International aid policy: public disease control and private curative care?

Política de ayuda internacional: ¿Control público de enfermedades y servicios curativos privados?

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Abstract

Integrating disease control with health care delivery increases the prospects for successful disease control. This paper examines whether current international aid policy tends to allocate disease control and curative care to different sectors, preventing such integration. Typically, disease control has been conceptualized in vertical programs. This changed with the Alma Ata vision of comprehensive care, but was soon encouraged again by the Selective Primary Health Care concept. Documents are analyzed from the most influential actors in the field, e.g. World Health Organization, World Bank, and European Union. These agencies do indeed have a doctrine on international aid policy: to allocate disease control to the public sector and curative health care to the private sector, wherever possible. We examine whether there is evidence to support such a doctrine. Arguments justifying integration are discussed, as well as those that critically analyze the consequences of non-integration. Answers are sought to the crucial question of why important stakeholders continue to insist on separating disease control from curative care. We finally make a recommendation for all international actors to address health care and disease control together, from a systems perspective.

Health Services; International Acts; Health Policy

Introduction

Many authors have stressed the necessity of integrating vertical programs into local health facilities in order to achieve reasonable prospects for successful disease control [1,2,3,4]. Admittedly, there are clear indications for some non-integrated vertical programs [5]. However, any health policy allocating public health activities and disease control programs to Ministry of Health (MoH) structures and general health care to private facilities precludes their integration even in circumstances where it would be sensible to do so.

The present paper examines whether the current international aid policy does indeed tend to allocate health care and disease control to different health facilities – and thereby undermines both. To do so, multilateral aid policy papers are scrutinized. In a second step, we analyze whether there is evidence to support separate allocation of disease control programs and curative health care. Finally, we look for reasons that might explain this policy promoted by international agencies.

This paper aims at outlining a policy's doctrine. It does not attempt to assess its actual implementation, which may differ from the theory due to specific political, social, geo-strategic, and economic factors. The doctrine's analysis is relevant per se, since it enlightens the health policies promoted by international organizations, and it has influenced national policy design in developing countries.

Do international aid agencies propose to allocate health care and disease control to different health facilities?

The history of international aid is one of action and reaction: the restoration of an order delineated in the 1950s and reconfirmed in the 1990s, as opposed to the primary health care strategy parenthesis written in the 1970s. We contend that the allocation of disease control and health care to separate sectors is the result of both this history and an explicit doctrine.

Vertical programs are an organized set of resources, management, and activities aiming at the control of a single or a few health problems. In the 1950s and 1960s, policies for disease control in many countries of Africa and Asia focused on vertical programs with a disease-oriented approach. The most important achievement of this approach was the eradication of smallpox in 1979. This success eventually became a major argument for this strategy: Foege et al. [6] suggested organizing health services along the lines of fire brigades based on epidemiological surveillance modeled after smallpox control (the techniques of which inspired the approach). This proposal failed to recognize the specificity of health service organizations and underestimated the epidemiological features of smallpox, characterized by very slow transmission. So far, successful disease eradication has not been repeated (the failure of the malaria eradication campaign is a good example), although the burden of poliomyelitis, dracunculiasis, onchocerciasis, and measles was greatly reduced owing to disease control programs.

In 1978 a new approach was approved in Alma Ata, under the leadership of World Health Organization (WHO) Director-General Halfdan Mahler: Primary Health Care. This new vision on health promoted comprehensive care and community participation to democratize publicly-oriented services, users being called to co-manage health services, together with their professionals and civil servants. This health for all concept brought WHO several head-on confrontations with multinational companies (on breast milk substitutes and essential drugs), with the United States even withholding its contribution to the WHO's regular budget in 1985 [7].

This caused a return to the strategies of the 1950 – vertical programs – at least for developing countries. One year after the Alma Ata conference, Walsh & Warren [8], from the Rockefeller Foundation, wrote a paper in the *New England Journal of Medicine* to reduce the scope of Primary Health Care to the control of four or five diseases, a strategy labeled *Selective Primary Health Care*. This was officially promoted by the Rockefeller Foundation and the United Nations Children's Fund (UNICEF), which contended that the public sector should be selective in the services it offers and that most health care is better delivered and financed privately. The numerous scientists mobilized around the world against this initiative [9,10] failed to sway the U.S. policy. Instead, soon after, the World Bank followed the United States. Its 1987 report *Financing Health Services in Developing Countries: An Agenda for Reform* [11] (p. 38) began to distinguish between health care and disease control: "*For some types of health care, especially simple curative care, private providers may well be more efficient than the government and offer comparable or better services at lower unit cost*", and "*many health-related services such as information and control of contagious disease are public goods*". It argued in favor of greater reliance on private-sector health care provision and the reduction of public involvement in health services delivery. As a United Nations Research Institute for Social Development (UNRISD) report states: "*What is not in doubt is the scale of the policy pressures over the last two decades from, particularly, multilateral donors to commercialize health care. The World Bank has been particularly influential in promoting the concept of health care as largely private good, hence deliverable through the market, all the while downplaying the well-understood perverse incentives structures in health care markets*" [12] (p. 6).

In 1993, echoing the selective primary health care policy, the World Bank report *Investing in Health* [13] proposed a basic service package to be provided by public health services, and other curative care by private-for-profit providers. The report, the World Bank's most comprehensive document regarding health, viewed health care not as a need, much less as a right, but as a demand, defined by the consumers' ability and willingness to pay [14]. As observers in developing countries noticed, the World Bank's 1993 report opened avenues for private investment in formerly public programs [15,16].

A 1996 World Bank discussion paper recommended governments not to tie public finance to public provision, "*though that does not necessarily mean eliminating public provision, which will sometimes be the best solution*" [17] (p. 56). The objective, the paper went on, was to "*minimize deadweight losses from public intervention and leave as much room as possible for private choices*".

The 1997 Strategy Paper for the World Bank Health, Nutrition, and Population Program was even more explicit [18]. It stated that "*in low-in-*

come countries, where private sector activities often dominate, governments will be encouraged to focus their attention on the provision of: services with large externalities (preventive health services); essential clinical services for the poor; and more effective regulation for the private sector, and to promote greater diversity in service delivery systems by providing funding for civil society and non-governmental providers on a competitive basis, instead of limiting public funds to public facilities" [18] (p. 26). The minimal package for the poor to be provided or mandated by governments would include "*basic immunization, management of sick children, maternal care, family planning, targeted nutrition, school health, communicable disease control*" [18] (p. 26). Excluded from the package were family medicine, or patient-centered care with an assessment of social, family, psychological and somatic factors that may influence the problem and its solution, and expensive hospital care.

In its 1997 report, *The State in a Changing World*, the World Bank recognized that markets undersupply a range of collective goods, among which public health goods [19]. Still, the report favored the private sector as the provider of choice for individual health care. It focused on programs that would take a vertical approach to disease control while ignoring the effect of non-specific mortality in deprived groups. The results were expert-decided standardized disease control over context-dependent priority setting by the local community and national MoH, and failure to support an integrated approach to health services.

The history of competition for leadership in international health between the World Bank and the WHO can be written as the record of neoliberal ideology capturing international policy. Neoliberalism refers to political-economical policies that de-emphasize or reject government intervention in domestic economies, but favor the use of political power to open foreign nations to entry by multinational corporations. In a broader sense it is used to describe the movement towards using the market to achieve a wide range of social ends previously filled by government. Arguments for the effectiveness of this movement follow the neoliberal paradigm of market performing best in allocating and using resources, even in the field of public health [20]. It is the story of market values replacing the vision of medical ethos and humanitarian aid, of industry controlling the scientific community, of free-market philosophy overtaking social and democratic ideals. WHO's third function, advocacy for changes in health policy, which came to the fore with the launch of *Health for All* in 1977, had been taken over by the World Bank and the WHO had retreated into its technical and biomedical shell [20,21].

The WHO, in its well-known report *Health Systems: Improving Performance* [22] in the year 2000, emphasized the increasing demands on health systems and the limits as to what governments can finance. It then recommended a "*public process of priority setting to identify the contents of a benefit package available to all, which should reflect local disease priorities and cost-effectiveness*" [22] (p. 15). In this way, implicitly, it separated disease control and individual curative care. Besides, it reaffirmed the key role of government as stewardship, to "*row less and steer more*". It also promoted quality-based competition among providers, together with a combination of public subsidy and regulation for private providers in middle-income countries.

A good example of the heavy influence of the World Bank on WHO was the 2001 report on *Macroeconomics and Health: Investing in Health for Economic Development* [23]. Investing in Health, the subtitle of this Commission's report, echoed the World Bank's controversial World Development Report 1993: *Investing in Health* [13]. The *Report on Macroeconomics and Health* updated the earlier Rockefeller Foundation campaigns against endemic infections, which were deemed necessary to improve labor productivity. It recommended, against critiques from several sources [24], a vertical approach to the eradication of specific diseases, rather than encouraging the development of integrated health care systems.

The authors of the report, all of them commissioned by WHO but most holding extensive experience with the World Bank, the International Monetary Fund (IMF), or other multilateral economic organizations [25], argued that investment to improve health was a key strategy towards economic development. This development meant reform: "*streamlining the public sector, privatization, public funding of private services, introduction of market principles based on competition*" [26] (p. 523). The proposed system would involve a mix of state and non-state health service providers, with financing guaranteed by the state. "*In this model, the government may own and operate service units, or it may contract for services with for-profit and not-for-profit providers*" [26] (p. 524). One of the working papers [27] of the Commission of Macroeconomics and Health bluntly stated that in order to make progress in liberalizing health services in the current round of the General Agreement on Trade in Services (GATS), more member countries would need to schedule this sector. "*Given privatization trends and greater public-private cooperation in the delivery of health services around the world, often*

necessitated by declining public sector resources, more countries may be willing to table health services in this round of GATS discussions" [27] (p. 88). The neoliberal formula was accepted without critical analysis and was seen as a desirable goal in this WHO-funded paper, despite reports on poor results of health sector reform in countries like Chile and Colombia, which applied it radically [28,29,30].

The European Union did not lag behind. A 2002 communication from The Commission to the European Council [31] (p. 14) stated: "*The European Community will work closely with development partners including government, civil society, and the private sector*", "*exploring opportunities to work with the private non-for profit and for-profit sectors*". A more active approach would be adopted for "*community work with the private for-profit health sector*", and mechanisms would be sought to "*enhance co-operation with private investors to improve their responsibility for health in developing countries*".

The *World Development Report 2004* [32] (p. 215) separated "*highly transaction-intensive and individual-oriented clinical services*", requiring individually tailored diagnostics and treatment, from "*population-oriented outreach services, services that can be standardized and include vector control, immunization or vitamin A supplementation*" [32] (p. 133). These were new ways of denominating and, at the same time, administratively and operationally segregating curative individual medicine and disease control programs. The report stated that even governments with limited capacity could provide the latter (or write contracts with public or private entities to provide them, which now opens the door for private sector involvement in disease control programs), while the former were best left to private initiative.

The report stresses the problems for the public sector to provide clinical services for the poor, since both the long route, which requires the policymaker to monitor the provider, and the short route of direct control of the patient over his provider fail. The first fails because of the complexity of clinical services and the heterogeneity of health needs, which make it difficult to standardize service provision and to monitor performance. The second fails because of the lack of accountability of public providers. It does not mention that the long route is the one that worked in Northern European countries. Neither does it recall that the short route in private practice may not be so short because of information asymmetry, supplier-induced demand, and the opportunity cost for communities of monitoring private providers.

The *World Development Report 2004* recommended private provision of clinical services, except for the few countries with a strong public ethos, pro-poor policies, and enforcements of rules. The Bank maintained its bias against government-provided services, presenting obstacles to improving traditional public services as ample justification for shifting to new institutional arrangements. Still, obstacles to market-based approaches, even if severe, were characterized as challenges that could be met. For instance, according to the *World Development Report 2004*, a situation in which a public sector regulator is not independent from a policy-maker justifies the contracting-out of care. However, when the issue is privatization, the absence of regulatory experience (monitoring quality and compliance of private providers) only leads to recommendations for regulatory capacity-building.

In conclusion, industrialized countries do have a doctrine on international aid policy in health. Multilateral agencies unanimously promote disease control programs without the possibility to integrate them into first line health services as they allocate disease control to the public sector and curative health care to the private sector. International financing and trade organizations present a construction that favors privatization of health services, and a limited role for public sector activities, focusing mainly on unprofitable but necessary public health functions [26].

Is there evidence to support this policy of allocation to separate facilities?

As stated in this paper's introduction, most authors agree that the vast majority of disease control programs should be integrated into first line health services. Programs that cannot be integrated are the exception, and a few examples include: (a) breakdown or absence of health centers; (b) vector control; (c) disease control activities for which there is no demand, such as epidemiological surveillance; (d) diseases too rare for health professionals to maintain their skills; (e) outreach to specific risk groups, such as commercial sex workers and drug addicts; and (f) control of some epidemics and emergencies.

Disease control programs require a network of first line health services and a referral system toward second line services, the district hospitals [33]. In addition, to produce good results, health services hosting them need to achieve decent general utilization rates of individual curative care [34].

Clues contradicting the international aid doctrine on this issue can be classified into two categories. Some justify integration and others critically examine the consequences of non-integration. Let us scrutinize the first evidence group.

1) According to the World Bank, the essential clinical package comprises tuberculosis, but ignores a much larger morbidity caused by acute lower respiratory infections, chronic obstructive pulmonary disease, and asthma. The narrow disease control approach not only leaves too many avoidable deaths unattended, it also fails to approach all these respiratory diseases as a group of symptoms. To detect a patient with tuberculosis, the program clinician needs accessing patients with cough because patients ignore their condition's etiology. Therefore, disease control programs lack effectiveness if they are carried out in (government) services abandoned by patients.

2) The aid agencies' recommendations invariably end in a dual system, with good clinical care for the wealthy and low-quality "essential" care for the poor. They act as if expansion of the private sector were compatible with public provision of the essential clinical package for the poor, as if the private sector would not drain limited personnel and other resources, as if reform of the referral level (hospitals) were not critical for success. Nevertheless, the two vessels are connected. Instead of adding extra capacity, the commercial presence of the private sector undermines public services by drawing away key medical personnel and picking the "low-hanging fruit", the healthiest and wealthiest consumers, destroying the possibility of cross-subsidization and risk pooling on which universal access is based.

3) Barbara Starfield [35] demonstrated that health systems with a strong, comprehensive publicly-oriented first line obtained significantly better results in terms of health indicators and satisfaction of their populations in ten industrialized countries, in relation to overall costs of the systems. Similar research in developing countries has not been done, but countries like Costa Rica, India (Kerala State), and Cuba seem to show the same tendency [36], especially when first line services are equipped with general practitioners or family physicians.

In the second category of evidence we find the following:

1) Evidence against separation of disease control and curative care comes from health economists: a recent paper assesses the relationship between public spending on health care and the health status of the poor, from demographic health surveys in 44 countries. Results show that public spending on health care has a consistent and significant impact on child mortality among the poor, as well as on infant mortality and birth attendance by skilled staff [37]. In absolute terms (number of deaths per 1,000 live births), since child mortality is much higher among the poor, public spending has a larger impact on the poor. A 1% increase in public spending on health reduces child mortality nearly three times more among the poor as compared to the non-poor. This effect is stronger in low-income countries. Knowing that in developing countries, public spending for the poor is mainly channeled through public services, these findings constitute a strong argument for continuing public investment in comprehensive public health services. A recent, influent editorial [38] on bacterial infections as a major cause of death among children in Africa stresses the need for comprehensive, integrated, and accessible health services and questions whether the dominating, narrow, disease-based approach is appropriate.

2) Public health specialists agree that a high degree of well-planned decentralization, down to the level of the health district with first and second level services, is the most effective and efficient way of organizing health systems [39]. Vertical programs do not mix well with decentralization. When health centers consist mainly of a collection of vertical programs, scope for local decision-making is very limited and strategic decisions remain with central program managers and government [40].

3) There is no evidence that accountability, problem number one in public services according to the World Bank, would be better assured in contracts with private-for-profit providers. Indeed, experience in the Philippines [41] and many other developing countries shows the emergence of private monopolies or oligopolies that easily get their way by contributing funds to the electoral campaigns of their favored politicians. In developing countries, where social control of the state apparatus is limited, these political connections might protect business from accounting for their inability or unwillingness to provide quality services.

4) One key condition to ensure that the private health sector does not undermine public health and contributes properly to control disease is through close regulation based on quality standards and control. However, because of regulatory limitations that GATS places on the exercise of health sovereignty, in order to remove "unnecessary trade barriers" the treaty substantively undermines a country's capacity to regulate its health services. Moreover, the lock-in feature of GATS means that commitments to liberalization are effectively irreversible. Pollock & Price [42]

(p. 1075) emphasize that "*there is compelling evidence to show that GATS and the World Trade Organization (WTO) involve national governments in trading some of their sovereignty for the putative economic gains of liberalization. In the process, governments lose rights to regulate and to protect non-economic values and the principles that shape provision of public services*".

Within its limited objectives, disease control has failed in developing countries by all standards. Despite a ten-fold increase in external financing for tuberculosis control over the last decade, only a quarter of confirmed pulmonary tuberculosis cases have access to the package foreseen by the Directly Observed Treatment Short-Course (DOTS) strategy. Less than 1% of AIDS patients in Africa and 5% in Asia are under appropriate treatment. As for malaria, the WHO estimates 1.5 to 2.5 million deaths per year, compared to one million per year 20 years ago. Our discussion suggests that these figures represent the failure of a policy and not only the "developing" condition of poor countries.

If there is no evidence to support separation of disease control and general health care, why do international agencies promote it?

The *World Development Report* 2004 somewhat surprisingly states that technical quality of services is often slightly better in public than in private services. It also aims a spotlight on Cuba and Costa Rica, commenting quite positively on the Cuban health system, which has obtained good health without growth, basically thanks to three pillars: providing unequivocal instructions to public providers (the only ones), motivating staff, and monitoring and evaluating the system [32]. Both countries provide useful examples of how not to separate disease control and clinical services.

Ideally, public health practitioners incorporate scientific evidence in developing policies and implementing programs. In reality, however, these decisions are often based on short-term demands rather than long-term study: policies and programs are sometimes developed around anecdotal evidence [43]. As the Institute of Medicine stated a decade ago in its landmark report *The Future of Public Health*, decision-making in public health is often driven by crises, hot issues, and concerns of organized interest groups [44]. It goes on to say that decisions are made largely on the basis of competition, bargaining, and influence rather than comprehensive analysis. The idea that politics can be restricted to the legislative area, while the work of public agencies remains neutral and expert, has been discredited.

If there is no evidence in favor of separating disease control programs and curative health care, why do multilateral organizations insist on it? There is of course the almost hegemonic neoliberal doctrine, and one additional hypothesis could be that multilateral organizations are under pressure from international companies in quest of new health care markets. According to a recent report by the influential non-governmental organization Save the Children UK [45] (p. 8), "*the commercial presence of foreign health care companies in domestic systems is counted as trade in health services under GATS, and several companies see the expansion of investment opportunities as one of their chief gains from ongoing GATS negotiations*". Private sector health care and health insurance companies from the United States and Europe have already expanded their operations into the lucrative markets of Latin America [46,47]. Health care expenditures account for over US$ 3 trillion a year in OECD countries alone, yet contribute comparatively little to international trade. The GATS 2000 negotiations are intended to remedy this perceived failing. The US Coalition of Services Industries has stated that "*GATS negotiations are an opportunity for US business to expand into foreign health care markets* (…) *Until now, public ownership of health care has made it difficult for US private-sector health care providers to market in foreign countries*…" [48] (p. 28) [49,50]. There is a clear conflict between many governments, for instance in Latin America, which define health as a right and health services as a public good, and US government and agencies' philosophy of free trade and promotion of a market economy, which assumes that by expanding the private sector, economic conditions and thus overall health will improve, with a minimum government provision of health care [51].

Moreover, many physicians in developing countries with dual private/public employment are happy with a prosperous private market and a deficient public sector, since they poach patients from the latter to the former. Finally, Western politicians and donors support the battle against infectious epidemics that emerge in developing countries and threaten rich countries (tuberculosis, AIDS, SARS, Asian flu etc.).

Conclusion

Does international aid have an underlying "doctrine"? The answer is yes: it allocates public health and disease control activities to Ministries of Health and health care to the private sector.

And as we have shown, there is scant evidence to support this doctrine.

However, these theoretical conclusions need to be interpreted carefully, in light of this study's methodology: first, our literature review is limited to multilateral aid, while bilateral aid was not assessed. Second, the international agencies that formulated this doctrine did not implement it bluntly or homogeneously everywhere. International investments in public facilities are well known in numerous circumstances. In fact, international agencies have complex decision-making mechanisms, with different countervailing forces operating on different subjects at different points in time, as shown by the following examples. The World Bank policy of the *World Development Report 1993* was not fully reflected in actual World Bank health disbursements. Neither was this doctrine applied when private expenditures were so low that no investors were interested in a particular market (for instance in some West and Central African countries).

Successful disease control requires integration with curative care, and both require accountable, responsive, and decently financed publicly-oriented services. These objectives can only be achieved through an attempt to make them more democratic and responsive through community participation, along the primary health care lines designed in the 1970s. Coverage with publicly-oriented services could build upon Ministry of Health facilities but also NGOs, denominational facilities, mutual aid, social security, and municipal institutions. Community participation in health services management is badly needed to improve the score of all these public health services on responsiveness and accountability, and to acquire the characteristics of a public interest organization: a social population-based perspective without any kind of discrimination and with not-for-profit objectives.

International aid should address communicable disease control priorities in ways that strengthen rather than undermine local health systems. This applies particularly to initiatives like the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Although welcome as complementary funding to existing donor aid, it should not repeat the errors of past mass campaigns and hamper the development of district health systems with internationally driven ambitious targets.

A sign of policy change has recently been sent by the late WHO Director General Dr. Jong-Wook, recommending the reconstruction of health systems and increase in access to general, appropriate health care in the services, while at the same time developing disease control. It is too early to assess how deep this reorientation will reach.

Resumen

El control de enfermedades es más factible cuando se encuentra integrado con los servicios curativos de salud. Este artículo examina si la actual política de cooperación tiende a atribuir el control de enfermedades y servicios curativos a distintos sectores, impidiendo así su integración. Tradicionalmente, el control de enfermedades fue conceptualizado en programas verticales. Eso cambió mediante la visión comprensiva de Alma Ata, para luego ser reinstaurado por el enfoque de la Salud Primaria Selectiva. Analizamos documentos de los actores más influyentes, tales como la Organización Mundial de la Salud (OMS), el Banco Mundial y la Unión Europea. Estas agencias sí tienen una doctrina en cooperación: la de colocar control de enfermedades dentro del sector público y servicios curativos dentro del sector privado, donde sea posible. Examinamos si hay un respaldo científico detrás de esta doctrina. Ponderamos los argumentos en pro de integración con las consecuencias descritas de no-integración. Determinamos cuáles son los motivos de los actores claves para seguir separando el control de enfermedades de los servicios curativos. Recomendamos, finalmente, a los actores que apoyen simultáneamente el control de enfermedades, los servicios y los sistemas de salud.

Servicios de Salud; Actos Internacionales; Política de Salud

Contributors

The authors participated in the paper's design, execution, and analysis and have seen and approved the final version.

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