often predicated, in our view, on international political ties and commercial relationships. Thirdly, a strong current of thinking in the book is the view, often neglected, that policies have a direct impact on the motivation and practice of professionals in the health sector and that such professionals can, and should, contribute towards developing health services with a social mission whatever the national health policy might dictate. In other words, the book approaches many of the contradictions of current policies from the perspective of practice. It thus offers a combination of theory, evidence from four continents and practice interwoven with guidance directed at policy makers, researchers, doctors, and nurses on ways and means to achieve comprehensive health care (CHC) provision in order to strengthen health systems.

Consequently, this is a textbook also on health services organization, designed to open avenues for reflection and action for the reader. Its targeted audience includes students, researchers, and practitioners of public health as well as health professionals with a practice in LMICs.

Whilst hierarchy conveys a top-down flow of authority, information, and ideology, this book aims at providing health professionals with action perspectives to amend (inter)national health policies in an experience-based perspective, in order to encourage the development of publicly oriented health services under any circumstance, wherever the health practitioners may be posted and whatever might be the national health policy. The book thus offers the reader arguments

[1] To turn into, or treat as, a commodity; make commercial.

reversing the well-established hierarchical flows of information that sustain a normative order. It provides in its place a fresh policy perspective, a methodology, and strategies to develop publicly oriented health services, to implement a more equitable care delivery and tentatively influence national policies.

Origins

Some 10 years ago, the Public Policy and Management Unit (PPMU) at the Department of Public Health (DPH) of the ITM began in-depth research into international health policies in order to understand some of the factors behind the incompatibility of existing health care management techniques with policies that were being advocated worldwide, despite the variations in context. This resulted in a series of papers and articles, highlighting the linkages and contradictions between integrated, co-managed health services delivering comprehensive care and existing policies that were rooted in systems of segmentation and fragmentation. We learned from our experience that the latter results in poor quality and high cost health care that leads to the exclusion of large elements of the population from health services.

Six concerns governed the preparation of this book:

1. There is a need to explore whether there is an underlying commonality to the policies advocated by multilateral organizations as diverse as the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the European Union (EU), Organisation of Economic Co-operation and Development (OECD), the World Bank, the International Monetary Fund (IMF) and others, despite their declared diversity of perspective on health services.
2. The nature and type of links between these policies and the prevailing fragmentation of the health sector in LMICs is examined. In particular the policy of limiting the problem-solving capacity of LMIC public services to disease control (under the guise of prioritization and efficient use of limited resources) is clearly linked to attempts to expand health markets. As put by a Rockefeller Foundation report, 'If public health agencies are encouraged to expand their focus on specific populations and interventions, at the expense of general primary and chronic care, the private sector may fill the void' (Lagomarsino et al., 2009).
3. The analysis of the nature and impact in terms of the cost, accessibility and the quality of health care provision of international health policies may be best undertaken through interdisciplinary tools and not by economic analysis alone.
4. Given the current impasse and seemingly irreversible changes to the health sector, we question the extent to which it is possible to posit alternative options with an emphasis on comprehensive care and on the health system as a whole. This perspective is based on the understanding that the credibility of an option may depend not just on the existence of successful case studies, but also on the 'know-how' and the evidence gained from actual experience in the delivery and management of health care.
5. It is increasingly acknowledged that there are shades of grey between health services in public and in private ownership. In most cases it is never exclusively one or the other. Despite shared characteristics in different regions and contexts such as in the need for profit, there are different types of private provision of care (Baru, 1998; Bhat, 1999; Maarse, 2006; Marriott, 2009; Newbrander & Rosenthal, 1997). In addition the traditional

typology of health services may also be blurred by the confusion often generated between their statutes and mission or practice (Giusti et al., 1997). Commercial provision in the health sector is premised on the primary need for profit (the quest for maximization of financial return) even if it is engaged in partnership with many not-for-profit providers or if it consists of individual physicians providing family medicine.

6. Services are often not subject to an effective regulatory system which would encourage them to operate in line with the criteria of a publicly oriented, social mission.

Following two decades of privatization policies and repeated calls for regulation, most developing countries still appear not to have the regulatory structures to appropriately monitor medical care and enforce quality standards (Asiimwe & Lule, 1992; Hozumi et al., 2008; Yesudian, 1994). The Rockefeller Foundation recently observed that 'While comprehensive regulatory regimes are absent in most low income countries, a few narrow regulatory programmes have been somewhat successful … in the domain of pharmaceuticals distribution' (!). The report listed a number of obstacles to decent regulation in LMICs (Lagomarsino et al., 2009). It states that 'Without a mechanism to intervene and control health markets, this distribution of wealth and disease perpetuates the inequitable delivery and financing of care' because 'Health markets favor wealthier segments of the population.' However, and paradoxically, the report recognizes that 'Progress toward stewardship of mixed health systems – especially the non-state sector – is a long-term aspiration rather than a short-term goal.' In other words, it suggests that regulation in LMICs could prove to merely be a lure for continued privatization.

Having examined the evidence this book thus contends that health policies and systems should be categorized into those with a social motive (their standards are described in Section 5, Chapter 14) and those with a commercial incentive (for-profit, aiming at maximizing return). With others, it argues that publicly oriented providers, strengthened, coordinated, and democratized in each country context, are needed to improve population health and access to health services (Blam & Kovalev, 2005; Drache & Sullivan, 1999; Evans, 1997; Macintosh & Koivusalo, 2005; Sen, 2003; Whitfield, 2001; World Health Organization, 2009). Their social motivation can be enhanced with appropriate financing and contracts.

Content

What, then, is the underlying theme of the book?

Section 1: Identifying international policies and paradigms

Based on a review of both published and grey literature, produced by the key institutional players in international health policy making over the past two decades, the two chapters in the first section summarize their doctrine and our concerns about their implications worldwide. This then serves as an introduction to the whole book.

WHO, the World Bank and the European Union do have a doctrine on aid and international health policy. They divide up health institutions into government and private and classify health interventions into health care and disease control. Whenever possible, they allocate disease control to the public and curative health care to the private sector. Such policies are neoliberal in their promotion of commoditization and privatization as they tend to restrict public services to the delivery of disease-control programmes.

Section 2: Demonstrating the epidemiological consequences of international policies

This section addresses the failure to control epidemiological challenges ('disease control'), although this has been the paradigm of international policies for LMICs for the past three decades. Together with other factors, disease-specific programmes are responsible for the lack of effectiveness of disease control and for many avoidable deaths in LMICs, as suggested by the monitoring of Millennium Development Goals (MDG) attainment. The failure mechanism is as follows. On a data set of Mali, a mathematical model allows us to see that to be effective, the malaria control programme – and others relying on clinical interventions – need to be integrated in health facilities where there are patients, representing a pool for early detection and continuity of care (Section 2, Chapter 3). Unfortunately, disease-control programmes undermine access to care in these facilities where they are implemented, via several mechanisms, e.g., multiplication of disease-specific divisions in national health administrations; failure to clarify the lines of command and opportunity costs (Section 2, Chapter 4). This chapter also illustrates that the organization of the services delivering disease-control interventions has been affected by the commercial constraints of the General Agreement on Trade in Services (GATS) and of regional commercial agreements such as ALCA/TLC, which undermine access to polyvalent multi-function health care. In theory this contradiction could have been solved by privatizing disease control. However, the first attempts to contract out tuberculosis control fell short of their goal even where private services represented the bulk of health care services as in India (Section 2, Chapter 5) because the professional, private sector was not very interested in such a prospect, owing to the lack of profitability, the opportunity costs involved and because it was scarce in LMIC rural and poor urban areas. Notice that these observations also hold for maternal care (Unger et al., 2009).

We therefore continue to question why access to comprehensive health care (CHC) was not included as part of the MDGs and why CHC continues to remain largely excluded from aid programmes.

Section 3: International health policies and their impact on access to health in middle-income countries: some experiences from Latin America

International policies are neoliberal in that they promote the commodification of health insurance and health care. This section suggests that this policy is not evidence-based. The analysis of Costa Rican, Colombian and Chilean policies does not confirm what a rapid WHO classification of country performances suggested in 2000 (World Health Organization, 2000): that health care privatization would yield significant efficiency gains. Instead these reform experiences confirm that health policies based on well-financed publicly oriented services are both effective and efficient, a conclusion also reached about European health care systems, as early as 2004 (European Commission, 2004). Costa Ricans spend nine times less on health than US citizens and enjoy a better health status. Hence the question: Why does the Costa Rican model not serve as a model for international policies? (Section 3, Chapter 6). Colombia has carefully applied the recommendations of Bretton Woods agencies since 1993 and has failed dramatically to secure access to decent quality versatile care and to control costs (Section 3, Chapter 7). Finally, we show that the good output of the Chilean health system is to be attributed to the public services, which managed to survive Pinochet's dictatorship, and by no means to the private sector (Section 3, Chapter 8). While Colombia and Chile are

still cited as 'model' experiments (Lagomarsino et al., 2009) by those foundations promoting neoliberal policies (Lagomarsino et al., 2009), these Latin American case studies show that, being neoliberal in essence, the international health and aid policies to date have a share of responsibility in the failure to secure universal access to care. The demonstrated failure of the Colombia and Chile private sectors to deliver undermines the credibility of a key argument to privatize health care: if mixed health system stewardship mechanisms – regulation, commercial risk-pooling, and purchasing – failed in these two MICs presented as models, they are unlikely to operate in LICs.

One of the main questions raised in this book is whether current international health policies being implemented in other countries have actually taken into account the evidence gained from these experiments of health reform, in order to formulate their objectives and strategies. Our initial findings based on the case studies and reviews suggest that this may not be the case, despite the fact that so-called evidence-based policy has evolved almost into a discipline by itself, serving as a guiding rhetoric for most donors and funding institutions.

Section 4: An analysis of the political, commercial and historical determinants of international policies

The three case studies in Section 4 provide an opportunity to scrutinize the effects of bringing in different disciplines to explore the determinants and implications of neoliberal health policies: sociology and political sciences in India; economic analysis in China and history in Lebanon, where many commercial interests have found it all too easy to penetrate into the health sector with a weak political organization of the poor, powerful mechanisms of corporate lobbying and support from experts and local elites (Section 4, Chapters 9, 10 and 11). These case studies also allow one to challenge the one-sided nature of the evidence base that is utilized for policy making and illustrate with a powerful lens their long-term consequences for population health and equity in access to care. This section reinforces the evidences for the blanket nature of reforms (current and past) and the inability or unwillingness of donors and national policy makers to learn from lessons.

We have not included case studies from the African region (except for some elements of the second section). This region, despite its diversity, presents many LICs and some typically fragile states. Most have extremely limited access to care; a focus on essential packages rather than comprehensive care; substantial rural–urban and rich–poor divides in the availability of services and low levels of public expenditure on health per capita. Their health system, though not applicable to every country in the region, may be described as an over-riding pattern of donor assistance, accompanied by high levels of bureaucratization of public structures and an almost exclusive focus on disease control in the public health sector. The demise of the public sector in most countries of the region over the past 20 years is partly linked to Structural Adjustment Programmes (SAPs) that encouraged debt repayment as a priority, over support for public services. This strategy, among other impacts, actively encouraged an exodus of medical staff (internal and international migration) from this sector in most countries. Now widely documented, it is causing a crisis of professional human resources throughout LMICs, and particularly in Africa (Buckley & Baker, 2008).

Therefore, the four first chapters identify some of the dismal consequences of policies premised on neoliberal thinking that have been imposed on LMIC health sectors. Firstly, there are conditions associated with (inter)national trade which oblige LMICs to privatize health care delivery while they are structurally unable to regulate it. Secondly, disease-control

programmes have yielded a worldwide institution of bureaucracy of unprecedented size. Thirdly, there is a cost to LMIC states which have frequently had to subsidize the international policies by providing human resources and infrastructure. The expansion of private provision and donor-supported public–private global health initiatives caused an internal brain-drain of medical personnel from the public to the private sector and to the aid-funded disease-specific programmes. Fourthly, in turn, this has been detrimental to their health services and to their ability to deliver health care. Access to care was eroded to a large degree because the private sector did not replace the collapsing public health systems. In addition, to the vast majority of users throughout low- and many middle-income countries, the private sector did not mean more than unregulated drug outlets, unlicensed nurses, and village health workers. The reduced access to care has led to suffering and deaths that could have been avoided and to catastrophic health expenditure. In many LMICs the cost of health care became a primary cause of falling into poverty.

Although reached with radically different methodologies, these observations are in line with those of a recently released and debated (Moszynski, 2009) Oxfam report (Marriott, 2009), which argues that health policies based on privatization and commercialization packages are not only costly, but have also failed to deliver on their own aims as well as causing much suffering, particularly for those most dependent upon public providers. It contends that the private sector is not a single entity but that the cost and quality of provision is very uneven. The report also shows that the private sector often survives through public subsidy, conveniently named public–private partnerships (PPPs) that have been advocated as the dominant mode of provision by lenders such as the World Bank since the publication of its 2004 report 'Making Services Work for the Poor' (World Bank, 2004). It claims that, although attracting much international attention and investment, the registered private sector is not a significant provider of care in many LICs: 'Oxfam's analysis of the data used by the International Finance Corporation (IFC) finds that nearly 40% of the private provision it identifies is just small shops selling drugs of unknown quality.' Moreover, those accessing trained health workers represent a small fraction of this sector clientele. In India, where 82% of outpatient care is privately delivered, only half the mothers get any medical assistance during childbirth. The private sector does not provide (as is often argued) additional investments to cash-starved public health systems but rather manages to attract significant public subsidy. In South Africa the majority of private medical scheme members receive a higher subsidy from the government through tax exemption than is spent per person dependent on publicly provided health services. Private participation in health care is associated with higher expenditure, as shown in the report through a comparison of Lebanon and Sri Lanka (e.g., due to the difficulty of regulating private providers in developing countries). There is a lack of evidence to support claims for the superior quality of the private health care sector, and in particular that it is any more responsive or any less corruptible than the public sector. Rather than helping to reach the poor, private provision can increase inequity of access because it naturally favours those who can afford treatment.

SAPs and international financing institutions used loans as a leverage to reorient LMIC health policies towards health care privatization. Today both regional economic treaties (such as TLC between Latin American countries and USA) and World Trade Organization (WTO) GATS negotiations force developing countries to implement such policies and open their market to international health care trade – with potentially catastrophic consequences. The similarity between international trade treaties and the rationale of international aid suggests that capital return and profits for industrialized countries were

the real motives for contemporary design of international aid – which is elaborated further in Section 1.

However, international health policies have not been alone in promoting these policies. The expansion of commercial health care has often favoured the LMIC minority urban middle class. This elite supported the status quo, as it thought it was protected against the rising cost of care by private insurances. Often the ability to afford private provision was viewed as a mark of distinction from the rest of the population. The experience of the United States (Himmelstein et al., 2001), Chile and Colombia suggest that such policies lead to escalating costs, well beyond the limits of insurance. All this has led some to contend that many of the policies advocated in recent decades are rooted in ideology and commercial interest, rather than upon evidence of effectiveness, quality and equitability in the provision of health care (Buckley & Baker, 2008, Kessler, 2003, Pollock & Price, 2000).

Section 5: Principles for alternative policies for planning, management and delivery

As an alternative aid and international health policy, we propose an integrated, social and democratic strategy based on the financing of – and technical support to – publicly oriented (not-for-profit, socially motivated) health services. The kind of medical care these would deliver, and the sort of management needed to run them, is specific. This implies that there is not one medicine but two, and not one managerial science for health but two, according to whether the motive is profit or not. In parallel we plead for a specific disease-control organization, likely to protect access to polyvalent health care.

Section 5 provides principles for the development of such a sector. These principles encompass a paradigm shift in functions of public services and methodologies to identify them (Section 5, Chapter 12); the design of integrated health policies (Section 5, Chapter 13); health care delivery and management with a social objective (Section 5, Chapter 14); the planning of health services and systems (Section 5, Chapter 15); and the management of disease-control programmes in order to avoid undermining access to health care in public services (Section 5, Chapter 16).

Community participation and co-management among users of publicly oriented services is an important cross-cutting theme throughout the proposed policy. It is applicable only to health facilities with a social, rather than a commercial mission. The rationale of participation is partly technical since the effectiveness of health interventions ideally requires an individual and sometimes a collective *dialogue* between professionals and users of those services. It also has a political function since co-management contributes to making public health services more democratic, accountable, and responsive. Furthermore, health services development relying on community participation needs to recognize and build on popular cultures[2] rather than, as has often been the case, upon the power of local elites and non-governmental organizations (NGOs) making up the 'civil society.' We would argue that a contribution to the cultural dynamics as well as to social progress of a particular locality or region needs to be a criterion

[2] The term 'culture' has many meanings: 1. The symbolic organization of a group, the transmission of its knowledge and values enabling self-representation and encompassing its relationships with the universe. 2. It also describes the group traditions, beliefs, language, ideas, as well as its environmental organization – its material culture. 3. Another definition also conveys a political dimension: the potential for collective action, inherited from traditions and revealed by exceptional individuals, such as artists, poets and philosophers, who often cross the boundaries of privilege to reflect the universal value of humanity.

when assessing policies for health services, alongside the quest for equity, solidarity and the struggle against social injustice.

Section 6: A public health, strategic toolkit to implement these alternatives

This section focuses on a learning process for strategic action derived from professional practice. On this basis, it challenges policy makers to make use of the best experiments from the field to design national health policies.

In Colombia, where neoliberal reforms have been completed, professionals now complain of poor salaries, lack of professional stability, reduced professional responsibilities, over-standardization of clinical decision making related to managed care, and deteriorating ethics. Just as professionals were instrumental in promoting neoliberal policies, in our view, they could help reverse the trend if equipped with appropriate knowledge – management strategies to develop and run publicly oriented health systems and public health academic units. Although covering a limited area of their decision making, these strategies were conceived to reduce uncertainty in decision making and encourage creative thinking, while at the same time being specific in terms of targeted action and processes of change. These strategies encompass the development of family and community health in publicly oriented services (Section 6, Chapter 17); the promotion of publicly oriented hospitals with systemic responsibilities; the organization of districts and local health systems (Section 5, Chapter 15); the use of reflexive methods to bridge the gap between medical and public health identities of health professionals and improve practice (Section 6, Chapter 19); the improvement of access to health care (Section 6, Chapter 18, Part 1) and drugs (Section 6, Chapter 18, Part 2); social control at the peripheral level to increase accountability and responsiveness in publicly oriented facilities; the reorientation of international research, university teaching (Section 6, Chapter 20) and in-service training efforts.

National (tax-based or social insurance) and additional international sources are required to provide viable financing for this alternative strategy. Supply-side subsidies and contracting of not-for-profit health facilities responsible for care delivery (and disease control) are concrete ways to implement the widely advocated strengthening of health systems. Finally, our proposed policy also calls for networking and lobbying in the international arena. Whilst we are certainly not the first to undertake this task, with our proposals we hope we introduce a particular set of philosophical values in the practice of health services.

Relevance – why now?

International health policies appear to be in a period of transition, and this book aims at providing conceptual and knowledge ammunitions to those who wish to promote change. A decade following the launch of the MDGs, multilateral agencies have begun to examine their achievements and some even recognize the conceptual mistake of not considering 'access to health care' as a core MDG and the negative implications of the commercialized discourse predominant in health policies of recent years (Action for Global Health, 2009; Chan, 2008; Economic Governance for Health, 2009). In 2003 the Pan American Health Organization

(PAHO) was among the first multilateral organizations advocating a change in international policy orientations (Pan American Health Organization, 2003). In 2008 WHO followed suit (World Health Organization, 2008).

During the second half of 2008, while holding the EU presidency, France considered CHC in LMICs as one of its main priorities – a sign of possible change in the strategy put forward by the influential 1993 World Bank report 'Investing in Health.' However, the way such thinking and strategy will unfold and whether it will be devoid of commercial undertones is uncertain. Moreover, once-confident financial institutions, such as banks, have been visibly shaken by the financial worldwide crisis in 2008, which has had a devastating impact on all other sectors, notably those of employment, housing, health, social security, and pensions. The cascade effects of the international crisis on the social sectors indicate an escalation in costs of premiums, medical equipment and pharmaceuticals. The full impact of the financial and economic crisis on fragile health systems (e.g., 1.02 billion people are undernourished today, with 100 million more between 2006 and 2008) (Food and Agriculture Organization of the United Nations, 2009) and upon access to health care are yet to unfold.

The book questions the extent to which large sections of the scientific community who have been working closely with donors (Behague & Storeng, 2008), preparing aid policies and seeing through their implementation, are also prepared for change; that is from promoting the idea of markets in health care, to supporting comprehensive and accessible health care. Though this does not encompass the whole scientific community, it is clear that over the past two decades substantial sections of it have argued the case of dismantling public and CHC in favour of provider choice and supposed quality in private provision, despite strong evidence to the contrary. Whether we are right to raise the issue in this manner is a question that is best judged by the readership, premised on the evidence that is provided and on an understanding of the underlying motives of international health policies. Whilst many international NGOs continue to rather uncritically apply international health policies as they exist in their domains, there are also signs of change in this sector. Christian Aid among a handful of others have documented the negative effects of health policies that promote commercialized care upon access for the majority of people in countries where they have become the mainstay of the health sector. This applies especially to conflict zones such as Afghanistan and Iraq where the need for public provision is at its greatest (Christian Aid, 2004). More recently, the above quoted Oxfam report (Marriott, 2009) delivered a damning critique of the policies of disinvestment in public provision and the policy of privatizing health care particularly in LICs.

Nowadays, the health sector represents some 17% of the US gross domestic product (GDP) – most of it in the hands of private interests – and has probably the potential to grow to a similar proportion of the world GDP if the US model continues to be exported worldwide. There is much to be gained by the insurance business and the medical industry and lobbying by private interests will remain active. Public investment would thus go on 'maturing' markets through creating further restrictions on public services, and expensive health care for the middle classes will offer outlets for the booming corporate care, in partnership with biomedical and pharmaceutical industries.

It would be easy for aid to continue to remain project-based – with a wealth of evaluations, consultant firms and reports. Its epistemological paradigm could remain focused on high-tech medicine for the rich and alleged 'trickle-down' economic development, and disease control for the poor rather than on the reconstruction of systems providing access to family and community medicine, hospital care and on democratization of public services that require a sense of social solidarity and political commitment.

Declarations from the WHO in favour of strengthening health systems through the strategy of PHC may, as a result, be unable to reverse the trend. Access to quality health care could remain a commodity, instead of a human right with a strong potential for the redistribution of wealth. Thus these are ever more reasons why health professionals require support to develop knowledge awareness and avenues for action, to counteract a powerful economical determinism, and to take advantage of the signs of change among policy makers who have begun to realize that the lack of access to quality health care could in reality generate a great deal of political instability across many LMICs.

Definitions in health care and disease control

Some definitions are crucial to understanding the ideas contained in the forthcoming chapters. The following are definitions of disease-specific programmes (DSPs) and CHC.

Disease-specific programmes

Coherent sets of activities, know-how, and resources designed to control a single or a limited number of related disease(s) are known as disease-control programmes (Cairncross et al., 1997) or disease-specific programmes. They include:

- clinical (curative and preventive) interventions delivered in professional health facilities;
- health promotion activities carried out outside the health services;
- mass distribution of drugs (also called community distribution);
- water and sanitation interventions including vector control activities (e.g., of Simulium and Tsetse flies).

The portfolios of disease-specific programmes are huge and problematic. Funding levels for HIV/AIDS, for example, have been known often to exceed the entire national health budget (Shiffman, 2008) in several sub-Saharan African countries. In theory DSPs are designed to address major health problems and epidemiological challenges. In practice they also tackle conditions as well as diseases that cause a lesser burden on the population. Cost-effectiveness analysis was intended to determine priority control interventions but in practice, proved to be an illusion (see Section 5, Chapter 12).

Global health initiatives (GHIs)

Over the past decade, in LICs and fragile states, GHIs (or Global Health Partnerships) emerged as key donors in the health sector alongside bilateral and multilateral agencies. Funded by public and private partners, they have contributed to a significant amplification of health sector aid. Development assistance for health has increased from just over USD 6 billion in 1999 to USD 13.4 billion in 2005 (OECD, 2008).

Comprehensive health care (CHC)

CHC includes care delivered at the patient's initiative as well as care initiated by health professionals and DSPs. This care is delivered by polyvalent (versatile, multi-functional) services and includes hospital medicine able to handle at least medical, obstetrical and surgical

emergencies. In LMICs first-line health services would include family and community medicine, which encompass individually tailored prevention and promotion activities in health institutions as well as mass prevention and clinical interventions that are part of the DSPs. Such care may be delivered by an array of professionals from physicians and assistant medical officers, to clinical officers or nurses, but not by community health workers. CHC has been demoted in LICs through political moves, but also with the collaboration of scientists (e.g., use of the cost–benefit model).

Community health workers (CHW) are community members, trained often for a few weeks depending on location and context (whether LIC or not). Historically they have played a useful role in remote villages, e.g., in participating in professional mobile preventive clinic activities, and in contributing to the continuity of health care and the distribution of drugs.[3] To operate properly, they need to be regularly supervised. There is a risk that in the future the concept of PHC remains limited to the deployment of an army of CHW and excludes professional services from its scope – to secure the status quo of commercial interests.

CHC does not usually include water and sanitation, or interventions such as vector control, but may exceptionally include some of these (bed net distribution, for instance).

Patient-centred care is discretionary by definition. It responds to the patient's demand for the alleviation of pain and suffering, anxiety, and perceived risk of death. It is often triggered by signs or symptoms (say a cough). The related care is often curative and polyvalent (versatile), and includes first-line services (family/community medicine) and specialized hospitals. Another type of care may be described as provider-led and is active in the early detection of patients in communities (e.g., patients suspected of trypanosomiasis/sleeping sickness). Government support for patient-initiated care may be limited in terms of a system's tiers (for instance limited to health centres and district or regional hospitals) and/or scope (e.g., excluding aesthetic surgery).H. Arendt. Condition de l'homme moderne. Calmann Levy Ed., Paris, 1983, p. 286.

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[3] Mass drug distribution consists of prophylactic drug distribution to entire communities. It generally targets tropical diseases (e.g., with ivermectin, albendazole). We call it multifunction when several drugs are delivered together by one organization, in order to cut down on operating costs. Mass drug distribution can also be viewed as the object of a vertical organization led independently from health care services.

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