

Box 1.4 Medical equipment and pharmaceutical industries are major economic forces

Global expenditure on medical equipment and devices has grown from US\$ 145 billion in 1998 to US\$ 220 billion in 2006: the United States accounts for 39% of the total, the European Union for 27%, and Japan for 16%⁹⁰. The industry employs more than 411 400 workers in the United States alone, occupying nearly one third of all the country's bioscience jobs⁹¹. In 2006, the United States, the European Union and Japan spent US\$ 287, US\$ 250 and US\$ 273 per capita, respectively, on medical equipment. In the rest of the world, the average of such expenditure is in the order of US\$ 6 per capita, and in sub-Saharan Africa – a market with much potential for expansion – it is US\$ 2.5 per capita. The annual growth rate of the equipment market is over 10% a year⁹².

The pharmaceutical industry weighs even more heavily in the global economy, with global pharmaceutical sales expected to expand to US\$ 735–745 billion in 2008, with a growth rate of 6–7%⁹³. Here, too, the United States is the world's largest market, accounting for around 48% of the world total: per capita expenditure on drugs was US\$ 1141 in 2005, twice the level of Canada, Germany or the United Kingdom, and 10 times that of Mexico⁹⁴.

Specialized and hospital care is vital to these industries, which depend on pre-payment and risk pooling for sustainable funding of their expansion. While this market grows everywhere, there are large differences from country to country. For example, Japan and the United States have 5–8 times more magnetic resonance imaging (MRI) units per million inhabitants than Canada and the Netherlands. For computerized tomography (CT) scanners, the differences are even more pronounced: Japan had 92.6 per million in 2002, the Netherlands 5.8 in 2005⁹⁵. These differences show that the market can be influenced, principally by using appropriate payment and reimbursement incentives and by careful consideration of the organization of regulatory control⁹⁶.

specialists and technologies, and keep costs under control. They have done this by introducing supply-side measures including reduction of hospital beds, substitution of hospitalization by home care, rationing of medical equipment, and a multitude of financial incentives and disincentives to promote micro-level efficiency. The results of these efforts have been mixed, but the evolving technology is accelerating the shift from specialized hospital to primary care. In many high-income countries (but not all), the PHC efforts of the 1980s and 1990s have been able to reach

a better balance between specialized curative care, first contact care and health promotion⁸¹. Over the last 30 years, this has contributed to significant improvements in health outcomes^{81,82}. More recently, middle-income countries, such as Chile with its *Atención Primaria de Salud* (Primary Health Care)⁸³, Brazil with its family health initiative and Thailand under its universal coverage scheme⁸⁴ have shifted the balance between specialized hospital and primary care in the same way⁸⁵. The initial results are encouraging: improvement of outcome indicators⁸⁶ combined with a marked improvement in patient satisfaction⁸⁷. In each of these cases, the shift took place as part of a move towards universal coverage, with expanded citizen's rights to access and social protection. These processes are very similar to what occurred in Malaysia and Portugal: right to access, social protection, and a better balance between reliance on hospitals and on generalist primary care, including prevention and health promotion⁶.

Industrialized countries are, 50 years later, trying to reduce their reliance on hospitals, having realized the opportunity cost of hospital-centrism in terms of effectiveness and equity. Yet, many low- and middle-income countries are creating the same distortions. The pressure from consumer demand, the medical professions and the medico-industrial complex⁸⁸ is such that private *and* public health resources flow disproportionately towards specialized hospital care at the expense of investment in primary care. National health authorities have often lacked the financial and political clout to curb this trend and achieve a better balance. Donors have also used their influence more towards setting up disease control programmes than towards reforms that would make primary care the hub of the health system⁸⁹.

Fragmentation: health systems built around priority programmes

While urban health by and large revolves around hospitals, the rural poor are increasingly confronted with the progressive fragmentation of their health services, as “selective” or “vertical” approaches focus on individual disease control programmes and projects. Originally considered



as an interim strategy to achieve equitable health outcomes, they sprang from a concern for the slow expansion of access to health care in a context of persistent severe excess mortality and morbidity for which cost-effective interventions exist⁹⁷. A focus on programmes and projects is particularly attractive to an international community concerned with getting a visible return on investment. It is well adapted to command-and-control management: a way of working that also appeals to traditional ministries of health. With little tradition of collaboration with other stakeholders and participation of the public, and with poor capacity for regulation, programmatic approaches have been a natural channel for developing governmental action in severely resource-constrained and donor-dependent countries. They have had the merit of focusing on health care in severely resource-constrained circumstances, with welcome attention to reaching the poorest and those most deprived of services.

Many have hoped that single-disease control initiatives would maximize return on investment and somehow strengthen health systems as interventions were delivered to large numbers of people, or would be the entry point to start building health systems where none existed. Often the opposite has proved true. The limited sustainability of a narrow focus on disease control, and the distortions it causes in weak and under-funded health systems have been criticized extensively in recent years⁹⁸. Short-term advances have been short-lived and have fragmented health services to a degree that is now of major concern to health authorities. With parallel chains of command and funding mechanisms, duplicated supervision and training schemes, and multiplied transaction costs, they have led to situations where programmes compete for scarce resources, staff and donor attention, while the structural problems of health systems – funding, payment and human resources – are hardly addressed. The discrepancy in salaries between regular public sector jobs and better-funded programmes and projects has exacerbated the human resource crisis in fragile health systems. In Ethiopia, contract staff hired to help implement programmes were paid three times more than regular government employees⁹⁹, while in

Malawi, a hospital saw 88 nurses leave for better paid nongovernmental organization (NGO) programmes in an 18-month period¹⁰⁰.

Eventually, service delivery ends up dealing only with the diseases for which a (funded) programme exists – overlooking people who have the misfortune not to fit in with current programme priorities. It is difficult to maintain the people's trust if they are considered as mere programme targets: services then lack social sustainability. This is not just a problem for the population. It puts health workers in the unenviable position of having to turn down people with “the wrong kind of problem” – something that fits ill with the self-image of professionalism and caring many cherish. Health authorities may at first be seduced by the straightforwardness of programme funding and management, yet once programmes multiply and fragmentation becomes unmanageable and unsustainable, the merits of more integrated approaches are much more evident. The re-integration of programmes once they have been well established is no easy task.

Health systems left to drift towards unregulated commercialization

In many, if not most low- and middle-income countries, under-resourcing and fragmentation of health services has accelerated the development of commercialized health care, defined here as the unregulated fee-for-service sale of health care, regardless of whether or not it is supplied by public, private or NGO providers.

Commercialization of health care has reached previously unheard of proportions in countries that, by choice or due to a lack of capacity, fail to regulate the health sector. Originally limited to an urban phenomenon, small-scale unregulated fee-for-service health care offered by a multitude of different independent providers now dominates the health-care landscape from sub-Saharan Africa to the transitional economies in Asia or Europe.

Commercialization often cuts across the public-private divide¹⁰¹. Health-care delivery in many governmental and even in traditionally not-for-profit NGO facilities has been de facto commercialized, as informal payment systems and cost-recovery systems have shifted the cost of services to users in an attempt to compensate

for the chronic under-funding of the public health sector and the fiscal stringency of structural adjustment^{102,103}. In these same countries, moonlighting civil servants make up a considerable part of the unregulated commercial sector¹⁰⁴, while others resort to under-the-counter payments^{105,106,107}. The public-private debate of the last decades has, thus, largely missed the point: for the people, the real issue is not whether their health-care provider is a public employee or a private entrepreneur, nor whether health facilities are publicly or privately owned. Rather, it is whether or not health services are reduced to a commodity that can be bought and sold on a fee-for-service basis without regulation or consumer protection¹⁰⁸.

Commercialization has consequences for quality as well as for access to care. The reasons are straightforward: the provider has the knowledge; the patient has little or none. The provider has an interest in selling what is most profitable, but not necessarily what is best for the patient. Without effective systems of checks and balances, the results can be read in consumer organization reports or newspaper articles that express outrage at the breach of the implicit contract of trust between caregiver and client¹⁰⁹. Those who cannot afford care are excluded; those who can may not get the care they need, often get care they do not need, and invariably pay too much.

Unregulated commercialized health systems are highly inefficient and costly¹¹⁰: they exacerbate inequality¹¹¹, and they provide poor quality and, at times, dangerous care that is bad for health (in the Democratic Republic of the Congo, for example, “*la chirurgie safari*” (safari surgery) refers to a common practice of health workers moonlighting by performing appendectomies or other surgical interventions at the patients’ homes, often for crippling fees).

Thus, commercialization of health care is an important contributor to the erosion of trust in health services and in the ability of health authorities to protect the public¹¹¹. This is what makes it a matter of concern for politicians and, much more than was the case 30 years ago, one of the main reasons for increasing support for reforms that would bring health systems more in line not only with current health challenges, but also with people’s expectations.

Changing values and rising expectations

The reason why health systems are organized around hospitals or are commercialized is largely because they are supply-driven and also correspond to demand: genuine as well as supply-induced. Health systems are also a reflection of a globalizing consumer culture. Yet, at the same time, there are indications that people are aware that such health systems do not provide an adequate response to need and demand, and that they are driven by interests and goals that are disconnected from people’s expectations. As societies modernize and become more affluent and knowledgeable, what people consider to be desirable ways of living as individuals and as members of societies, i.e. what people value, changes¹¹². People tend to regard health services more as a commodity today, but they also have other, rising expectations regarding health and health care. People care more about health as an integral part of how they and their families go about their everyday lives than is commonly thought (Box 1.5)¹¹³. They expect their families and communities to be protected from risks and dangers to health. They want health care that deals with people as individuals with rights and not as mere targets for programmes or beneficiaries of charity. They are willing to respect health professionals but want to be respected in turn, in a climate of mutual trust¹¹⁴.

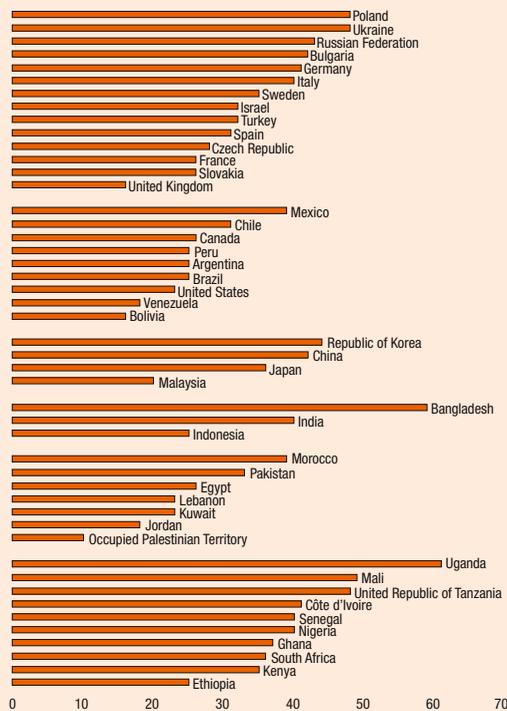
People also have expectations about the way their society deals with health and health care. They aspire to greater health equity and solidarity and are increasingly intolerant of social exclusion – even if individually they may be reluctant to act on these values¹¹⁵. They expect health authorities – whether in government or other bodies – to do more to protect their right to health. The social values surveys that have been conducted since the 1980s show increasing convergence in this regard between the values of developing countries and of more affluent societies, where protection of health and access to care is often taken for granted^{112,115,116}. Increasing prosperity, access to knowledge and social connectivity are associated with rising expectations. People want to have more say about what happens in their workplace, in the communities in which they live and also in important government decisions that



Box 1.5 Health is among the top personal concerns

When people are asked to name the most important problems that they and their families are currently facing, financial worries often come out on top, with health a close second¹¹⁸. In one country out of two, personal illness, health-care costs, poor quality care or other health issues are the top personal concerns of over one third of the population surveyed (Figure 1.11). It is, therefore, not surprising that a breakdown of the health-care system – or even the hint of a breakdown – can lead to popular discontent that threatens the ambitions of the politicians seen to be responsible¹¹⁹.

Figure 1.11 Percentage of the population citing health as their main concern before other issues, such as financial problems, housing or crime¹¹⁸



affect their lives¹¹⁷. The desire for better care and protection of health, for less health inequity and for participation in decisions that affect health is more widespread and more intense now than it was 30 years ago. Therefore, much more is expected of health authorities today.

Health equity

Equity, whether in health, wealth or power is rarely, if ever, fully achieved. Some societies are

more egalitarian than others, but on the whole the world is “unequal”. Value surveys, however, clearly demonstrate that people care about these inequalities – considering a substantial proportion to be unfair “inequities” that can and should be avoided. Data going back to the early 1980s show that people increasingly disagree with the way in which income is distributed and believe that a “just society” should work to correct these imbalances^{120,121,122,123}. This gives policymakers less leeway to ignore the social dimensions of their policies than they might have had previously^{120,124}.

People are often unaware of the full scope of health inequalities. Most Swedish citizens, for example, were probably unaware that the difference in life expectancy between 20-year-old men from the highest and lowest socioeconomic groups was 3.97 years in 1997: a gap that had widened by 88% compared to 1980¹²⁵. However, while people’s knowledge on these topics may be partial, research shows that people regard social gradients in health as profoundly unjust¹²⁶. Intolerance to inequality in health and to the exclusion of population groups from health benefits and social protection mirrors or exceeds intolerance to inequality in income. In most societies, there is wide consensus that everybody should be able to take care of their health and to receive treatment when ill or injured – without being bankrupted and pushed into poverty¹²⁷.

As societies become wealthier, popular support for equitable access to health care and social protection to meet basic health and social needs gains stronger ground. Social surveys show that, in the European region, 93% of the populations support comprehensive health coverage¹¹⁷. In the United States, long reputed for its reluctance to adopt a national health insurance system, more than 80% of the population is in favour of it¹¹⁵, while basic care for all continues to be a widely distributed, intensely held, social goal¹²⁸. The attitudes in lower income countries are less well known, but extrapolating from their views on income inequality, it is reasonable to assume that increasing prosperity is coupled with rising concern for health equity – even if consensus about how this should be achieved may be as contentious as in richer countries.

Care that puts people first

People obviously want effective health care when they are sick or injured. They want it to come from providers with the integrity to act in their best interests, equitably and honestly, with knowledge and competence. The demand for competence is not trivial: it fuels the health economy with steadily increased demand for professional care (doctors, nurses and other non-physician clinicians who play an increasing role in both industrialized and developing countries)¹²⁹. For example, throughout the world, women are switching from the use of traditional birth attendants to midwives, doctors and obstetricians (Figure 1.12)¹³⁰.

The PHC movement has underestimated the speed with which the transition in demand from traditional caregivers to professional care would bypass initial attempts to rapidly expand access to health care by relying on non-professional “community health workers”, with their added value of cultural competence. Where strategies for extending PHC coverage proposed lay workers as an alternative rather than as a complement to professionals, the care provided has often been perceived to be poor¹³¹. This has pushed people towards commercial care, which they, rightly or wrongly, perceived to be more competent, while attention was diverted from the challenge of more effectively incorporating professionals under the umbrella of PHC.

Proponents of PHC were right about the importance of cultural and relational competence, which was to be the key comparative advantage of community health workers. Citizens in the developing world, like those in rich countries, are not looking for technical competence alone: they also want health-care providers to be understanding, respectful and trustworthy¹³². They want health care to be organized around their needs, respectful of their beliefs and sensitive to their particular situation in life. They do not want to be taken advantage of by unscrupulous providers, nor do they want to be considered mere targets for disease control programmes (they may never have liked that, but they are now certainly becoming more vocal about it). In poor and rich countries, people want more from health care than interventions. Increasingly, there is recognition that the resolution of health problems should take into

account the socio-cultural context of the families and communities where they occur¹³³.

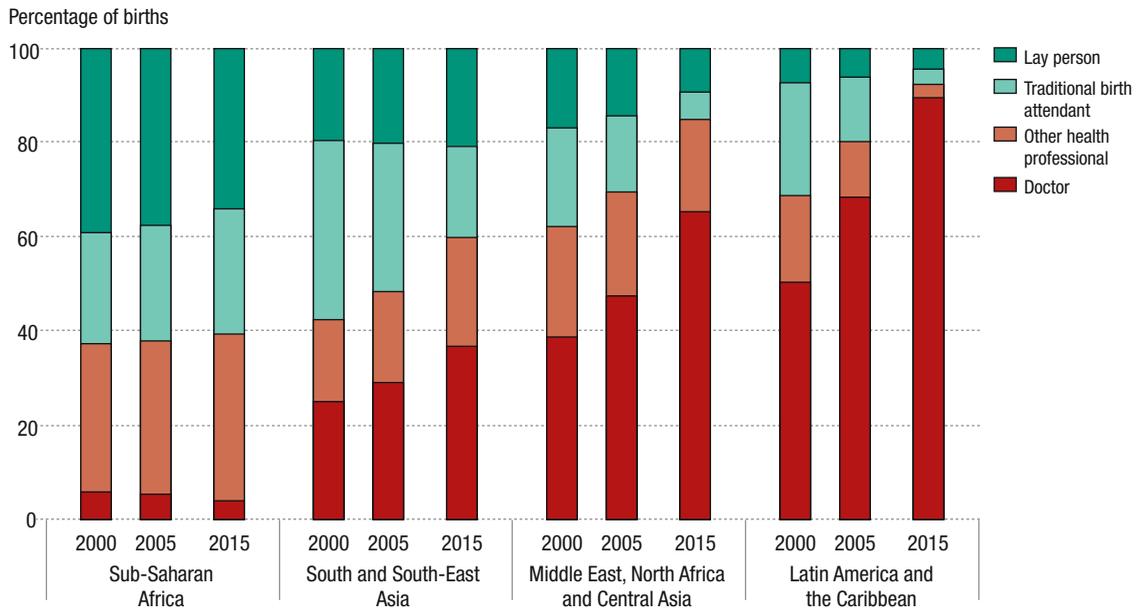
Much public and private health care today is organized around what providers consider to be effective and convenient, often with little attention to or understanding of what is important for their clients¹³⁴. Things do not have to be that way. As experience – particularly from industrialized countries – has shown, health services can be made more people-centred. This makes them more effective and also provides a more rewarding working environment¹³⁵. Regrettably, developing countries have often put less emphasis on making services more people-centred, as if this were less relevant in resource-constrained circumstances. However, neglecting people’s needs and expectations is a recipe for disconnecting health services from the communities they serve. People-centredness is not a luxury, it is a necessity, also for services catering to the poor. Only people-centred services will minimize social exclusion and avoid leaving people at the mercy of unregulated commercialized health care, where the illusion of a more responsive environment carries a hefty price in terms of financial expense and iatrogenesis.

Securing the health of communities

People do not think about health only in terms of sickness or injury, but also in terms of what they perceive as endangering their health and that of their community¹¹⁸. Whereas cultural and political explanations for health hazards vary widely, there is a general and growing tendency to hold the authorities responsible for offering protection against, or rapidly responding to such dangers¹³⁶. This is an essential part of the social contract that gives legitimacy to the state. Politicians in rich as well as poor countries increasingly ignore their duty to protect people from health hazards at their peril: witness the political fall-out of the poor management of the hurricane Katrina disaster in the United States in 2005, or of the 2008 garbage disposal crisis in Naples, Italy.

Access to information about health hazards in our globalizing world is increasing. Knowledge is spreading beyond the community of health professionals and scientific experts. Concerns about health hazards are no longer limited to the traditional public health agenda of improving

Figure 1.12 The professionalization of birthing care: percentage of births assisted by professional and other carers in selected areas, 2000 and 2005 with projections to 2015^a



^a Source: Pooled data from 88 DHS surveys 1995–2006, linear projection to 2015.

the quality of drinking water and sanitation to prevent and control infectious diseases. In the wake of the 1986 Ottawa Charter for Health Promotion¹³⁷, a much wider array of issues constitute the health promotion agenda, including food safety and environmental hazards as well as collective lifestyles, and the social environment that affects health and quality of life¹³⁸. In recent years, it has been complemented by growing concerns for a health hazard that used to enjoy little visibility, but is increasingly the object of media coverage: the risks to the safety of patients¹³⁹.

Reliable, responsive health authorities

During the 20th century, health has progressively been incorporated as a public good guaranteed by government entitlement. There may be disagreement as to how broadly to define the welfare state and the collective goods that go with it^{140,141}, but, in modernizing states, the social and political responsibility entrusted to health authorities – not just ministries of health, but also local governmental structures, professional organizations and civil society organizations with a quasi-governmental role – is expanding.

Circumstances or short-term political expediency may at times tempt governments to withdraw from their social responsibilities for financing and regulating the health sector, or from service delivery and essential public health functions. Predictably, this creates more problems than it solves. Whether by choice or because of external pressure, the withdrawal of the state that occurred in the 1980s and 1990s in China and the former Soviet Union, as well as in a considerable number of low-income countries, has had visible and worrisome consequences for health and for the functioning of health services. Significantly, it has created social tensions that affected the legitimacy of political leadership¹¹⁹.

In many parts of the world, there is considerable skepticism about the way and the extent to which health authorities assume their responsibilities for health. Surveys show a trend of diminishing trust in public institutions as guarantors of the equity, honesty and integrity of the health sector^{123,142,143}. Nevertheless, on the whole, people expect their health authorities to work for the common good, to do this well and with foresight¹⁴⁴. There is a multiplication of scoring

cards, rankings and other league tables of public action used either at the national or global level¹⁴¹, while consumer organizations are addressing health sector problems¹¹¹, and national and global civil society watchdog organizations are emerging^{146,147,148,149}. These recent trends attest to prevailing doubts about how well health authorities are able to provide stewardship for the health system, as well as to the rising expectations for them to do even better.

Participation

At the same time, however, surveys show that, as societies modernize, people increasingly want to “have a say” in “important decisions that affect their lives”^{123,112}, which would include issues such as resource allocation and the organization and regulation of care. Experience from countries as diverse as Chile, Sweden and Thailand shows, however, that people are more concerned with having guarantees for fair and transparent processes than with the actual technicalities of priority setting^{150,151}. In other words, an optimum response to aspirations for a bigger say in health policy matters would be evidence of a structured and functional system of checks and balances. This would include relevant stakeholders and would guarantee that the policy agenda could not be hijacked by particular interest groups¹⁵².

PHC reforms: driven by demand

The core values articulated by the PHC movement three decades ago are, thus, more powerfully present in many settings now than at the time of Alma-Ata. They are not just there in the form of moral convictions espoused by an intellectual vanguard. Increasingly, they exist as concrete social expectations felt and asserted by broad groups of ordinary citizens within modernizing societies. Thirty years ago, the values of equity, people-centredness, community participation and self-determination embraced by the PHC movement were considered radical by many. Today, these values have become widely shared social expectations for health that increasingly pervade many of the world’s societies – though the lan-

guage people use to express these expectations may differ from that of Alma-Ata.

This evolution from formal ethical principles to generalized social expectations fundamentally alters the political dynamics around health systems change. It opens fresh opportunities for generating social and political momentum to move health systems in the directions people want them to go, and that are summarized in Figure 1.13. It moves the debate from a purely technical discussion on the relative efficiency of various ways of “treating” health problems to include political considerations on the social goals that define the direction in which to steer health systems. The subsequent chapters outline a set of reforms aimed at aligning specialist-based, fragmented and commercialized health systems with these rising social expectations. These PHC reforms aim to channel society’s resources towards more equity and an end to exclusion; towards health services that revolve around people’s needs and expectations; and towards public policies that secure the health of communities. Across these reforms is the imperative of engaging citizens and other stakeholders: recognizing that vested interests that tend to pull health systems in different directions raises the premium on leadership and vision and on sustained learning to do better.

Figure 1.13 The social values that drive PHC and the corresponding sets of reforms





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