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Introduction

Much of the efforts made by the Board for the last few years, were focussed on strengthening the health services at district level by **private public partnership**, through the way of contracting. Half of the health services in sub-Saharan rural Africa are managed by church institutions. Contracting is a means to tune in the PHC activities of church and government, in areas where they are, as usual, operating independently from each other. A study is made on the moment by MMI and WHO to identify types of contracting at local district level, in countries where they are already applied and shaped in a sustainable way.

In November 2001 MMI participated in the WHO Inter-country meeting in Addis Ababa. Subject was: **Lessons from health sector experience in contracting in Africa**. In three national delegations the churches national coordinating body was part of the official deputation. A report of their presentations we like to publish already now.

Health Wealth and Aids.

"Health promotes Development" was the title of the Krefeld Symposium in 1994 organized by Action Medeor and MMI. It sounded like a contradiction: was it not development that counts? Without development, poverty and misery will continue. So not the doctor but the engineer is improving the world. Were it not the hygienic measures that diminished so dramatically in the end of the nineteenth century the tuberculosis? And not so much the medical treatment?

Dr Vennemann is saying the contrary in his article that he presented during the august 2001 conference on antiretroviral therapy at the Wuerzburg Medical Mission Institute. He is following Harvard economist Professor Jeffrey Sachs who states that the health related variables are usually the most powerful indicators of economic growth. Read the interesting article and you may conclude that health, e.g. the doctor, is given a key position in development.

Access to essential drugs.

Patent rights are keeping the prices high for the medicines concerned. But during the last year we have seen that consumer organizations, NGOs like HAI, MSF, Oxfam, and on the other hand national governments, are becoming restless, and are trying to get cracks in the wall of protection. South Africa's trial on compulsory licensing of antiretroviral drugs was a beginning. The anthrax threat made the US administration decide to ignore the TRIPS, the international Patent rights, in case of emergencies (while Aids is still not considered as a global emergency!).

There is another way to approach the problem of keeping prices of pharmaceuticals artificially high through TRIPS. That is the moral issue, that for instance antimalarial and antiretroviral drugs are an example of "global public goods". Guy Kegels takes this ethical approach in his reflection of, and action on improving the affordability and availability of essential drugs.

Health and Power

Rome was the place where MMI-members presented, during a conference, two papers and participated in the discussions. Health and Power was the subject. Power can be a benediction or a threat for health. And where do you find power? Not only in the state or among the multinationals, but at least as much in the religious institutions, the Church. While churches manage so many health institutions, they continuously have to reflect on the principle that their power is given and can only be accepted and used for serving people. So the MMI speakers went and gave their views. We report the summaries of the two presentations.

Health Care for All

During the European Union chairmanship of Belgium, the ITG, Tropical Institute of Antwerp, had a two day conference organized on the old adage: Health Care for All. Critical questions, not-reached goals, changes, utopia dreams or realistic targets? Discussions at European level. MMI participated as NGO. The final declaration is worthwhile to reflect on. This you can read at the end.

An important study with many practical hints is issued by the MMI members AGEH/action medeor. The study is based on the successful Health Insurance Scheme of Damongo,

Ghana, a community based initiative. The booklet is comprehensive, 50 pages, and full of practical advice for the growing number of health institutions which are involved or have to start a community health insurance scheme.

The publication is, again, called: **Health is Wealth**.

Health means development, meaning curing the sick at a large scale, and promises economic growth and prosperity.

Sake Rypkema

CONTRACTING

Lessons from health sector experiences in contracting in Africa

In November 2001 Medicus Mundi was invited to the WHO Inter-country meeting in Addis Ababa. On behalf of MMI Marieke Verhallen was delegated. The full report and the actions MMI will take in order to support and develop contracting is still discussed and not yet ready. But three countries had in their delegation also NGO partners from their national churches health associations. Therefore it is interesting to read their presentations as an official cooperation between State and NGO coordinating body.

In the next Newsletter we come back to this important subject.

Sake Rypkema

GHANA

Participants: MoH and CHAG representative.

Together they reviewed 'outsourcing' of non clinical services; the developments regarding the contractual arrangements between MoH/GHS and CHAG and its members; the case of contracting a health sub-district to the Anglican Church; and the contracting of specialist services between health facilities. With respect to the Memoranda of Understanding and district contracts for CHAG, the existing drafts are currently being reviewed and it is hoped that they will be signed in 2002.

The recommendations they derived from their experiences were:

- To be able to develop adequate policies accurate information on the private sector is needed. The health care management information system should be brought up to date by a specific research or survey;
- Effective collaboration between public and private sectors depends on the institutional capacity of government to enter, monitor and steer contracts. Developing that capacity should be given priority;
- Health Sector Reforms, which aim at increasing private sector involvement, should be implemented alongside economic growth strategies. Effective demand for private services can only increase when poverty is reduced;
- Private sector growth requires a conducive and effective legal and regulatory environment. The regulatory bodies have to be equipped, with human and financial resources and proper guidelines, so that supervision and regulation can be effective nation wide.
- To improve the quality of private sector services, protocols, guidelines, and publication of best practice examples should be widely disseminated and used as basis to determine performance standards in contracting.
- Private sector development also needs a conducive economical environment. Government and donors should facilitate private investments and provide incentives such as tax exemptions, training opportunities and subsidies for equipment.

TANZANIA

The participants came from the Presidents Office, MoH and its liaison office for the private sector, the CSSC and WHO country office.

The presentation, prepared by all the Tanzanian representatives, first reviewed the present arrangements with the Voluntary Agencies (mostly church health facilities, also indicated as Not for Profit), as largest private sub-sector (up to 85% of health care services in the rural area's) and first in line for the contractual plans. Then he placed the plans for contracting in the perspective of the Civil Service and Health Sector Reforms.

There are two grant systems for the Voluntary Agency facilities: the medical grant in aid and the District Designated Hospitals (DDH) arrangement. The first counts for VA hospitals, which do not have the DDH status, and consists of an annual block grant with budget indications for staff and bed costs. At present the main problems are payment difficulties due to budgetary constraints and lack of monitoring and evaluation.

The DDH agreements were initiated, in the early eighties, by the MoH to compensate for the lack of district hospitals. MoH and the bishop/ owner of a church hospital, well paced to act as district hospital, signed an agreement in which the hospital was assigned all district referral duties and

allocated a block grant to cover all running costs expenditures to the same extent as government district hospitals. Though no systematic evaluation has been undertaken, some lessons have been drawn. The important weaknesses of these agreements are:

- there are no provisions for non-compliance of either party (f.i. government grants have decreased and no longer cover the running cost expenditures);
- no indicators were established to follow output.

The achievements, however, were quite significant:

- the health infrastructure was developed;
- access increased to 93% of population living within radius of 10 km of hospital, and 75 within radius of 5 km.
- equity improved;
- manpower training was extended.

Within the scope of Civil Service Reforms contracting enters in the plans for non core services.

In the Health Reforms, promoting health service delivery by all private sector partners in close collaboration with the public sector, figures high on the agenda. Implementation is being done gradually: at present five zones have started. The Voluntary Agencies welcome the new structural attention for collaboration and are preparing themselves for it. Both MoH and the CSSC foresee that the contractual approach can be a valuable tool to realise Reform strategy.

UGANDA

The Ugandan participants represented the MoH/Public Private Partnership in Health (PPPH) desk, the Church Medical bureau's, and WHO country office.

The presentation had been prepared by MoH and Uganda Catholic Medical Bureau (UCMB) together. It mainly focussed on the developments regarding the collaboration between Public and Facility Based Private Not for Profit Providers (FB-PNFP) as this is most advanced. In the context of the country's Poverty Eradication Plan, the Health Sector Reforms and the SWAp, a collaborative framework with the private sector was establishment. The PNFP sector provides approximately 45% of the services in the country. Allocation of grants to the FB-PNFP was restarted in 1996 and has been extended and increased considerably since then. Among the criteria for allocation, workload, socio-economic conditions of the target population, presence of a training school, and presence of outreach services are the most important. As Poverty Alleviation Funds (PAF) are used for the grants, a first kind of contractual arrangement has been installed. This consists of a Memorandum of Understanding between the manager of the unit and the chief district administrative officer, an annual work plan and budget and adoption of the guidelines for the use, management and accounting of the funds. Functionally the PNFP units are becoming more and more a part of the district health system and in the next phase of decentralisation (health sub-district) PNFP units are assigned the leading role.

From the start of the SWAp process (1998) the PNFP co-ordinating organisations (medical bureau's) have been full member of the Health Policy Advisory Commission (HPAC). A number of structures are being put in place to ensure structural dialogue at national and district level (Desk officer in MoH and PPPH desk and working group, district PNFP desk officer and co-ordination committee).

The positive outcomes till now are a.o.:

- the collaboration goes beyond service delivery;
- access to services has increased and user fees decreased;
- transparency of allocations and money flow as well as efficient use of public resources has improved;
- preventive and promotive orientation and co-ordinated referral care are promoted.

The important challenges relate to:

- efficiency: the flexibility of the use of funds is quite limited at present, the delays / non release of funds cause great obstacles in operations and it proves difficult to quantify value for money;
- equity: physical nearness of units and non selective subsidising give rise to duplication and the user fees of the PNFP units restricts access for the poor (in public sector units fees have been abolished in 2001);

- partnership: operationalising and institutionalising is hindered by low awareness of advantages at district level (the decentralisation policy aims at devolution), low functionality of HSD, co-ordination and information exchange difficulties, and lack of support structures.

The next steps planned are:

- creating a clear policy framework (the draft has been developed during the last six months)
- developing the tools of the partnership (refining the service level agreements and designing formal contracts)
- improving the overall efficiency of and equity in health service provision.

With respect to developing a more formal contractual approach, the policy formulation process has given rise to hesitations regarding its need, the conditions required, as well as the risks. The MoH wants to first study:

- the comparative performance in PNFP service provision;
- the impact of contracting on the PNFP institutions;
- transaction costs;
- required capacity to enter into and monitor contracts;
- legal implications for PNFP and Local Government.

Health, wealth and AIDS

Matthias JP Vennemann

May 1, 2001

That healthier is wealthier has long been known. In the early 19th century, when one fifth of the population in England and Wales was too sick and too hungry to matter¹ - both socially and economically - social reformers like Edwin Chadwick argued that disease was a cause of poverty and an unproductive drain on the economic well being of the community². These reformers were convinced that better health created wealth³.

50 years ago Gunnar Myrdal noted in a lecture for the World Health Assembly that a "persistent condition of ill health in a country constitutes both the cause and the effect of a low earning capacity, widespread illiteracy, and minimum levels of nutrition and housing". Myrdal was confident that improving health in underdeveloped areas could start a virtuous cycle where better health and general development would mutually reinforce each other. In the early 1960s, Selma Mushkin⁴ - extending the human capital approach to health - argued that investing in health was a "facet of economic development", because it resulted in improvements in "the quality of people". All this foreshadowed the present debate about health and development.

Health is key to prosperity

When the G8 leaders met last year in Okinawa they said, "Health is key to prosperity. Good health contributes directly to economic growth. Whilst poor health drives poverty". This simple statement radically challenges previous views about the relationship between health and wealth. Classic economic theory saw health as the 'benign product of development', assuming that as countries were getting richer they would also develop the resources needed to improve health. The healthier is wealthier approach that expresses itself in the Okinawa statement draws on new empirical research challenging classic economic theory. New analyses show⁵, that - while wealthier may be healthier - the inverse is also true. Better health is not only the consequence of higher incomes, but also one of its fundamental causes. *Ceteris paribus*, countries with healthier populations tend to perform better economically.

A number of mechanisms exist that can plausibly explain, why improving health should result in better economic performance in poor countries. Better health increases economic productivity. Economic historians tell us that in the early 19th century, because of the combined burden of malnutrition and premature death a substantial proportion of the population in Europe was too sick and too hungry to matter both socially and economically. These analyses indicate further that one third of the total gain in labor productivity in Europe in the last 200 years, or so, were linked to improvements in health, nutrition and resulting gains in adult height⁶. There is now growing agreement that human capital constraints caused by high disease burdens in impoverished tropical (see below) areas are perhaps the most important single factor for slowing down labor productivity and economic development⁷.

Another channel that is important for the positive effects of better health on economic outcomes has to do with the fact that healthier children can learn better. Moreover, the expectation of a longer life appears to affect the savings rate, which - in turn - is related to investment. Finally, the 'new demography' tells us that changes in the age structure of populations that follow the change from high to low mortality and fertility in the demographic transition can contribute substantially to economic growth. Since the Second World War, East Asia - for instance - has gone through the fastest demographic transition ever. The whole process was started by health improvements brought about by public health programs starting in the late 1940s. The rapid decline in mortality produced a cohort of 'baby boomers'. When subsequently fertility declined, this resulted in decreasing dependency ratios, which -

¹ Robert W. Fogel. Economic Growth, Population Theory, and Physiology: The Bearing of Long-Term Processes on the Making of Economic Policy NBER Paper W4638 Sep 1994

² Elizabeth Fee. Public Health: Past and Present. A Shared Social Vision: Introduction to Georg Rosen A History of Public Health. Baltimore 1993

³ Gunnar Myrdal. Economic aspects of health. Chronicle of the World Health Organization, 1952, 6: 203-218.

⁴ Selma Mushkin. Health as an investment. The journal of political economy. 70(5) 129-157 1962

⁵ John Luke Gallup and Jeffrey D. Sachs, with Andrew Mellinger. Geography and Economic Development. CID Working Paper no. 1, March 1999

⁶ Robert W Fogel, Dora Costa: A theory of technophysio evolution, with some implications for forecasting population, health care costs, and pension costs. Demography 1997 Feb;34(1):49-66

⁷ Strauss J, Thomas D. Health, nutrition and economic development. Journal of economic literature, 1998 XXXVI: 766-817.

together with appropriate economic policies and progress in education – became one of the foundations of the East Asian economic miracle of the 1970s⁸.

An emerging paradigm of tropical underdevelopment

David Landes - in the first chapter of his book on the wealth and poverty of nations – describes in great detail the importance of geography and climate for economic development in history. This challenges views that all countries are similar with regard to their chances for prosperity and that nature's inequalities do not matter⁹. As of recently Jeffrey Sachs has attempted to merge the available empirical evidence about the divide between rich and poor countries into a paradigm of "tropical underdevelopment". Observing that economies in tropical eco-zones are nearly everywhere poor, while those in temperate zones are generally rich, Sachs speculates that the divide between rich and poor countries to a large degree is a geographical divide. Sachs argues that the results of recent empirical analyses indicate that among the many factors that contribute to explaining this geographical divide, poor food productivity and high disease burdens in the tropics stand out. Sachs' model of tropical underdevelopment suggests further that adverse geography diminishes agricultural productivity and health and thereby directly impedes economic development. Adverse geography, through different pathways, also impacts on the quality of institutions. Resulting low levels of development lead to low levels of innovation and slow technological change, reducing endogenous economic growth even further.

Sachs observes that only few economies in the tropics were successful in escaping tropical underdevelopment and managed to narrow the gap in income with the richest countries¹⁰. Those who did, have two things in common: they diversified their economies away from primary commodities and tropical agriculture in favor of export oriented manufacturing activities, and they managed to improve public health prior to the onset of modern economic growth.

All this opens perspectives for a development strategy in poor tropical countries today that emphasizes health improvements as a means to promote economic development and to alleviate poverty.

Health is key to prosperity, but what is key to health?

There has been a longstanding debate about the reasons for the decline in mortality in Europe and in other wealthy regions of the world since the 19th century. In the 1960s studies by Thomas McKeown on the historical decline of mortality in England and Wales informed a paradigm in international health that saw health improvements largely as the consequence of improvements in the general conditions of life, attributing only a relatively unimportant role to specific health measures^{11, 12, 13, 14}. Recent research challenges the conclusion McKeown drew from his examination of the historical record. The McKeown hypothesis stated that the decline in mortality was largely caused by improvements in nutrition starting in the early 19th century. Recent work done by Robert Floud¹⁵ indicates that the nutritional status of the general population in England only started to improve substantially in the 20th, rather than in the 19th century. New data on the timing of the decline of mortality in England and Wales indicate that it only started after the advent of the microbiological era. All this suggests that McKeown – as later Omran – understated the role of scientific inquiry and medical technology for improving health. In all likelihood, health improvements in the 19th century in England resulted from specific health measures employed by the public health movement cleaning up the congestion caused by industrialization, as has been inferred from a re-analysis of McKeown's data by Thomas Szreter¹⁶.

Similarly, the notion that improvements in the general conditions of life and increasing income were the most important factor for bringing about health improvements in developing countries between the 1930s and the 1990s – while the contribution of the health sector was minimal is

⁸ David E. Bloom and Jeffrey G. Williamson. Demographic Transitions and Economic Miracles in Emerging Asia. The World Bank Economic Review, Vol. 12, No. 3: 419–55, 1998

⁹ David S. Landes. The Wealth and Poverty of Nations. London 1998

¹⁰ Jeffrey D. Sachs. Tropical Underdevelopment. CID Working Paper no. 57, December 2000.

¹¹ Carl Taylor, Marie-Francoise Hall Health, population, and economic development. International health programs have an important role in promoting economic development and population control. Science. 1967 Aug 11;157(789):651-7.

¹² McKeown, Record G. Reasons for the decline of mortality in England and Wales in the 19th century. Populations Studies 1962 16, 94-122

¹³ Preston SH. The changing relationship between mortality and income in the 20th century. Population Studies 1975 (29). 231-48.

¹⁴ Kunitz S. The value of particularism in the study of the cultural, social, and behavioral determinants of mortality. In: Caldwell J et. al. (Eds) What we know about health transition. The Australian National University 1990: 92-109.

¹⁵ Roderick Floud. Height, Weight, and Body Mass of the British Population Since 1820 NBER Paper H0108 1998

¹⁶ Szreter S. The importance of social interventions in Britains mortality decline. a reinterpretation of the role of public health. Social History of Medicine. 1988 1: 1- 37

contestable. Early work done by Samuel Preston on the decline of mortality in developing countries between the 1930s and 1960s showed conclusively that changes in income, education and nutrition could only explain 30% of the health improvements that occurred during this time period. More recently, Jia Wang and others based on an analysis of 115 low and middle-income countries demonstrated that differences in income and education – account only for about 50% of health improvements between the 1960s and 1990s. Both Preston and Wang inferred from these data that in all likelihood the development and utilization of new health knowledge in the 20th century must have contributed substantially to the health improvements that occurred^{17, 18}.

It is relatively easy to show that irrespectively of country or household income, access to and utilization of preventive and curative health services and health status are strongly and significantly associated. Figure 1 – for instance – shows the correlations between child survival and health service utilization in 18 African countries with a median income of 675 US dollar per capita (Figure 1).

Likewise, it can easily be demonstrated that specific interventions can impact on the scope of infectious diseases as the main causes for the high burden of disease in poor countries. When chemotherapy against tuberculosis became available in western countries mortality and subsequently the incidence of tuberculosis started to decline in an accelerated fashion (Figure 2). Likewise epidemiological trends in leprosy from countries as diverse as Sierra Leone and China show that disease control measures can have a profound effect on the scope of this disabling disease, which only 40 years ago by many was perceived as the scourge of the millennium (Figure 3). Likewise, malaria control with DDT and chinin treatment starting in the 1940s had a substantial impact on the decline of mortality in countries where its these interventions were scaled up (Figure 4).

Against the most important causes for the high burden of disease in poor countries effective health interventions are readily available¹⁹. Scaling up these interventions could make a lasting contribution to improve health and human welfare. This could become the starting point for a virtuous cycle where better health and economic development mutually reinforce each other.

AIDS

Since the beginning of the AIDS epidemic HIV infected at least 50 million people and killed 16 million. Like a magnifying glass, AIDS shows the dialectical relationship between health and development. Rather than a virtuous circle, however, we see a downward spiral of disease and economic collapse.

That AIDS is a development issue cannot be seriously doubted. Many societal and economic factors from poverty and inequality to gender inequity and migrant labor contribute to the spread of HIV. But given the dynamics of HIV transmission, reducing the burden of AIDS effectively within an acceptable time span requires to make a difference between causes of HIV spread that are immediately amenable to change and those that are not²⁰. The control of AIDS cannot be made contingent on reaching overall development and poverty alleviation goals.

In most countries severely affected by AIDS, implementation capacity for health and development programs is low and likely to deteriorate rapidly because of AIDS. In this situation, expanding activities is unlikely to contribute to program success²¹. It rather appears that in this situation it will be necessary to set clear and narrow priorities in prevention and care.

From a disease control and management viewpoint, the currently favored broad, multisectoral and intensified approach against AIDS is counterintuitive. Most program documents fail to define clear priorities and – somewhat naively - suggest that everything that would ideally have to be done against AIDS could be done equally and at the same time.

Prevention²²

¹⁷ see 13

¹⁸ Wang J et al. Measuring country performance on health: Selected indicators for 115 countries. Washington DC, The World Bank, 1999 (Human Development Network, Health, Nutrition and Population Series).

¹⁹ Health: A key to prosperity, WHO 2000

²⁰ Jha P., Nagelkerke N. et. al. , The evidence base for interventions to prevent HIV infection in low and middle-income countries CMH Working Paper Series Nr Paper No. WG5 : 2. March 2001

²¹ Ainsworth M, Teokul W.: Breaking the silence: setting realistic priorities for AIDS control in less-developed countries. Lancet 2000 Jul 1;356(9223):55-60

²² This section draws heavily on the paper by Jha and colleagues

Reviewing the evidence base for interventions to prevent HIV infection in low and middle-income countries, Jha et. al. conclude that apart from a lack of resources, it is largely owed to the failure of bringing evidence-based interventions against the sexual spread of HIV effectively to scale, that AIDS is out of control. They remind us of the basic epidemiology of the heterosexual transmission of HIV. The reproductive rate of HIV depends on the transmissibility of HIV, the duration of infection and the rate of partner change²³ For large HIV epidemics to develop, the basic reproductive rate of HIV needs to exceed 1. In no national population yet studied the rate of partner change is high enough to drive the reproductive rate of HIV above this level. For that it needs a core group of sexually highly active people such as women in prostitution and their clients. As the growth of the epidemic depends on the mixing between this core group and the general population, controlling the spread of HIV in the core group is highly effective in preventing the spread of HIV in the general population. Proven effective interventions to control the spread of HIV in this core group are condom based peer group interventions among sex workers and among males with high-risk heterosexual behavior; and the improved management of bacterial sexually transmitted infections. The only country so far that has managed to do that on a national scale is Thailand and this was key to keeping HIV infection rates at low levels.

Similar approaches based on peer outreach and STD treatment have been effective to prevent the sexual transmission of HIV among men who have sex with men.

Other interventions that possibly prevent the heterosexual spread of HIV are voluntary testing and counseling. The role of male circumcision in the prevention of sexual HIV spread is presently being examined.

Contrary to commonly held beliefs, mass education campaigns and educational programs for young people - albeit having been shown to be effective in increasing the knowledge about HIV – have not been shown to result in behavior change neither in the general public nor among high-risk youth.

Interventions of proven effectiveness for preventing HIV infection among intravenous drug users are peer outreach, needle exchange programs and methadone maintenance programs.

Among the interventions that prevent the non-sexual spread of HIV through blood, HIV testing of blood transfusions, reducing the number of blood transfusions and recruiting low risk donors results in decreasing HIV transmission from the blood supply.

Apart from preventing HIV infection of mothers, short courses of anti-retroviral treatment and replacement feeding are the means to prevent mother to child transmission of HIV.

Treatments

An appropriate management of opportunistic infections and associated diseases can go a long way in improving the quality of life of persons with AIDS. The advent of antiretroviral treatments has resulted in a drastic reduction of AIDS related deaths in rich countries. The fact that prices for anti-retrovirals have come down substantially and that funds may be becoming available for the financing of anti-retroviral drugs holds the promise that these medicines will also become more widely available in poor countries. Recently plans have been published how these treatments could be implemented in Africa on a large scale^{24, 25}.

Model calculations suggest that the widespread use of anti-retroviral treatments should have a drastic effect on the prolongation of life expectancy in the most affected countries²⁶.

It has been argued that the availability of anti-retroviral treatments should be a strong incentive for voluntary testing and counseling and therefore contribute substantially to the prevention of HIV transmission²⁷. In this respect, concepts are needed that integrate prevention and care at the

²³ Anderson, R.M. (1999): Transmission dynamics of sexually transmitted infections. In: *Sexually transmitted diseases*, edited by K.K.Holmes, et al. pp. 25-38. McGraw-Hill, New York, NY. May

²⁴ Attaran A, Sachs J. Defining and refining international donor support for combating the AIDS pandemic. *Lancet*. 2001 Jan 6;357(9249):57-61.

²⁵ Consensus Statement on Antiretroviral Treatment for AIDS in Poor Countries by Individual Members of the Faculty of Harvard University. April 2000

²⁶ Wood E, Braitstein P, et. al. Extent to which low-level use of antiretroviral treatment could curb the AIDS epidemic in sub-Saharan Africa. *Lancet*. 2000 Jun ;355(9221):2095-100.

²⁷ It needs to be appreciated, however, that at this point in time, the effects of making anti-retroviral drugs more widely available on the spread of HIV is not known and can only be speculated about. Transmissibility of HIV - among other things – depends on the viral load of infected persons²⁷. As treatment with these drugs reduces the viral load they can be expected to reduce the spread of HIV. On the other hand, it has been argued that such treatments could be counterproductive from a preventive viewpoint, because their use may result in increasing risk behavior.

health care delivery level. The PROTEST approach currently under field-testing appears to be a particularly promising method (ProTest)²⁸.

Bringing HIV prevention and medical care for persons with AIDS to scale: some lessons from leprosy and tuberculosis

For bringing HIV prevention and medical care to scale in poor countries, and in Africa in particular, the history of tuberculosis and leprosy control offers some lessons that are worth mentioning.

Debate about treatment and social issues

When tuberculosis treatment became available in western countries in the late 1940s a debate emerged about the possible contributions these treatments could make to reduce the burden of tuberculosis. Rene Dubos, one of the leading tuberculosis experts of the time, noted that – given that tuberculosis was a social disease, treatment was unlikely to affect the scope of tuberculosis. Furthermore, he speculated that *M.tb* would rapidly become resistant against the new drugs and that effective treatment would probably only be available for a transitional time period. Dubos was convinced that the only way to improve the tuberculosis situation was through 'social betterment', and that medical interventions were relatively unimportant. He also feared that providing treatment was likely to obscure the social causes of tuberculosis and would therefore prevent necessary social change.

Commenting on this historical debate, Barbara Gutmann-Rosenkrantz notes,²⁹ „ it is useful to remember that ‚social disease‘ primarily affects the socially marginalized who can ill-afford to wait for the fundamental insights and social transformations that challenge well-established associations of disadvantage and disease”.

Today we know that in developed countries the widespread use of tuberculosis treatment accelerated the decline of tuberculosis mortality and of transmission of *M.tb* in developed countries. By contrast, the decline of tuberculosis in western countries was not followed by a commensurate decline in developing countries. Death rates from tuberculosis in Africa today are still in the same order of magnitude as they used to be in England and Wales in the 1920s. The primary reason for that is that before the 1990s only few countries effectively scaled up readily available interventions against tuberculosis³⁰.

Complicated treatment regimens

When new medicines became available against tuberculosis and leprosy in the form of multi-drug treatment diagnostic procedures and treatment regimens were relatively complex. In the 1960s and 70s the diagnosis of tuberculosis was mostly based on X-rays, and a great number of different drug combinations were used in the treatment of the disease. The drugs in use at the time required lengthy periods of treatment and often-different number of tablets had to be taken at different times of the day. Likewise, when MDT against leprosy became available, the diagnosis and the determination of treatment endpoints required complicated laboratory examinations and the special knowledge of leprologists. Over time, however, through practice and research, simple 'cook book' approaches developed which allowed to diagnose and to treat both diseases successfully on a broad scale even under the conditions prevailing in poor country health systems. Most uncomplicated cases of leprosy and tuberculosis today are diagnosed and treated by paramedics rather than by leprosy and TB specialists.

Before AIDS treatment can be made available on a larger scale, simple treatment protocols need to be developed. Questions that need to be answered are the following: When to start, what with, when to switch, what to, what monitoring, what populations, how to promote adherence and what OI prophylaxis to use³¹?

Infrastructure

Much has been made of the poor health infrastructure in countries affected by HIV as an impediment to a more widespread use of anti-retroviral medicines in Africa. Some have

²⁸ Maher D, Raviglione M. et. al. Draft Discussion Document. An evidence based approach to developing a new WHO/UNAIDS strategy for TB in high prevalence populations. Stop TB Working Group on TB/HIV. March 9,2001

²⁹ Barbara Gutmann-Rosenkrantz. Introductory Essay. Dubos and Tuberculosis. Master Teachers in: Dubos Rene and Dubos Jean. The White Plague. New Brunswick 1992

³⁰ Styblo K. Tuberculosis and its control: lessons to be learned from past experience, and implications for leprosy control programmes. Ethiop Med J. 1983 Apr;21(2):101-22.

³¹ Kevin DeCock Keynote Lecture: Heterogeneity and Public Health in the Global HIV/AIDS Epidemic. <http://www.retroconference.org/2001/hearlec.cfm>

argued that before anti-retroviral therapies could be made available to patients on a wider scale, first the health infrastructure needed to be built. The history of leprosy and tuberculosis control shows that this is a “straw man argument”. Those who doubt, that it would be possible to treat millions of AIDS patients on a regular base in developing countries - because of a lack of infrastructure and health staff - need to recall that in these countries only 15 years ago about 4 million leprosy patients were registered for and received leprosy treatment on a regular base. In Africa, the number of leprosy patients on treatment in 1985 amounted to 1 million in 1985. Because of the successful implementation of multiple drug therapy after 1985 – which was successful in spite of the bad infrastructure - this number declined to about 65,000 in 1999³². Even before MDT in well-run leprosy programs case holding was in the order of 80%.

It is true on the other hand, that the lack of an appropriate health infrastructure in many poor countries is clearly not helpful for implementing AIDS treatments on a larger scale. It needs to be appreciated, however, that the advent of new interventions can be a strong incentive for accelerating the building of an appropriate health infrastructure. When supervised short course chemotherapy against tuberculosis and MDT against leprosy were implemented in Tanzania in the 1980s this was accompanied by a number of measures that strengthened the health system in the fields of surveillance and reporting, drug supply, accountability, supervision, monitoring and evaluation and perhaps most importantly competence and self-confidence of the health personnel involved³³.

The model to emulate for scaling up AIDS treatment with anti-retrovirals is provided by the approach to tuberculosis and leprosy control developed by the IUATLD and associated leprosy associations in Tanzania^{34, 35, 36, 37}. The lessons learned in Tanzania, and subsequently in Kenya, Uganda, Ethiopia and Nigeria are directly applicable to AIDS.

As tuberculosis and leprosy, AIDS cannot be controlled without the commitment of political leaders and this commitment need to express itself in tangible terms. Before starting a treatment program on a larger scale, it is important that funding is ensured for a foreseeable time period. This funding – in most instances – will have to come from outside. In particular a secure stock of drugs and materials needs to be available. Bringing effective AIDS treatments to scale will further require a network of centers that can carry out HIV testing and whose quality is controlled. Finally an information system for recording patients in whom treatment was started and the degree to which patients comply with prescribed drug regimens will be needed for monitoring and evaluation purposes. Administering drugs in a supervised fashion as it is done in tuberculosis and leprosy control appears to be the best way – in the beginning - to ensure compliance. Regular supervision of health units that offer such treatments will be as important as a proper training and retraining of staff.

Compliance

If patients do not comply with prescribed drug regimens, this results in treatment failure and drug resistance. The fear of that HIV becomes resistant against anti-retroviral drugs is perhaps the most serious argument against scaling up AIDS treatments. This raises the complex ethical question whether the lives of people living and dying today, is less valuable than the lives of people living in future?

From a more practical viewpoint, both leprosy and tuberculosis control have developed approaches that are useful for enhancing compliance of patients with prescribed drug regimens. Directly observed drug treatment (DOT), blister packs and fixed drug combinations are important in this respect. On the other hand the quality of the services, their ‘client orientation’ and their accessibility also matter. Another important factor is that treatment needs to be available when it is needed. This is a formidable management challenge. Well-run leprosy and tuberculosis programs show that it can be done and that it is possible to bring up compliance to satisfactory levels. Frequently, the patients are seen as the problem. This is

³² Leprosy elimination campaigns – Achievements and challenges Weekly Epidemiological Record. No. 49, 2000, 75, 397–408

³³ Taylor C, Jolly R. The straw men of primary health care. Soc Sci Med. 1988;26(9):971-7.

³⁴ Enarson DA. Principles of IUATLD collaborative tuberculosis programmes. Bull Int Union Tuberc Lung Dis. 1991 Dec;66(4):195-200.

³⁵ Rouillon A. The Mutual Assistance Programme of the IUATLD. Development, contribution and significance. Bull Int Union Tuberc Lung Dis 1991 Dec;66(4):159-72

³⁶ Kober H: Meilensteine. DAHW 1996

³⁷ Chum HJ. Ten years of the National Tuberculosis/Leprosy Programme in Tanzania. Bull Int Union Tuberc Lung Dis. 1989 Sep;64(3):34-6

not true. Most of the time inefficient health services and unmotivated, unsupported, unsupervised staff are the root cause patients not complying with prescribed drug regimens.

Stand alone programs vs. integration

“Interventions must be delivered by health systems and health systems without effective interventions are useless”. A long-standing and ideologically charged debate exists about selective and comprehensive approaches in health system development. Already in the late 1980s, ten years after Alma Ata, Carl Taylor and Richard Jolly observed that this debate is counterproductive³⁸. They argued that it is possible to be comprehensive in goals and strategy, while being selective in choosing tactics and program interventions and list a number of misleading points of polarization. Pitting vertical against horizontal approaches is one of these wrong polarizations, because both approaches are needed for an effective delivery of health services. Leprosy and tuberculosis control provide examples, how to combine both and to successfully deliver the interventions that are crucial for making a lasting impact on the scope of these two diseases under all possible circumstances. Combining AIDS control with tuberculosis and leprosy programs appears to be a promising approach for the future^{39, 40}.

³⁸ See 33

³⁹ Bechelli M. The concepts and the development of combined programmes of leprosy and tuberculosis. *Acta Leprol.* 1985 Oct-Dec;3(4):305-16.

⁴⁰ Croft RA, Croft RP: Tuberculosis control is good for established leprosy programmes. *Lepr Rev* 1997 Jun;68(2):139-46

Figure 1

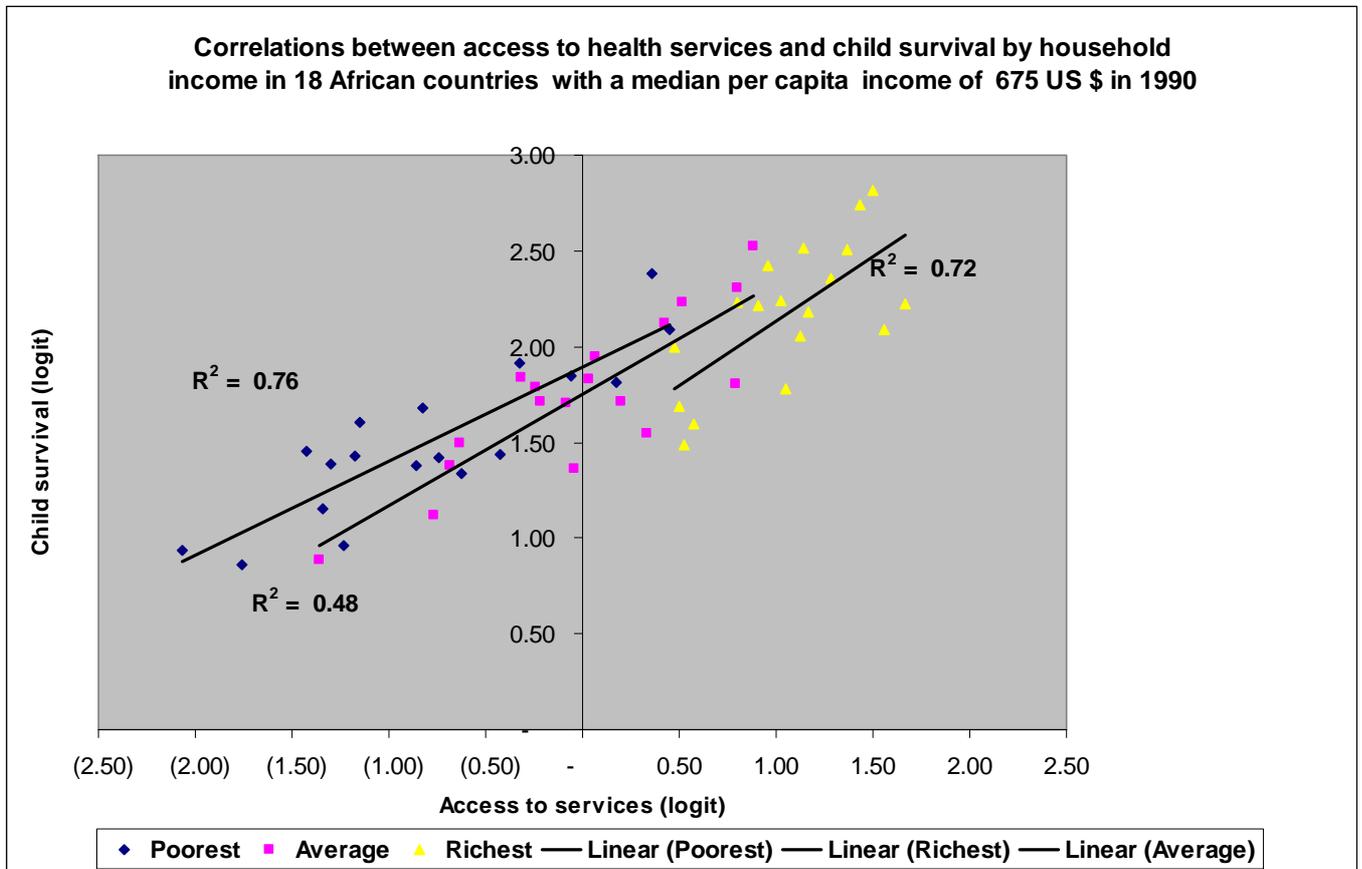


Figure 2

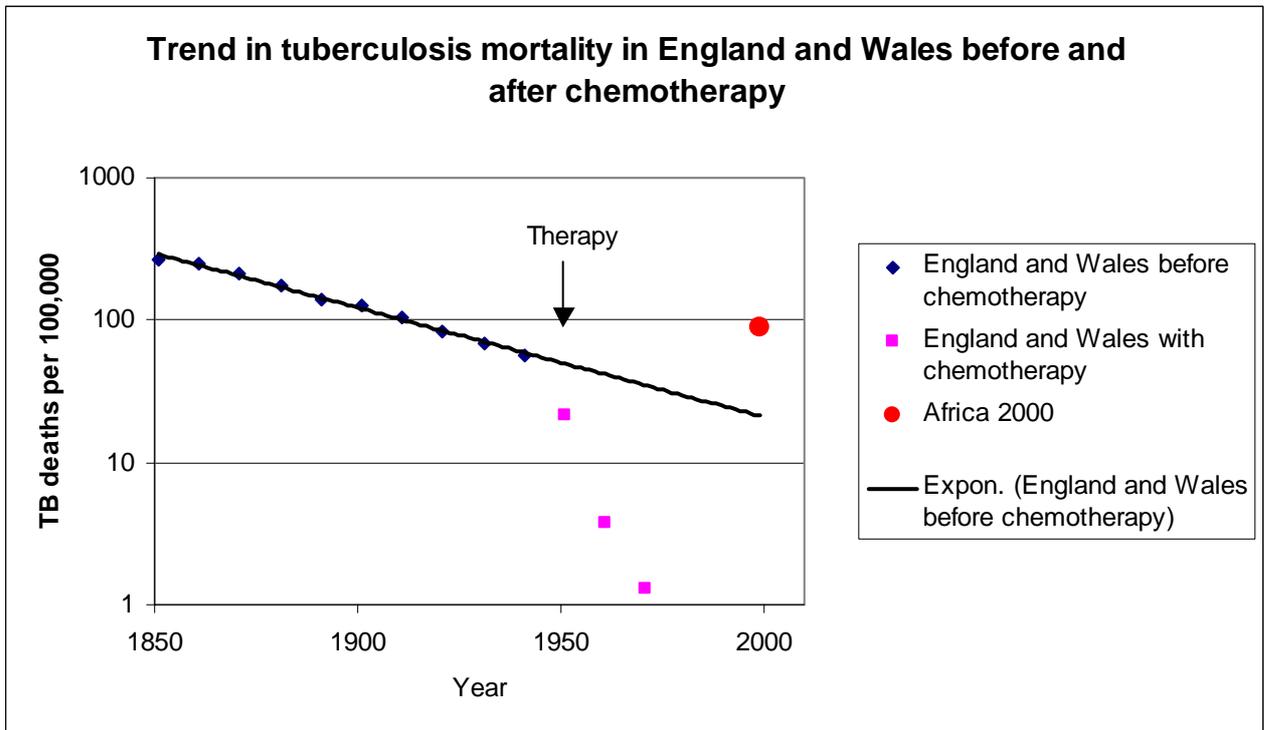


Figure 3

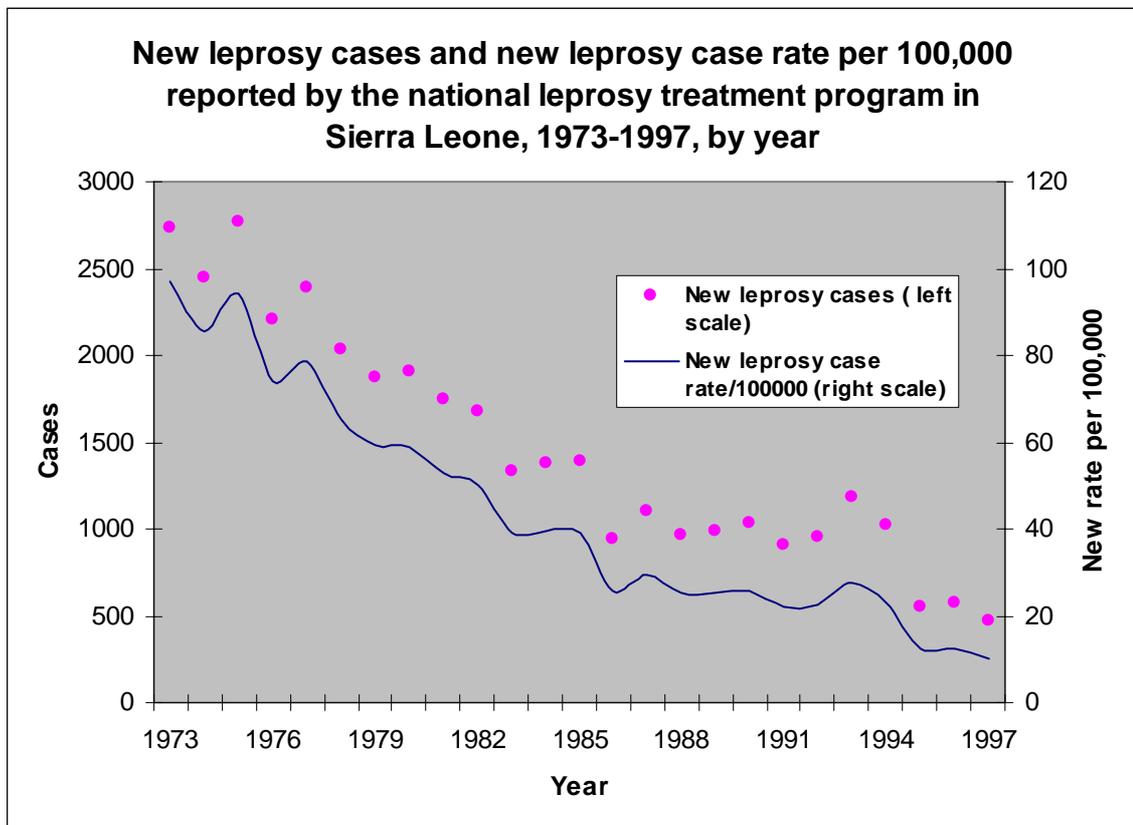
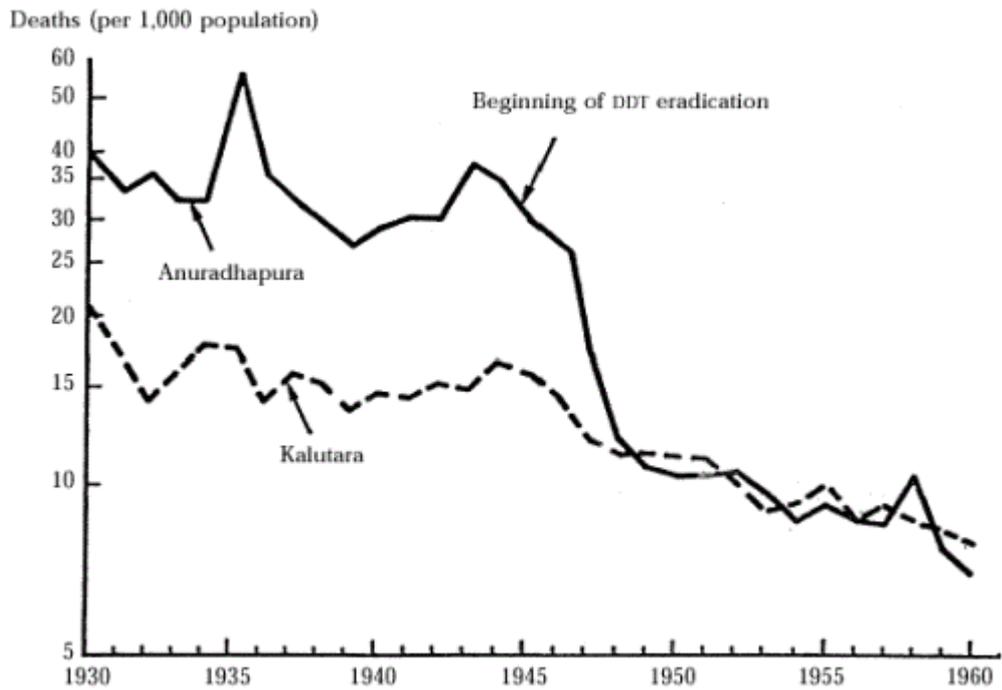


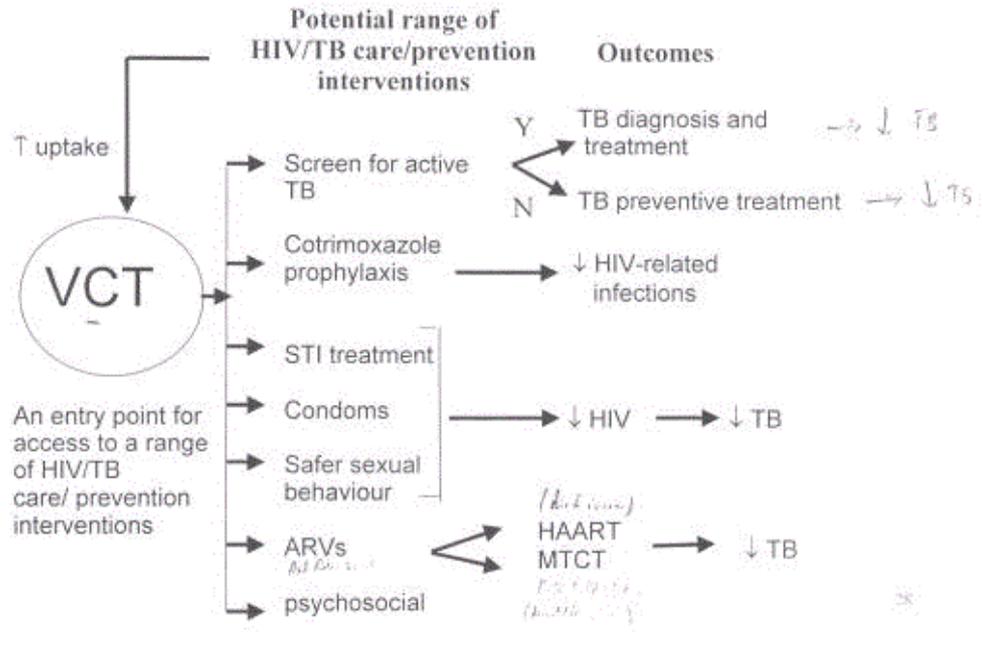
Figure 4

Figure 3. *The Effect of DDT Usage on Mortality in Sri Lanka, 1930- 60*



Source: Livi-Bacci (1992).

Figure 2. ProTEST - operationalising the links between TB/HIV care and prevention activities



Source: Draft Discussion Document: An Evidence-Based Approach To Developing A New Who/Unaids Strategic Framework For Tb In High Hiv Prevalence Populations
 Stop Tb Working Group On Tb/Hiv 09.03.01

Some issues in ensuring access to necessary pharmaceuticals

Guy Kegels

Introduction

'Redefining the unacceptable' – the expression came to me through Kerr L. White (1991)– is a dynamic and continuously ongoing process in the history of public health. Nowadays health (or at least the best possible health status) is considered to be a basic human right, which means that theoretically it should be attainable by all human beings. The extent to which this objective can be reached in practice, and the consensual agreements on strategies to get there, is also under constant pressure for change.

One of the elements to secure or restore health is the concept of essential drugs, which appeared officially in WHO documents in 1975, at the 28th World Health Assembly. In 1983 the Expert Committee, meanwhile created in order to respond to the Member States' request to the Director-General to advise them on the selection and procurement of these drugs, described essential drugs as « *those that satisfy the health care needs of the population; they should therefore be available at all times in adequate amounts and in the appropriate dosage forms* » (WHO 1983). Selection of the drugs to appear on the list was based on an evaluation of efficacy, safety, quality, price and availability. Sixteen years later, the Expert Committee, in its Ninth Report, added the affordability concept to the existing description, by supplementing it with the expression « *and at a price that individuals and the community can afford* » (WHO 2000).

Recent documents related to the reviewing of the procedures for updating the WHO Model List mention, among the several trends and developments that have an impact on the use of the List : « *The number of patented drugs on the WHO Model List is likely to increase in the future* »¹. In other words, the prices of these new(er) drugs are likely to be high, which creates tension with the affordability principle, reducing the individuals' and communities' entitlements to these substances. The price of pharmaceuticals is a very hot and topical issue.

Furthermore, the recent emphasis on 'global public goods' adds another perspective, or even another urgency, to the debate. Health is usually included in the list of examples of such global public goods (Kaul, Grunberg, & Stern 1999). to the extent that *bad* health or uncontrolled diseases have negative externalities that transcend the nation states' boundaries (spill-over effects). The health status of populations in developing countries is increasingly considered to be a global public good, as it is increasingly realised that, if it is bad, this negatively affects the health of people world-wide. If pharmaceuticals are necessary to improve bad health status in developing countries, it would then be 'wise' policy for rich countries to see to it that they are effectively available and accessible, and therefore affordable in conditions of relative or deep poverty.

The starting point of this exploration is that essential drugs, as defined here, are goods to which all individual entitlements should be guaranteed (comparable to food), while they are mainly developed, produced and marketed by large, profit-motivated and innovative organisations. To the extent that the accessibility-objective and the profit-objective can be opposed, an important element of the problem of accessibility of (essential) drugs can therefore be formulated as follows: how to organise forms of 'social control' – or societal control – on large profit-motivated organisations without endangering their capacity for (necessary) innovation and efficient production.

This is of course an extremely complex and controversial issue, and it will be impossible to produce any single or definitive answer. My aim here is to try and understand the mechanisms that are presently at work, in a realistic and sufficiently dispassionate way, and to identify a possibly common language and platform for a (more?) effective, balanced and productive interaction between the main actors. In this search for ways to arrive at what is 'reasonable', I will take the position that it is not possible to find an acceptable solution if the pharmaceutical industry's corporations limit their accountability exclusively to their shareholders, and I will draw much inspiration from Mintzberg's ideas and observations on

¹ WHO/EDM. Updating and disseminating the WHO Model List of Essential Drugs: the way forward (Revised version, 10 September 2001)

management and the place of corporations in society. I will end by examining briefly the proposal of differential (or 'tiered') pricing that has been put forward as a possible solution – or contribution – to the problem of affordability of essential drugs.

A problem?

Is there a problem?

When we consider affordability and access to pharmaceuticals on the established lists of essential drugs up till recently, we can observe policy-dependent results. If and where a coherent essential drugs policy at national level is implemented, like has been done in several countries in the framework of the Bamako Initiative, or otherwise, a majority of the population can have reasonable access to needed pharmaceuticals.

Major problems of availability-affordability can be foreseen, however, as important new patented drugs have to be considered for the status of essential drugs. If prices of these necessary new substances are left to the existing market mechanisms, they will be prohibitive for very large sections of humanity.

What is at the root of this problem?

From all available evidence it appears that the management of corporations in the present environment is under great pressure to maximise profit, not just to make it.

Socially desirable actions or decisions can be taken only as a function of their impact on eventual profit. The economic responsibility of management is perceived mainly in terms of accountability to the owners (the shareholders), even if this ownership is diffuse. Social responsibility of management is then reduced to (1) social goals internal to the organisation, and (2) quality assurance of their products vis-à-vis the outside world composed of their customers (including the representatives of the latter in the form of controlling agencies) – not including equitable distribution to those in need.

As this is the nature of profit-oriented organisations in a now global capitalistic market economy, these corporations would not have to be morally blamed for acting as they do; rather, the socially negative consequences of this economic behaviour should be (1) recognised, and (2) corrected if necessary. Failing that, we would have to conclude that there is insufficient social control over these organisations.

What are the mechanisms?

The search for a monopolistic position in a high-technology market.

Innovative pharmaceutical industry operates in an environment that is highly competitive in its challenges (developing the best medication for existing diseases, accepted as such by the medical professionals as well as the authorities). Corporations are thus highly innovative in this environment as far as their R&D activities are concerned (which are high-tech and expensive). Once the product is developed, they will protect this investment as much as possible by obtaining an exclusive marketing position and holding on to it as long as possible – like any other business would do.

Strengthened by the growing size of these companies?

Economically successful pharmaceutical corporations are large. This is dictated by the continuously important, not to say enormous, R&D investments necessary to keep in business, and by the efficiency of the practice to acquire small but one-time successful companies into larger divisionalised entities, in which the cost of competition is neutralised and in which R&D investment funds can be allocated more efficiently – thus further reducing the cost of competition. The recent mega-mergers only seem to confirm this tendency.

Resulting in mega-sized companies operating more and more as 'closed systems' instead of as 'instrumental' ones (Mintzberg 1989).

We have reached a moment in which a very small number corporations are seen to control the lion's share of the world's innovative pharmaceutical market one way or another. As they grow in size, they naturally grow in power and become less and less instrumental for outside controlling agencies or for a directing external "constituency", even if they once may have had the explicit mission to produce a socially highly desirable good. It has been claimed that, historically, the main principles of pharmaceutical research were developed in the context of the highly successful search for drugs active against the devastating tropical diseases.

Especially the sleeping sickness epidemics in the early years 1900 provided a powerful impetus for the development of a systematic research methodology for synthetic antimicrobials (Williamson, 1970). This can certainly be considered as a highly 'social' mission, even if it can of course also be viewed as a necessary condition to make the colonial project possible at all.

Shareholder structure becomes more and more institutionalised because of stable high profits – a self-firing /-fuelling mechanism toward profit maximisation.

The main motivating force for the management of these big companies are the owners, the only power to which they are, in the final analysis, economically accountable. However, the big companies' shareholding has become more and more diffuse as far as individuals are concerned, and at the same time more and more concentrated in the (impersonal) hands of institutional shareholders (such as - i.a. - the notorious large pension funds). The latter, in order to pursue their (often highly social) goal, understandably, seek to invest in low-risk, high-profit companies, and the result is that their prime interest is in maximum profits, high dividends and rising share values, so that their assets are maximised. Thus these investors may also contribute to fuel the purely economic logic of pharmaceutical companies with at least a partially social mission.

Finally, the transnational and complex nature of these corporations, operating in a very transnational market, is not conducive to high transparency.

What are the options for control – what are the most appropriate ones?

The question here is to know how society can bring – or keep – its large organisations under sufficiently adequate social control without endangering their capacity for efficient production. Large organisations tend to seal themselves off from external influence and control (becoming powerful 'closed systems'). Hence, they can determine to an increasing extent what will happen to large and important aspects of society. If one takes the position that organisations are created – or exist – to *serve* society, in the final analysis, it becomes legitimate to ask how society can try to see to it that this happens.

Mintzberg² (Mintzberg 1989) describes a spectrum in which 8 types of control mechanisms can be distinguished, some of which correspond to rather specific conditions (e.g. nationalisation, regulation, inducement), while others are of a more general application. Table 1 provides an overview of these options, in an order of decreasing public interventionism.

² Mintzberg H. (1989) Who should control the corporation? In: Mintzberg on management. Inside our strange world of organizations. Free Press. Pp. 303-329

Table 1. Mintzberg's spectrum of options for societal control over large organisations.

Control mechanism	Conditions / forms
◆ "Nationalise them"	<ul style="list-style-type: none"> - If a mission deemed necessary in society is not provided adequately by the private sector - If activities are so tightly linked to government policy that they are best managed as a direct arm of the state
◆ "Democratise them"	<ul style="list-style-type: none"> - At <i>overseeing</i> level (worker or pluralistic <i>representative</i> democracy) - At <i>internal decision making</i> level (worker or pluralistic <i>participative</i> democracy)
◆ "Regulate them"	<ul style="list-style-type: none"> - To control tangible externalities - To control asocial behaviour induced by too severe competition
◆ "Pressure them"	<ul style="list-style-type: none"> - Ceaselessly – it is always possible...
◆ "Trust them"	<ul style="list-style-type: none"> - If they can be 'socialised' sufficiently; Nobody is entirely <i>irresponsible</i>
◆ "Ignore them"	<ul style="list-style-type: none"> - If 'it pays to be good' (?) Rarely if ever ? ...
◆ "Induce them" (provide them with inducements - incentives)	<ul style="list-style-type: none"> - If social problems exist that cannot be attributed to specific corporations (otherwise <i>regulation</i> would be called for), yet require the skills of business for solution
◆ (Restore them to – pure – shareholder power)	??

Some clarification is useful on the option "democratise them". By using two dimensions to this democratisation concept (internal employees vs. external interest groups and overseeing level of decision making vs. the internal process of decision making), a set of 4 combinations emerges:

1. *employee representative* democracy (employees represented in the board)
2. *pluralistic representative* democracy (external interest groups represented in the board)
3. *employee participative* democracy (employees participate in internal decision making)
4. *pluralistic participative* democracy (outsiders participate in internal decision making)

In terms of the outward social responsibility, especially the combinations 2 and 4 may be workable or worth exploring. This could take the form of including directors in the board who are representatives of 'public interest' (2), or admitting outsiders to participate in formulating the objectives of new products (4).

Like in much of Mintzberg's work, it requires a certain amount of 'belief' to accept an enumeration of control mechanisms like this one. However, it is forcefully argued and appeals very much to common sense, once his point of view is understood: Mintzberg's reasoning is not primarily based on a political stance on the left-right or whatever other axis, but rather on his understanding of organisational theory in the present day world. It is about what works in an organisational sense. To my mind, this makes good sense.

One example is his reluctance to apply the extreme positions in this spectrum (the first and the last: 'nationalisation' and 'restoration') on the grounds that "*the evidence suggests that social difficulties arise more from the size of an organisation and its degree of bureaucratisation than from its form of ownership.*" Both forms of effective ownership referred

to by the extreme positions (the government in the first, private shareholders in the last) assume the organisation to be the instrument of some dominant group of (external) influent people, which results in no difference concerning the form of the organisation likely to result from that ownership. Mintzberg's position is not politically neutral, it is just not positioned – or not primarily – on a left-right axis.

This spectrum of control mechanisms is not necessarily complete, of course. Furthermore, it may well be that none of them is really or immediately applicable to the problem at hand, as the context in which the latter is situated is a transnational or global one. Still, the necessary institutions to accompany evolutions globally are developing, or existing global institutions are adapting their roles. To the extent that these developments are effective, more adequate or better-balanced solutions may be found. At least, Mintzberg's spectrum provides a coherent set of words for analysis, rational discussion or even dialogue.

Differential – 'tiered' - pricing

Several attempts have been made to invent mechanisms, within and/or compatible with the competitive market system, that would help to motivate the pharmaceutical industry's corporations to be interested by the market of the poor. Practical examples include the International AIDS Vaccine Initiative,³ Malaria Vaccine Initiative,⁴ Action TB,⁵ and an idea, to my knowledge not yet much publicised, baptised 'transferable market exclusivity'⁶, which would allow extended market exclusivity on a profitable (existing) medicine in exchange for development of an 'orphan' product for developing world patients.

The problem of the highly unequal purchasing power between the rich and the poor may find a solution – or may be turned into an opportunity – in the proposal, backed by the present European Commission, to develop systems of differential (or 'tiered') pricing. The idea here is, basically, to adapt prices to purchasing power. The R&D investment would be paid back through high prices for the rich whereas the poor would pay prices more close to real production cost. In order to be workable and 'fair' within the global economic system several safeguards would need to be developed, which can be summarised as safeguards against 'fraud' and against some form of 'free riding'. Fraud could be committed by traders buying up the product in poor countries at low price and selling it back to rich markets at high prices. Free riding would occur, simply put, if the rich had access to the cheaper products.

Tiered pricing assumes that it is possible to stratify countries, communities, groups, or individuals according to their ability to pay. For the extremes on the spectrum, if the stratification is to be done at the level of countries, this is clearly possible; the practical difficulties for this type of stratification in the intermediate groups, and at the level of existing subgroups within a country, are clearly very difficult to manage (stratifying populations – and/or individuals – according to ability to pay, and consistently applying stratified prices to them). But maybe this is a case of 'the best being the enemy of the good'. It is not because something cannot be expected to work perfectly that it would not be able to do a lot of good,

³ Established in 1996; participants are developing countries, vaccine and biotechnology companies, research institutions, NGOs, governments and private corporations; purpose: support the development of safe, effective and accessible HIV vaccines for use throughout the world, but particularly those that could be used in developing countries, see <http://www.iavi.org/>.

⁴ Established in 1999; initiative of the Program for Appropriate Technology and Health; purpose: accelerate the clinical development of promising malaria vaccine candidates and ensure future accessibility to the developing world, see <http://www.alltheweb.com/go/1/H/www.malariavaccine.org/res-int-gwperkin.html>.

⁵ Established in 1993; 10-year industry-academia partnership; purpose: identify new drug targets and vaccine candidates for tuberculosis, see <http://www.alltheweb.com/go/1/H/www.uct.ac.za/depts/mmi/1steyn/glaxo.html>.

⁶ Bourgeois J & Burns T (2001). Transferable Marketing Exclusivity: an Incentive for Development of Medicines for the Developing and Least Developed World. Brussels Office of Akin, Gump, Strauss, Hauer & Feld.

in its imperfect form; not doing it because it is imperfect would then be a lost opportunity. Yet, in the case of differential pricing, very careful planning and management will be needed, and not only to ensure fairness. The situation being what it is, it can also be anticipated that increased availability of new and potent pharmaceuticals in a low performance health care services environment is going to create problems of absorption and misuse.

Differential pricing, in order to work, would have to be based on (1) a product needed by the rich world as well as by the poor one, and (2) a sustained willingness of the rich(er) to systematically subsidise the poor(er). Herein lies its beauty, but, evidently, also its weakness. If self-interest were the only motivating force, then it would only be considered by the rich if the diseases of the poor can also happen to them. In the case of diseases that are (almost) exclusively concentrated in poor countries, the concept of tiered pricing, originally simple, would be far less attractive or it would have to be broadened to or complemented with more complex and abstract formulations of utility – or simply expressions of solidarity.

'The unacceptable' will continuously need to be redefined.

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Health and Power

XVI International Conference, Pontifical Council for Health Pastoral Care. 15-16-17 November 2001, Vatican City.

Summaries by Mr. B. Pastors en Dr. E. Widmer

Practical actions to be promoted in relation to the power of pharmaceutical industries

Bernd Pastors, action medeor / MMI

Hundreds of millions of people in the poverty-stricken regions of our world have no access to urgently needed and life-saving drugs. According to a definition by the WHO, four factors:

- rational selection and use;
- affordable prices;
- sustainable financing and a
- reliable health and supply system

and five actors:

- governments of developing countries
- governments of the industrialized nations
- pharmaceutical companies
- consumer groups and NGOs
- international organizations and foundations

determine the complex area of drug availability.

By creating and supporting a worldwide supply network for essential drugs for about 11,000 partners in 130 countries, action medeor is helping particularly small health centers to maintain access to essential drugs.

The establishment and maintenance of local procurement centers in Africa, Asia and South America helps strengthen local structures and is a way to greater independence. Access is also improved through the rational use of drugs, the provision of expert assistance and a sustainable financing of healthcare provision. The establishment of a quality assurance system as recommended by the WHO and set up of local pharmaceutical production facilities wherever technically possible, is also extremely helpful.

Permanent frank dialogue with representatives of the pharmaceutical companies aids understanding of the interests of our partners and reduces mistrust. Cooperation rather than confrontation helps the approach of "one step at a time". Whereas lobby groups such as BUKO, use the media to denounce loudly and provocatively the misdeeds of the pharmaceutical industry, within the calmer atmosphere of the dialogue, the shortcomings are objectively discussed and solutions and improvements are devised.

Provocation by the lobbying groups and objective dialogue between church groups and the pharmaceutical industry are not mutually exclusive.

In view of the increasing mergers between pharmaceutical companies, this dialogue between the pharmaceutical industry and the churches should take place in all industrialized countries. Such discussions would supplement and complement the international lobbying campaigns of MSF and Oxfam, amongst others. A worldwide network of dialog programs and a mutual exchange of experiences would certainly improve access to essential drugs.

Practical actions to be promoted in relation to hospitals and other health centres

Edgar Widmer, MMI

Speaking of health, power and actions to be promoted in relation to hospitals and other health centres we will consider the first referral level, institutions within the so called District Health System.(DHS), which has to be considered as the nucleus of a National Health System. Most Church-bound Health Institutions are part of this peripheral level and in many countries of sub Saharan Africa they represent up to 40 percent of the overall health services. The owners of these institutions have a great responsibility for their integration into the DHS and here lies a great potential for reaching optimal efficiency of health services. Power is not only defined as force joined to intelligence, but as capacity to generate consensus. Power has to be shared and channeled according to competence and in the interest of certain values and rules: What is the vision of the Churches role for health, does there exist a Mission Statement, a Policy Statement or a Diocesan Health Concept? Is the power shared within a National body of Non Governmental Health Institutions? How far does the Concept of Health Pastoral or Charisma play a role? What about Ethical Standards, Human Rights, National Health Policy? We have to consider medical professional directives and social obligations towards the employees. Further factors are the financial constraints, the communities' participative involvement and donors' conditions.

The above given framework concerning power is discussed. Indications are given on instruments for power, insisting on a dispute, free of command, in which convincing each other is the main prerogative.

As a conclusion the proper and democratically controlled use of power can be identified as a real service for the well being of the single and society and represents an enormous potential for the improvement of efficiency in the Health Care System.

Norms which determine power

- I. Vision of the Churches Role for Health.
Mission Statements and Policy Statements
Diocesan Health Concept
- II. Policy of the National Co-ordinating Agencies of Church Related Health Services
- III. Concept of Health Pastoral
- IV. Charisma
- V. Ethical Standards
- VI. Human rights
- VII. National Health Policy
- VIII. Medical Professional Directives
- IX. Social Obligations

DECLARATION ON "HEALTH CARE FOR ALL"

Formulated and endorsed by a ministerial working group and the participants of the "Health Care for All" Meeting, Antwerp, 25-26 October 2001 *

PREAMBLE

Health care in this declaration is not limited to health providing curative services but also includes health promotion, prevention, rehabilitation and cure.

Access to adequate health care is above all a fundamental human right, and thus a social, economic and political issue. Poverty, inequality, violence and injustice are still at the root of ill-health and death in many low income countries. Ensuring health care for all demands a review of the impact of globalisation, within a coherent socio-economic and political framework aiming at sustainable human development.

The universal objective of "Health for all", called for by the World Health Organisation and all its member states in the Alma Ata Declaration of 1978, has not yet been reached. Where states have played a strong role in social investment, and in particular in health systems, substantial improvements in the overall health conditions of their citizens have been made. These successes have largely been based on the interplay between the public demand for health services, better living conditions and adoption by the State of community supportive approaches to ensure universal access to health care, consistent with the spirit of Alma Ata

For many low income countries, however, the increasing burden due to HIV/AIDS, tuberculosis, malaria, other tropical and infectious diseases, malnutrition and non communicable disorders, as well as the health needs of populations at risk from natural and man made disasters, have severely worsened and complicated the challenge to reach "Health for All".

In addition, economic restructuring has lead to reduced public spending, shortages and demotivation of staff, lack of resources and training, poor maintenance of infrastructures. International and national market failures contribute considerably to the imbalance in the global access to health care. The scarce human resources available for the health sector are limited or even reduced by structural adjustment programmes and brain drain. International assistance to low income countries, directed at strengthening national and local health systems and improving health, has not responded adequately nor timely to the increased needs.

Having reviewed their achievements, problems and needs, the participants of the meeting have formulated and endorsed the following declaration.

We consider that:

Access to health care is a fundamental human right. While recognising health for all as the ultimate goal, accessible, efficient, adequate and equitable health care for all is the most urgent need for improving global health, fighting diseases and reducing poverty. Pursuing the goal of providing accessible health care to all is also a common agenda behind which all stakeholders can unite their forces, for the following reasons:

- (1) **Social** - access to health care is a key to poverty alleviation, socio-economic productivity, human development and political stability;
- (2) **Medical** - quality health services are essential for proper case management, and the sound use of drugs, vaccines, health technologies and commodities;

(3) **Epidemiological** - well structured and functioning health systems are indispensable for the sustainable control, prevention and surveillance of diseases;

(4) **Scientific** - new tools and methods need adequate health systems for efficient application and the adherence to medical ethics of research;

(5) **Economic** - adequate and well financed health systems provide the structural market conditions for the distribution and development of drugs, vaccines and commodities;

(6) **International** - universal access to health care is crucial to reducing poverty and to realising the development goals in health of the Millennium Summit of the United Nations and other initiatives.

We recognise that:

(1) States have a responsibility to ensure the best possible health for their people, who have a right and duty to participate in their health improvement. The international community has the obligation to assist low-income countries in reaching their social goals, especially access to health care for all and the reduction of the burden due to poverty-related diseases.

(2) Governments must provide the necessary stewardship, by creating optimal policy frameworks and conditions for all stakeholders in the health system, assuring and co-ordinating adequate public and private inputs, and guiding international assistance. They must ensure accessibility, particularly for the poor, financial sustainability, quality, efficiency and fairness of the health systems. Health services should be client oriented, responsive to the needs and demands of the population, and fully respect the individual.

(3) The international community has the duty to provide all necessary financial investments and technical support to low income countries in order to ensure global access to health care, but must also promote fair market mechanisms for essential drugs and commodities, and the development of the human resources in the health sector.

(4) Health research must go beyond the development of new drugs and vaccines. Research on the improvement of health systems and of existing control interventions must be strengthened. Strong emphasis should be given to the reinforcement of the research capacities in the disease-burdened countries, the development of international networks, and the linkage between the research communities and the policy makers, health workers, civil society and the population.

We call on:

national governments, international organisations, and all agencies and individuals concerned with health and development to:

(1) Recognise access to health care for all, requiring adequate human resources, infrastructures, essential drugs and commodities, as a basic human right, and as essential for the control of the poverty related diseases.

(2) Acknowledge the need for multi-sectorial approaches to reduce the burden of HIV/AIDS, tuberculosis, malaria, and other infectious and non-communicable diseases.

(3) Ensure that specific disease control programmes strengthen regular health systems and that they are co-ordinated with other programmes and interventions;

(4) Ensure that health systems are responsive to the needs and expectations of the populations, contribute to improving health outcomes, and ensure fair and sustainable financing;

(5) Strengthen in partnership the financial, logistic, operational and scientific capacities of the low-income countries to improve their health services and disease control programmes, and to orient international research to the needs of the people and the health systems;

(6) Ensure that market mechanisms allow and promote global access to essential drugs and health-promoting commodities, and to facilitate and encourage the development and management of human resources in the health sector.

(7) Share this declaration and the goal of "Health CARE for All" as a common agenda behind which all stakeholders can unite.

This declaration supports all health initiatives to realise "Health for All" and renews the commitment of the International Community to provide "Health Care for All".

* The meeting on "Health Care for All" in Antwerp, Belgium on 25-26th October 2001, initiated by the Belgian Government as President of the European Union and the Antwerp Institute for Tropical Medicine, was attended by Ministers and Directors of Health of the fifteen African partner countries of Belgium, directors and high-level representatives of the European Union and its member states, of UN-based and non-governmental organisations, of the pharmaceutical industry, and scientists and experts concerned with world-wide health development and disease control.

Further information can be found on www.itg.be/hca

Round about the Antwerp Meeting

Edgar Widmer

The world, still under the shock of the terrorist's attacks of September 11th, is fighting under the lead of the USA a battle against the aggressors and no one knows where war is leading nor whether justice can be reached.

We only know that enormous amounts of money are invested and eventually diverted from other urgent needs in order to revenge the 5,000 to 6,000 killed persons of New York and Washington. Upon this a few dozens of Antrax cases keep the whole world in alert and are part of our daily news.

Despite the terrible tragedies the conference organised by **the Belgian government and the Antwerp Institute of Tropical Medicine as part of the EU-presidency came up with a call for "Health Care for All"** as a response to the much greater tragedy the world community is living in. The health crisis of today is of an apocalyptic dimension and has straight links to the poverty of billions of people.

Only since a few years the Worldbank has changed its policy. The slogan "No Aid, but Trade" has changed. Its director Wolfenson after the 11th of September has declared: "The conquest of poverty is the quest for peace". As a matter of fact, since the beginning of the new millennium, the European Union, UN-agencies and the G-8 currently are disputing several international initiatives, such as establishing the Global Fund for AIDS, Tb and Malaria, to improve drug accessibility by price reductions,- to offer debt release for the Least Developed Countries, - to improve trade conditions and so on.

The third United Nations Conference on the Least Developed Countries on May 16th 2001 declared the fight against poverty as a crucial element of UN-programmes, since the number of impoverished countries within the last ten years has nearly doubled.

It has been declared that health is the main condition for enhancing productive capacities in order to overcome poverty.

In Antwerp health care has been declared as a basic human right and as the prerequisite for the fight against the main infectious diseases. Even with free drugs, antiretroviral treatment (ART) for AIDS is not possible without solid medical structures. The universal strategy for tuberculosis control, the so called "Directly Observed Treatment Short-Course" (DOTS) needs "observers". WHO's Roll Back Malaria (RBM) programme calls first of all for strengthening the health care service.

We were informed that the newly created Global Fund should have reached 10 Billion Dollars. The response to this appeal was rather poor compared to the money the security efforts after September 11th will cost, not to speak of the ongoing war expenses. About 1,5 Billion Dollars are available. (In these days the Swiss will spend three times more for the revival of a national air company). At least the Global Fund should gender additional money to the current Government budgets. The Fund is principally based on partnership between the governing board of the fund and the receiver-countries and within the receiving countries on partnership between Government and its Health Institutions including NGOs. It is hoped that the Fund becomes operative on January 2002 and that it will be able to accelerate activities such as political commitment, strategies for change, administrative preparedness and leadership.

Speaking of **partnership** it was mentioned that it has to be based on mutual respect, comprehension, complementarity, reciprocity, dialogue and sharing. Once a consensus reached, agreements and well defined **contracts** may follow. Equity is a main target but notwithstanding decentralised money allocation may create inequities when each province or region uses different criteria for training, curing and prevention or concentrates on some issues while leaving others aside.

Partnership with the private sector needs criteria for accreditation, being aware that health services for the scope of profit can be another reason for inequities

How to increase national health budgets?

- The Global-Fund for AIDS, TB and Malaria, as mentioned, provides **additional** money to the national health budget.
- There is the tendency and an urgent need to increase the national health budget up to the target of 14 % of the whole budget (Why not reduce the defence budget?).

- The debt release is another factor of income.
- The aid of donor countries should reach the target of 0,7 % of their gross domestic-product
- reduction of health costs may be reached by price-agreements with the pharmaceutical industry
- security, stability, continuity and a clearly defined multisectorial national health policy avoids misuse of money and wastage.
- democratic control promotes good governance
- the memory on cultural values and the traditional capacity of survival is part of a nations capital
- last but not least the human resources are the most important capital of a society.

The importance of human resources.

Health worker performance is key to the operation of health services and is under multifactorial influence. A living wage is an obvious prerequisite for health worker morale and motivation, but though it is a necessary condition for good performance, it is an insufficient one. This applies in force in a weak regulatory environment where liberalising economic reforms result in a decline of community values and a rise in self-interested behaviour. A multidimensional programme of public health worker rehabilitation is needed including some components like: provision of decent living and working conditions, including adequate supplies of operating inputs, especially drugs; quality improvement programmes, regular support from trained supervisors, participatory management systems and an incentive structure offering professional and financial rewards for good performance.

Individual contracts between the employer and the health worker should regulate the above mentioned circumstances under the condition of a satisfactory adherence of the given job description, and working hours; no informal charges; no misappropriation of drugs, materials or money; and no poaching of patients to private practise.

The selection of staff should follow a merit based and transparent selection process providing equal job opportunities. Internal ongoing training should lead from a basically programmatic training to management training and finally to the transmission of a corporate culture allowing identification with the institution's philosophy.

Lack of money is the key reason why the human resources are badly off in most developing countries. While in most countries enough staff is trained, many Governments can not afford the employment of those they have trained. From Uganda I heard that every year about one hundred of the newly trained doctors remain without any possibility to find a job and they never get the necessary practice. for what they learned. The situation for nurses is similar or worse, an enormous waste of investment. And those who have work too often are frustrated. Absenteeism, corruption or misappropriation of drugs and money can be the consequence. Finally brain drain causes enormous losses for so many developing countries. Thousands of African doctors work in industrialised countries.

Why in such a situation external aid never covers salaries of local staff, while expatriates get ten and much more times higher salaries.?

Many speakers of the conference have urged to find solutions for the impossible situation of health workers. Rather invest in salaries than over proportional training, someone said. Quite desperate was the proposal of a Congolese representative: "Why not create a doctors-market as already has happened for footballers? "

In any case the **human factor is the pillar number one** in the health system and certainly needs more attention.

The representative of Ruanda said that there have been unrests in his country as a revolt to lacking health facilities. There can be a risk that unrest changes into aggressive revolts or terrorism. The first speaker of the conference, Dr. Kyonga, the former minister of health of Uganda and now director of the Global Fund for AIDS, TB and Malaria, was right when he said that the dramatic health situation in the world is a global threat

One speaker said: "The world needs a socially managed globalisation".

WHO PRESS RELEASE

Health worker crises threaten to undermine health improvement in Africa

Speaker after speaker at a World Health Organization-World Bank meeting that concluded today in Addis Ababa, Ethiopia drew attention to an emerging crisis of health manpower in Africa. The situation threatens to defeat the efforts of African governments, private health care providers, NGOs, and donors for health improvement. Training programs unsuited to changing health conditions, inadequate cooperation among the many parties concerned, and the losses of staff to opportunities outside Africa risk making Africa's health care facilities barely able to function for lack of qualified, motivated doctors, nurses and other health workers. This situation is made even worse by the AIDS epidemic, which reduces further the availability of trained health workers by staff deaths and increases the demand for care. These were the principal findings at a Consultative meeting on improving collaboration amongst health professionals, government and other stakeholders on health workers issues. The meeting opened on 29 January, with statements by the World Health Organization Regional Director for Africa, Dr Ebrahim Samba and His Excellency, Dr. Demmisse Tadesse, Vice Minister of Health of Ethiopia.

The Chairperson of the meeting, Honourable Dr. Marie Coll-Seck, Minister of Health of Senegal, told participants of her personal commitment to ensure that health labor force issues are high on the agenda of her Government. Dr. Samba explained that, while reliable data are extremely hard to obtain, preliminary information available to WHO suggests that there are tens of thousands of African doctors and nurses outside Africa, and more leaving every day, making it increasingly difficult to furnish patient care in African countries. He appealed to African Ministers of Health to take the initiative to address the issue with other members of their Governments, with professional associations of doctors, nurses and other health workers, with private sector healthcare providers, and with donor countries and institutions. Dr. Ok Pannenberg, Director of the World Bank's work on health in Africa, placed the problem of African doctors and nurses in the global context of an increasingly flexible labor market, which facilitates migration of high level African manpower to other countries. He noted that Uganda was making progress in addressing the problem, and stressed that each country had to find its own solutions.

Meeting participants underscored that doctors, nurses and other health workers who provide patient care are the most important health system input. The consultative meeting found that health sector reform strategies have failed thus far to adequately address this critical health system component. The importance of forming new partnerships between Ministries of Education and Ministries of Health for the education of Africa's future doctors and nurses was stressed by numerous speakers. Action taken in this area by Senegal was highlighted. Appropriate policies and plans to address health workforce problems, such as in Botswana, exist in few African countries. Dramatic events such as the recruitment by a European country of an entire graduating nursing class in one African country exacerbate the problem of staff losses, and add a new sense of urgency. Indeed, without urgent action there is a risk that the moneys soon to be committed in Africa by the new Global Fund to combat AIDS, tuberculosis and malaria will not even have a serious possibility of achieving their goals. Participants at the WHO-World Bank consultation recognized that new funding initiatives such as debt relief through the HIPC (heavily indebted poor countries) program and the global HIV/TB/malaria fund, combined with heightened awareness of the issue amongst Africa's development partners, provide new opportunities to address the health manpower issues in all their various dimensions.

WHO, the World Bank, and other partners (including USAID and the Rockefeller Foundation) have agreed to establish a joint secretariat to support actions by African countries to address the health manpower crisis in Africa. Participants undertook to widen the dialogue on the issues at home, and identified individual, country-specific measures that they could take, including review of training curricula and establishing country-specific benchmarks for fairness in health reform. Decisions on specific actions and the execution of country-specific work programs will take place, with support from the joint secretariat, in the months ahead.

The joint consultative meeting was organized by WHO/AFRO and the World Bank, and co-sponsored by WHO/AFRO, the World Bank and UNESCO, with financial support from the Government of Norway. Participants came from 17 African countries - Algeria, Angola, Cameroon, Chad, Cote d'Ivoire, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Niger, Nigeria, Senegal, South Africa, Tanzania, Uganda and Zimbabwe. Senior officials attended from ministries of health, higher education, labor, planning and finance - giving participants a unique opportunity for consultation across institutional barriers that are frequently difficult to bridge. Health educators were also prominent at the meeting, including deans of medical and nursing schools, and representatives of a wide range of professional and other non-government institutions.