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DFID Health Systems Resource Centre

"MAKING THE MOST OF THE PRIVATE SECTOR"

Report of a workshop organised on behalf of the UK Department for International Development by the Health Systems Resource Centre with the Health Economics Financing Programme, London School of Hygiene & Tropical Medicine
11-12 May 2000

It is now well recognised that the private sector plays a major role in the delivery of health services in low and middle income countries and that even the poor are paying large amounts of money to access such services. In many countries the growth of the private sector has been extremely rapid and largely unregulated. This does offer potential benefits in terms of providing patients with a wider choice of options, broadening access to essential services and helping take the strain off the public sector. However there are major concerns that that many of the services being provided by the private sector are high cost but low technical quality (and are sometimes even harmful) and that a growing private sector is undermining Governments' capacity to deliver an effective safety net for the poor.

Against this background, DFID hosted a meeting in May 2000 to review what is already known about the performance of the private sector and public private partnerships (PPPs) with the aim of identifying key lessons and areas where we need to learn more. Participants were drawn from donor agencies, academia, developing country partners, and private organisations. The full version of the report, including the presentations, is now available on the Health Systems Resource Centre's (HSRC) website

The general messages that arose from the meeting were:

- A more informed policy in relation to the private sector and public private partnerships will require more intelligence on what the private sector is doing. A better understanding of the determinants of private sector behaviour and its performance is needed. More information should be gathered about the impact of private sector behaviour on the poor and on the nature and impact of interactions between public and private sectors.

- Partner Governments can help create an enabling environment by ensuring that policy towards the private sector is clear, realistic and consistent with broader health policy. At present in many countries, a far higher standard is set for private providers than public providers and this sends a clear and negative message to the private sector. It is important that partner Governments take the lead in developing public private partnerships. Even where services are being delivered by the private sector, Government should still set the overall agenda and working through the private sector should not be seen as a way of bypassing Government bureaucracy

- Donors can support Governments by helping develop the new skills and the new ways of working required to support effective partnerships. Key areas where skills are currently lacking include policy analysis, purchasing or commissioning of services, setting provider incentives, monitoring and evaluation and the provision of information to consumers. They can also help by replicating successful pilots

although experience has shown that this rarely happens and we need to critically review why this has been the case.

- Expectations of what can be achieved should be high but not unreasonable. Whilst we need to recognise the limitations of such partnerships there is still significant potential to tap into new areas. On the one hand public private partnership interventions are unlikely to meet the needs of the poor let alone the very poor and Governments will have to find other ways of meeting such needs. On the other hand, the private sector could play a larger role in the delivery of essential services if only the demand was there.

There is a need for Government and donors to jointly identify opportunities for introducing change and its timing. Reforms may not be politically feasible if vested interests are allowed time to build up and radical change may only be possible in times of crisis.

In terms of next steps, the main conclusions were to:

- begin a dialogue on the development of a rapid assessment guideline to help DFID advisers and ultimately a broader group in developing public private partnerships

- consider commissioning further work - with a focus on what works where, what are the limitations, and what experience has been in other sectors - on:
  - vouchers, contracting, working with the informal sector, social marketing, targeting the poor, reconsidering the priority roles of Government, regulation and learning from other donors' experience host follow up meeting(s) of UK practitioners/researchers to get a broader overall picture private sector research and projects in low and middle income countries and/or to focus on some of the issues not addressed at this meeting

- foster better links with other departments within DFID, notably the Governance Department through informal meetings on governance, enterprise and regulation issues

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[1] For information on this and other reports, publications and seminar summaries that are produced by the DFID Health Systems Resource Centre, please visit our website: http://www.healthsystemsrc.org Alternatively please contact the HSRC's Information Officer Rabiya Reza either by e-mail rabiya.reza@ihsd.org or by telephone: +44 (0)20 7253 2222

SID
Society for International Development

Istituto Superiore di Sanità

Report

International Seminar on 'Global Public-Private Partnerships for Health and Equity'

November 23 – 24, 2000

Organized by:
the Society for International Development (SID)
World Health Organization (WHO)
Istituto Superiore di Sanità (ISS)

Held at the National Health Council
Rome, Italy

Background

The International Seminar brought together a group of nearly thirty policy makers, public health professionals, members of civil society, private foundations and the private sector from the North and South in order to 'brainstorm' the implications of public-private partnerships for global public health. The meeting was called in response to the strong concern raised about the direction and engagement of the World Health Organization in global public-private sector partnerships (GPPPs). The meeting addressed the successes and failures of public-private partnership in health looking at the key issues of conflict of interest, governance and the concept of partnership itself. The meeting took a frank look at the type of 'new' decision making processes and institutional arrangements that are required for WHO to lead the way in ensuring that GPPPs contribute to the global health and equity agenda.

International Seminar Background Papers:

'Why private public partnership' by Amalia Waxman, NMH/WHO

'Global public-private partnerships: part 1 – a new development in health and part 2 what are the health issues for global governance' by Kent Buse and Gill Walt (*Bulletin of the World Health Organization*. 2000. 78 (4 and 5)

'Towards a better definition of global 'public-private partnerships' for health' by Roy Widdus, Sunil Chacko, Karin Holm and Louis Currat (Initiative on Public-Private Partnerships for Health Global Forum for Health Research)

Defining partnership

In their opening presentation, Gill Walt and Kent Buse stated that partnerships 'bring together a set of actors for the common goal of improving the health of populations based on mutually agreed roles and principles'. Global public-private partnerships 'are collaborative relationships which transcend national boundaries, bring together at least three parties (amongst them a corporation and an inter-governmental organization) to achieve a shared health-creating goal, on the basis of a mutually agreed division of labour.' Roy Widdus, in his presentation on the new forms of collaboration in health between institutions in the public and private sectors, identified nearly seventy collaborative relationships that are emerging for co-ordination and joint action for health, particularly to tackle problems more efficiently or to devise new ways of working on intractable health issues. He identified some major groupings at the global level: public sector programmes with private sector participation, operating under the auspices of intergovernmental agencies, and not-for-profit 'public-private partnerships' operating under the national laws of various countries. He underlined that evaluating collaborative relationships with profit-making groups in areas such as governance, accountability, influence on policy agendas and representation has to take into account the unique features and variation among collaborations.

In general, the term 'partnership' was questioned. To some participants, the term 'partnership' does not convey adequately the specificity of the new forms emerging. Some participants felt that while 'partnership' is a convenient catch-all term that conveys a sense of co-operation, it does not capture the diversity of these new, non-traditional relationships. It may also overstate the closeness of collaboration, according to some participants, because in reality there can be a power differential. Therefore the degree of shared decision-making and mechanisms to guide the process

– necessary attributes of true partnership – do not always address the problem of unequal partners.

As the term partnership has to be continually qualified it is perhaps better to not use it. Another more cynical perspective expressed was that in today's ideological crisis the health and development community has moved 'from dignity to rights to fights' with partnership emerging as the way to manage fights. At a minimum, the term 'partnership' may need to be kept in brackets, or defined according to each individual situation. In this report the term GPPPs is used to mean the set of global collaborative relationships formed to meet to unmet health needs. Such a definition is underpinned by the recognition of its limitations in terms of access and equity of health service provision. GPPPs can be seen as an opportunity, and may be desirable in some cases, but they are not compulsory. A careful matching operation needs to be performed among the different private and public parties fully aware of the potential benefits or trade-offs, and of the economic and political context in which GPPPs are operating.

Setting the questions

The meeting returned to the definition of partnership continually, reflecting the complexity and newness of the issue. The major focus of the meeting, however, was whether GPPPs can or cannot help WHO fulfil its goals. Questions that were addressed in both the plenary discussion and two sessions of working groups included: how should WHO prepare for GPPPs and maximize potential benefits? How should the WHO draw the line among the types of GPPPs it should join or encourage? How does WHO assess if GPPP are delivering benefits for health or causing potential harm? Are GPPPs the best way to achieve public health goals? What are the true costs of GPPPs to the public sector? What are the possible strategic alliances among the different types of 'partners' (the multiple stakeholders, unions, NGOs, consumers)? What are the governance mechanisms required to establish equitable GPPPs? How does one set up the governance structures to assess and monitor the GPPPs as they proceed? How can GPPPs be made more open to civil society, networks and identity group participation? How can GGGPs build and support rather than fragment UN and international public health efforts?The seminar's tentative answers to these questions can be schematically divided into four areas: the broad characteristics of GPPPs, governance, conflict of interest and concrete suggestions to WHO.

Desired characteristics of GPPPs

GPPPs work best when they build on traditional roles of the 'partners': have specific objectives and agreement on expected outcomes, clearly stated at the outset; operate with clearly articulated roles and responsibilities 'ground rules'; and are implemented only where all parties agree they will add value.
GPPPs should not aim to create new structures/institutions as an alternative to legitimate international organizations where a legitimate decision making process has been established such as in the World Health Assembly. However imperfect the WHA may be, this is currently the best way available and most democratic way forward.

GPPPs must be clearly defined especially in relation to the ground rules. The criteria for participation among each 'partner' should be openly declared and debated in terms of how it fits into their organizational values.

GPPPs need the time and correct process to build up trust and sustainability, to share common goals even if partners have different missions. Awareness and openness about the power differential among 'partners' is a sensitive and critical issue. It is important that GPPPs are not just seen as ways for the public sector to gain resources in the short term. A long term perspective demands more than just 'cherry picking' (the public sector creating GPPPs only when the private sector is willing to allocate resources). It is important not to have GPPPs that allow the private sector to step into the space left by the dwindling resources, fragmentation and fragility of public health services. Nor should GPPPs provide a safety net for political leaders who fail to provide adequately for the health of their populations.

GPPPs should be as broadly based as possible. It is important to involve appropriate civil society organizations as a strong 'partner' representing consumer concerns along with public and pro-profit sector interests.

GPPPs are in part a response to political changes brought about by globalization. Nations and regions are losing sovereignty to larger global networks. Globalization imposes new and higher standards of accountability, transparency, and performance on the health sector and sovereign states to provide adequately for their populations. It is important to take advantage of GPPPs as part of a new mode of integration beyond traditional spheres -- and this should be done in a way that is compatible and complementary with the agenda setting function of the UN. In the view of several participants, some GPPPs may be delegitimizing this function of the UN and should be challenged.

GPPPs are usually being formed in the 'product' development area, with obvious potential to benefit health. But participants raised concern where short term profit making, media attention seeking concerns such as genetic technologies, or selected disease priorities (TB, Malaria, HIV-AIDS) appear to drive the agenda. What needs to be higher on the list for potential GPPPs are longer term investments that, for example, would improve health equity by building capacity in health systems, open up new opportunities for health gains, strengthen institutional arrangements, provide telemedicine to rural populations, drug development for developing country diseases, improve prevention, reduce harmful risk factors and change consumer habits.

Governance

In order to harness the potential of GPPPs, there was a consensus that clear rules need to be set down. These should be based on a long term agenda for equity and health and established through an open and transparent governance structure.

Good governance of GPPPs for global public health requires agreement among all partners on the formal and informal procedures for:

- membership, participation, representation;
- cautionary principles and special set of rule to govern conflict;
- decision-making, enforcement, sanctions, monitoring;
- roles and responsibilities for the organization and activities of the GPPP;
- knowledge management;
- adequate structural capacity;

- resource mobilization and allocation;
- 'exit' clauses for the partners in GPPPs; and
- development of a self-assessment tool.

It is essential that the decision-making process remains transparent to all partners in any proposed relationship as well as within the structures of WHO and to non-participants in order to have an open debate of all issues. Representatives of governments and civil society groups should be included in the process to guarantee equitable participation of all parties, legitimacy and accountability to the constituencies the GPPP serves. Everyone has interests or biases, including the public officials who work in Ministries or agencies like the WHO. This is why transparency and accountability are important principles for designing and assessing GPPPs.

The criteria for the selection of countries involved in GPPPs needs to be developed prior to the GPPP. Use of standard economic indicators (like GNP, which is used for GAVI) and preferential selection of a country may not always be the best set of criteria. Accurate indicators of the needs of the people should be evaluated before establishing GPPPs and attempts made to avoid inequities within and between countries involved in the GPPP.

The long-term agenda should be set by a scientific body and aim to build on the social capital within the GPPP and reconcile public and private goals/principles. It is of utmost importance that an agenda is established independently of the weight of potential funders in 'dollars'. The considerable risk of the party with more money setting the agenda should be avoided.

Transparency was strongly underlined in the discussions. The decisions leading to a GPPP need to be in the public domain and must include clarity on why the partners are entering the GPPP. There should be open acknowledgement of potential areas for conflict of interest and information on the funds that are allocated and spent.

Accountability to not only the partners but also to the public was discussed with the recognition that much more has to be known about the mechanisms for accountability of GPPPs as a hybrid institutional form. Every GPPP must have a public to whom it reports and it must be accountable to a legitimate and democratic institution.

Conflict of interest

The mission of the private and public sector can be kept completely separate from the shared goal of the GPPP initiative, recognizing that GPPPs can help to overcome market or public policy failure, mobilize public commitment and build international social capital if there is a good governance structure with transparency and accountability in place.

It may be possible through the GPPP procedure that the private sector is not just a cash or in-kind donor but also involved in other areas (changes in private sector policy for example to come into line with WHO mandate, assisting the public sector in practical management skills and efficacy). This can be an important way to ensure that GPPPs do not exacerbate the fragmentation of international institutions and work at odds with the scientific and technical agenda set by WHO for global health and equity.

There is no consensus on the workability of GPPPS especially in being able to maintain public sector values. Given the divergence of opinion, it would be helpful for the WHO and other UN bodies to support research on how well GPPPs support the principles of public health, and review the structure, process and outcomes of GPPPs (including within the UN). The research would provide historical evidence and solid analysis on how public health can work best in a globalized world and how in that context GPPPs do or do not improve health services and social development.

Concerns were raised around how the private sector sometimes seems to be using their involvement in GPPPs solely to promote a positive image through the media. Raising public awareness of global health issues can be worthwhile, but without concrete actions to back up public campaigns, the promise of GPPPs in health will not be realized. Participants also noted that short-term output or product interest of the private sector can be in conflict with health as a public good, which needs long-term commitment and interest. The public sector needs to understand how the skills of the private sector can be used as a tool to improve public health. The difference between the approach of short term, media grabbing, non participatory GPPPs that fragment rather than strengthen the UN was contrasted with the UN Foundation's approach, which consolidates on-going mandates of the UN.

An important mechanism to avoid potential conflict of interests or agendas is for the public sector to take the time to evaluate and assess corporations in a search for suitable partners and to be prepared to turn down potential offers from the private sector if they are incompatible with the goals of the public sector.

Suggestions to WHO

WHO, as the leading organization for global public health and equity, must clearly set the rules of GPPPs within this mandate. It is timely for WHO to step back from the current situation and reflect on the appropriate role of GPPPs in order to meet public health and equity needs.

- WHO needs to set the priorities for agenda setting of GPPPs building on its technical capacity and scientific knowledge.
- WHO needs to look at its own governance structures at the highest level in terms of strategic priority setting for GPPPs. It needs to be accountable, transparent and democratic in its own decision-making processes in order to have a logical rather than ad hoc approach to GPPPs.
- WHO's Guidelines on the Interaction with Commercial Enterprises need to be reviewed and to be placed in a broader conceptual framework that extends beyond bilateral interactions. The Guidelines have to provide a clear statement on rules and responsibilities that is transparent internally and externally so that global multilateral partnerships are inserted into a framework related to priorities set by WHO.
- WHO needs to strengthen its capacity to negotiate and engage with for profit and civil society sectors, to be clear when GPPPs are not appropriate and, in such cases, to be prepared to say 'no' to potential donors.
- WHO needs to support research and processes that will clarify the complexities and difficulties of GPPPs.
- WHO needs to be accountable to the people and listen more to the peoples' needs and in particular the South's concerns and to empower civil society as an equal member of a GPPP.
- WHO needs to monitor on-going procedures of GPPPs and to assess the activities of potential partners prior to the formation of the GPPP.
- WHO needs to make long-term projects more appealing (particularly support for institution strengthening). WHO therefore needs to find new ways to package and convey public health messages.

Commitments taken for the follow-up to the meeting:

1. To request that the topic of GPPP be placed on the Executive Board Agenda in January 2001 in order to encourage WHO to consider the issue internally, examining the evidence for the pros and cons of GPPPs, when they are appropriate and when not, and to define an open process about how to decide for or against partnerships that goes much further than the present guidelines. The WHO should encourage the broadest possible range of inputs to this inquiry.

2. To draw up a more comprehensive document that informs WHO guidelines and takes into account issues of governance, transparency and accountability based on the discussions and the background papers of Waxman, Walt and Buse and Widdus. The process for contribution and shaping of the paper would be open to all interested parties, taking into account evidence and analysis at the global but also at the national level.

3. To bring the outcome of the meeting on GPPP including perspectives of the G77 via the Chair of the Health Group into the G8 meeting to be held in Genova in 2001.

4. To investigate how to support a systematic process that can address the issue systematically in WHO and with its constituencies particularly involving voices from the South. One model for that process could be the 'Crucible' group based in Canada that looked at private public-partnerships with a process that did not request consensus, laid out and worked with the tensions and conflict of interest and produced a series of studies and guidelines for GPPP and resulted in a series of high level consultations and publications.

5. To circulate the report of the meeting through an e-forum in order to continue an open and transparent debate among the participants.

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PUBLIC-PRIVATE PARTNERSHIPS: ILLUSTRATIVE EXAMPLES

Adetokunbo Lucas

The World Health Organization, now openly promoting public-private partnerships, has developed a number of innovative collaborative ventures with the private sector. The pioneering work of TDR and some other special programmes have guided WHO's bold new approach. The Global Forum for Health Research, whose major goal is to intensify research effort on problems affecting the poor, is also actively promoting public-private partnerships.

In many countries, there are long established links of the public sector with non-governmental organisations and other non-profit institutions in the private sector for the delivery of health care. (Cross, 1998). On the other hand, until recently, the relationship between the public and the for-profit private sector was often characterised by antagonism, suspicion and confrontation. For example, the World Health Organization's (WHO) promotion of the Essential Drug Programme initially provoked strong reactions from the pharmaceutical industry. Concern about the inappropriate marketing of baby foods in developing countries, prompted some non-governmental organisations and other activists to mount pressure on manufacturers of baby foods; this negative reaction also influenced attitudes to the pharmaceutical industry. However, in recent years, increasing rapprochement between the public and the private sectors, is giving rise to positive encouragement of public-private partnerships in the health.

In this paper, the term "public-private partnership" is used to refer specifically to the collaborative programmes between the public sector and the for-profit section of the private sector. In the rest of the paper, the term "private sector" will be used to refer to the for-profit, commercial private sector, excluding not-for-profit non-governmental organisations and institutions within civil society. The paper describes two illustrative examples of public-private partnerships:

A. UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR)

B. Philanthropic drug donation programmes.

A. TDR - AN EXAMPLE OF PUBLIC-PRIVATE COLLABORATION

TDR was established 25 years ago with two inter-related objectives (Godal et al. 1998):

- **Research & Development:** to develop safe, acceptable and affordable methods of prevention diagnosis, treatment and control of TDR's target diseases.[1]
- **Training & Strengthening:** to strengthen the capability of developing disease-endemic countries to undertake the research required to develop new drugs

[1]Initially, six groups of diseases were included in the programme: Malaria: Schistosomiasis. The trypanosomiases - African trypanosomiasis and Chagas disease; The leishmaniases; The filariases - onchocerciasis and lymphatic filariasis: Leprosy. More recently, dengue and tuberculosis were added to the list of diseases in the TDR portfolio

Co-sponsored by the United Nations Development Programme, the World Bank and WHO, TDR was clearly a public sector initiative but it collaborated with the private sector on aspects of its programme. It was clear that TDR could not achieve some of its specific goals, especially the development of new drugs, without the collaboration of industry. Box 1 gives an illustrative list of private institutions that were involved with TDR during the first two decades of its operation. Because of the acrimonious controversies between the public and the private sectors, TDR's interactions with the pharmaceutical industry were initially cautious, guarded and closely monitored by the programme's governing bodies. They kept a watchful eye on TDR's links with industry, assuring the sponsors and other interested parties that in all the contracts and joint activities, the public interest was well protected.

TDR interactions with the private sector included:

- Participation of scientists from the pharmaceutical industry in TDR's advisory committees.
- Services to TDR from industry; and
- Joint programmes

Box 1

TDR'S COLLABORATIONS WITH THE PHARMACEUTICAL INDUSTRY

1. ACF Beheer, B.V., Maarssen, Netherlands
2. Bayer A.G., Leverkusen, Germany
3. Biobras-Bioquimica do Brasil, Montes Claros, Brazil
4. Burroughs Wellcome Company, Research Triangle Park, North Carolina, USA
5. Ciba Geigy, Ltd., Basle, Switzerland
6. Daiichi Pharmaceutical Co. Ltd., Tokyo, Japan
7. Eli Lilly and Company, Greenfield, Indiana, USA
8. Genetic Institutes, Boston, Maryland, USA Glaxo Group Research Ltd., Greenford, UK
9. IHARABRAS S.A., Industrias Quimicas, Sao Paulo, Brazil
10. International Federation of Pharmaceutical Manufacturers Associations, Geneva, Switzerland
11. Janssen Research Foundation, Beerse, Belgium
12. Laboratorios Gador, Buenos Aires, Argentina
13. Merck and Co. Inc., Rahway, New Jersey, USA
14. E. Merck Pharma, Darmstadt, Germany
15. Novo Nordisk A/S, Bagsvaerd, Denmark
16. Pasteur-Mérieux-Connaught, Swiftwater, Pennsylvania, USA
17. Pharmacia Farmitalia Carlo Elba, Milan, Italy
18. Rhône-Poulenc Rorer Doma, Antony, France
19. SmithKline Beecham Pharmaceuticals, London, UK
20. Vestar Inc., San Dimas, California, USA
21. Zeneca Pharmaceuticals, Macclesfield, UK

Source: UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (1994)

Contributions of scientists from pharmaceutical companies to TDR

TDR used a global network of scientists to develop, implement and review its research and development projects. The scientists, drawn from academic and research institutes as well as from industry, were selected strictly on the basis of individual merit and relevance to the needs of the programme. The scientists from drug companies contributed to TDR's task forces, working groups and steering committees in their special areas of expertise, but they were not appointed as representatives of their companies. These outstanding scientists from industry (including two Nobel Prize winners) gave service to TDR on a pro bono basis; they received no fees or honoraria beyond their travel and subsistence expenses.

Specific Services to TDR

TDR requested and obtained a variety of services from pharmaceutical companies including:

- **Special reagents required by research scientists** e.g. radio-labelled chemicals.
- **Good Manufacturing Practice facilities** for biological reagents that will be tested in humans e.g. Armadillo-derived leprosy bacilli, subsequently used for producing test vaccines, were processed and stored by the Wellcome Research Laboratories on behalf of TDR.

Joint activities of TDR with industry

Drug companies participated with TDR in exploring some promising leads and ideas:

- **TDR screening facilities.** TDR made available to industry its drug screening facilities. Over 10,000 compounds passed through the network of biological screens for testing candidate drugs for treatment of onchocerciasis. One compound, ivermectin, proved to be an outstanding product.
- **Clinical evaluation.** TDR worked with industry in the clinical evaluation of new drugs e.g. mefloquine (Hoffmann la Roche); ivermectin (Merck. & Co Inc.); eflornithine (Hoechst Marion Roussel Inc.)

TDR's research and development effort has been credited with the successful introduction of effective new technologies. (Box 2).

Box 2
TDR IN A CAPSULE

Since its inception in 1975, TDR's inputs and outputs include:
- **8000** projects involving **6500** scientists

Research & Development	Research Capability Strengthening
5300 projects in 127 countries totalling US$300 million	2700 projects in 80 countries totalling US$117 million

- **1100** scientists from developing countries completed research training
- **67** disease control tools developed of which **38** are in use for disease control
- Using tools and strategies generated with TDR support, there is now the possibility that **onchocerciasis, lymphatic filariasis, leprosy and Chagas' disease** can be eliminated

Source: TDR web site http://www.who.int/tdr

Features of TDR's partnerships with the private sector

Characteristic features of TDR's involvement with industry included the following elements:

- **Mutual respect.** In some international multilateral agencies, political considerations influence the selection of technical advisers to a degree that compromises the quality of their expert panels. Distinguished scientists find it difficult to work comfortably in such teams. TDR's working groups included distinguished scientists from all over the world: from developed and developing countries; from both sides of the iron curtain; and from academia, research institutes, health departments as well as from industry. The realisation that they had been selected on the basis of their personal expertise facilitated peer-level relationships among the scientists and generated mutual respect for each other as well as for the programme.

- **Clear goal orientation.** Although TDR supports a wide range of research activities, each group works towards the achievement of clearly defined goals. The strategic work plans include benchmarks for monitoring progress. Scientists from industry are well adapted to this approach but scientists from academia, more used to open-ended type of research plans, also become engaged with the TDR industrial production approach.

- **Sensitivity to each other's requirements.** As a publicly funded programme TDR's activities had to be transparent for the purpose of accountability to the sponsoring agencies as well as to the public at large. On the other hand, some of the collaborative research involved information and intellectual property of commercial value. TDR was able to accommodate both requirements by providing full disclosure of its operations but arranging for confidentiality on specific matters where indicated. For example, in screening chemical compounds for industry, TDR agreed to handle coded samples without requiring the company to disclose the structure of the molecules.

- **Protecting the public interest.** The essence of partnership is joint investment of effort and fair sharing of rewards. In drawing up contracts with the private sector, TDR pays close attention to the rights of the public sector to intellectual property that is produced through joint efforts. It has been possible to obtain various concessions in the public interest such as tiered pricing for sales to the public sector (e.g. mefloquine) and sub-licensing of patents (e.g. eflornithine). (Box 3)

Box 3
PUBLIC/PRIVATE PARTNERS IN SLEEPING SICKNESS

WHO and Hoechst Marion Roussel Inc. sign a License Agreement allowing WHO to arrange for the production of eflornithine - the 'resurrection drug' for African trypanosomiasis.

The initiative involves the drug eflornithine, on which WHO and Hoechst Marion Roussel have collaborated for a number of years. This drug has been nicknamed the 'resurrection drug' because of its spectacular effect on patients in the late stages of the disease, when the patient is comatose. However, although first registered for use in sleeping sickness in 1990, the drug is not in commercial production, partly because of the limited market, which makes it not at all attractive to the private sector, and partly due to its expense and hence non-affordability by endemic countries. On 6 December 1999, the World Health Organization and Hoechst Marion Roussel Inc. signed a License Agreement, in Geneva, granting WHO reference right to the license to produce eflornithine. The agreement will allow technology for production of the drug to be transferred from Hoechst Marion Roussel to a third party, in the private sector, which will manufacture eflornithine.

Present at the signing was Dr C. Bacchi, who discovered that eflornithine cured trypanosome infection experimentally while working under support from TDR, and drew attention to the parasite's unique polyamine metabolism. The drug was originally developed for use in cancer but did not meet expectations; it is now licensed for use in sleeping sickness in the US, Europe, and 12 African countries. The arrival of eflornithine provided an alternative drug for the treatment of gambiense sleeping sickness, the form of sleeping sickness that occurs in west and central Africa; but for the rhodesiense form of sleeping sickness that occurs in central and eastern Africa, there is no alternative treatment.

The agreement is a response to the challenge of access to drugs to treat diseases of the poor, and illustrates the new determination of WHO to 'make a difference'.

Source: TDR website — http://www.who.int/tdr

Comment on the TDR experience

TDR's experience with industry shows what can be achieved by carefully designed public-private partnerships. The relationships have been cordial and productive. TDR's mandate was to discover and develop new and improved technologies for the control of tropical diseases affecting the poor in developing countries. Neither the public sector nor the private sector working alone was able to achieve this goal. Through public-private partnerships, TDR assembled the critical mass that has produced a steady stream of new knowledge and effective technologies. Not only have new products emerged, but there is now evidence that several of the target diseases are now in the process of being eliminated. (TDR 1997; Blanks et al., 1998)

B. SPECIAL DRUG DONATIONS PROGRAMMES

Donation of drugs is a well-established charitable activity of private drug companies. Such gifts provide relief in times of disasters and other emergencies as well as supporting poor countries and their communities. A more recent phenomenon is the donation of specific drugs with explicit major public health goals. Merck and Co. Inc. through their donation of ivermectin (Mectizan), was the pioneer of this new type of giving. The basis of the donation is summarised in Box 4. (Dull & Meredith, 1998; Fettig, 1998)

Box 4
IVERMECTIN COMES FREE

On 20 June 1986, Robert D. Fluss of Merck Co. Inc.'s Division of International Public Affairs telexed the Director of TDR, Adetokunbo Lucas, with this message:

"...Merck and the WHO have collaborated extensively on the development of ivermectin for onchocerciasis. We are very encouraged by the prospects that this drug will be the first new agent available in several decades which will allow for the safe and effective treatment of patients on a mass scale. Merck intends to continue to co-operate with the WHO, the Onchocerciasis Control Programme and endemic country governments, in their efforts to develop and implement programs so that the drug, when approved for use, can be distributed efficiently.

"The special circumstances associated with this disease and the interest of several organizations and governments have caused Merck from the outset to consider ways of accommodating a variety of objectives. First and foremost is ensuring that the drug will be put to optimum use for the benefit of onchocerciasis patients and others who may be at risk of developing this disease. The company concluded that, in this case, the best way to achieve the full potential of ivermectin was to ensure that the economic circumstances of patients and governments in onchocerciasis-endemic areas would not prevent or restrict widespread use of the product once it is approved. Consequently, Merck is undertaking to make appropriate arrangements, if necessary with other interested parties, to ***make needed quantities of the drug available to these governments and patients at no cost to them for the treatment of onchocerciasis...***"

Source: UNDP/World Bank/WHO Special Programme for Research and Training in tropical Diseases (1994)

Charity versus Philanthropy

Andrew Carnegie, the well known philanthropist, in speeches and writings, notably his famous essay on "The Gospel of Wealth", made a clear distinction between charity and scientific philanthropy. He presented philanthropy as the mechanism by which "the surplus wealth of the few will become the property of the many, ... **administered for the common good, ... this wealth can be made a more potent force ... than if distributed in small sums to the people themselves.**" He warned that charity could have a "degrading pampering tendency on the recipients" whereas philanthropy was socially significant and beneficial. (Wall, 1970) For the sake of clarity, the first type of donation, consisting of simple random distribution of largesse, can be rightly described as charity. The donation of ivermectin, involving a clearly defined public health goal, can be classed as philanthropy. Several other companies have now followed Merck's example in initiating philanthropic programmes. (Kale, 1999; Wehrwein, 1999) (Table 1) (Box 5; Box 6)

Characteristic features of drug philanthropy

The four programmes listed in Table 1 have three important characteristic features:

- **Purposeful:** In each case, the donation aims at a clearly defined public health goal in terms of a measurable and significant impact on the target disease. The objectives are described in somewhat ambitious terms e.g. "Global elimination of lymphatic filariasis"; "It is possible now that the world can soon end its fight against blinding trachoma, a war that has been waged for at least 200 years." (See Box 5)

Table 1
PHILANTHROPIC DRUG DONATION PROGRAMME

Drug Company	Drug Target Diseases	Public Health Goal	Programme Manager	Major Partners*
Merck & Co	**Mectizan:** Onchocerciasis Lymphatic filariasis**	Elimination of onchocerciasis	Task Force for Child Survival & Development (Carter Center)	• Merck & Co • Task Force for Child Survival & Development • WHO • African Programme for Onchocerciasis Control
Pfizer	**Zithromax:** Trachoma	Elimination of blinding trachoma	International Trachoma Initiative	• Pfizer Inc. • Edna McConnell Clark Foundation • WHO
SmithKline Beecham	**Albendazole:** Lymphatic filariasis	Elimination of Lymphatic filariasis	WHO	• SmithKline Beecham • WHO
Glaxo Wellcome	**Malarone:** Malaria	Control of drug-resistant malaria	Task Force for Child Survival & Development (Carter Center)	• Glaxo Wellcome • Task Force for Child Survival & Development-WHO -- Roll Back Malaria

* In each case, many more partners are involved than are shown on these illustrative lists.
** An additional commitment by Merck Co. Inc.

- **Programme:** The drug donation is designed as a component of the strategic plan for dealing with the problem. For example, in the donation of azithromycin for the elimination of trachoma, the control programme includes four elements, the so-called S.A.F.E. strategy: **S**urgery, **A**ntibiotic therapy. **F**ace washing, and **E**nvironmental change (to increase access to clean water and better sanitation, and to increase health education) (Prüss & Mariotti, 2000)

- **Partnership:** Implementation of each programme requires the collaborative effort of several partners. (WHO, 1999a) Apart from the national government, partners usually include the donor company, WHO, institutions responsible for programme management, and non-governmental organisations that may undertake drug distribution and other interventions.

Box 5

MALARONE DONATION PROGRAMME

A public-private sector partnership between Glaxo Wellcome and the Task Force for Child Survival & Development, operated in partnership with Ministries of Health.

Objectives

- To reduce suffering and deaths from malaria by appropriate use of donated Malarone in endemic areas with known resistance to standard treatment
- To examine the most effective and responsible method of introducing a new, donated anti-malarial for use in endemic countries
- To explore ways to develop public/private partnerships for improving the health of people at risk from tropical disease

Commitments

- No active commercialisation of Malarone in endemic countries
- Comply with existing malaria control strategies
- Pilot studies to ensure that implementation is practicable and sustainable before expansion

Source: http://www.malaronedonation.org/.
See also: Oyediran & Heisler (1999)

Comment on drug philanthropy

The Mectizan Donation Program has accumulated a decade of experience but the other programmes are relatively young and are still largely in their formative period. Even at this early stage, it is valuable to ask critical questions about the concept of drug philanthropy and its implementation. It is relevant to ask some critical questions at this stage:

- **Priorities:** Does the programme address a problem of significant public health importance? Or, will it divert attention and resources away from more important national and regional priorities?

- **Programme:** Is the programme technically sound? Does the drug have an appropriate profile of features to suit the needs of the programme: **efficacy, safety, tolerance, mode of application, etc.?** Does it constitute a significant improvement on the existing package of interventions?

- **Prospects:** Are the stated goals realistic? Can the distribution of the drug together with the other planned inputs deliver the expected outcomes? Is there an appropriate infrastructure in place or can it be developed to support the planned interventions?

These and similar issues need to be addressed in the planning stage of a special donation programme.

Experience gained so far

The Mectizan Donation Program (MDP) has operated long enough for one to undertake a meaningful review of its functioning and its achievements. (Foege, 1998) Since its inception just over a decade ago, MDP has enabled over 100 million doses of the drug. Most of the endemic areas of onchocerciasis both in Africa and in south America are covered. Each year, the programme approves requests for 30 to 40 million treatments.

Table 2

Number of Mectizan treatments approved through community based, mass treatment and humanitarian donation programmes, by year (1988-1999)

YEAR	Community Based	Humanitarian*	Total
1988	255,000	26,000	281,000
1989	239,200	112,000	351,400
1990	1,321,500	342,500	1,664,000
1991	2,779,800	448,300	3,228,100
1992	4,879,500	509,800	5,389,300
1993	9,050,300	324,600	9,374,900
1994	11,801,800	282,200	12,084,000
1995	15,607,700	269,900	15,877,600
1996	19,141,400	159,700	19,301,100
1997	33,725,000	169,500	33,894,500
1998	30,668,500	73,200	30,741,700
1999	29,740,700	110,400	29,851,100
TOTAL	**159,210,400**	**2,828,300**	**162,038,700**

* The Humanitarian programme responds to random requests from individual practitioners for use in clinics and in other institutions. The programme is managed directly by Merck & Co from their Paris office.

Several factors have contributed to the success that MDP has achieved so far:

i. An outstanding drug: Mectizan has a profile of good features that make it ideal for mass distribution: efficacy[2], safety, simple regime (single dose by mouth once a year), well tolerated (improved sense of well being encourages patients to report for repeat doses). Di-ethyl carbamazine (DEC) that was previously used for treatment of onchocerciasis, provoked reactions in infected eyes, often causing further damage; ivermectin did not cause such damaging complications and promotes the healing of early lesions. (Abiose, 1998)

ii. Unequivocal commitment by Merck Co. Inc.: The donor company's commitment is summarised in the statement: **"Providing Mectizan to as many who need it for as long as necessary"**. Merck & Co., recently announced an expansion of the Mectizan Donation Programme. In response to the finding that Mectizan is also effective against lymphatic filariasis, Merck will expand its donation within Africa for the treatment of lymphatic filariasis.

iii. Effective Management: The Task Force for Child Survival and Development has set up an efficient mechanism for distributing the drug through the health authorities in the endemic countries and their partners.

iv. Expert Guidance: The Mectizan Expert Committee, consisting of public health experts, and liaison persons from Merck and WHO, provides technical guidance to the programme. With this arrangement, the donor company keeps in close touch with the programme whilst ensuring that commercial interests do not interfere with operational decisions.

[2] Mectizan is the most potent anti-infective agent in clinical use; the single adult dose of 12mg once a year compares favourably with antibiotics like penicillin and tetracycline that require doses of 1000mg or more per day! Mectizan does not kill the adult worm and so it must be given annually to eliminate the larvae.

Guidelines for drug philanthropy

Philanthropy from the pharmaceutical industry is not a new phenomenon. The Wellcome Trust, the largest medical philanthropic foundation with assets of the order of £13 billion pounds sterling (over US$20 billion), was the product of the munificence of the owner of a pharmaceutical company, Sir Henry Wellcome. WHO's guidelines for drug donations deal mainly with response to emergencies and some long term bilateral charitable gifts. (WHO, 1996, 1999b). The first version was issued in May 1996 and represented the consensus of WHO in consultation with a wide range of organisations.[3] It would be useful to define guidelines that are appropriate to the philanthropic donations. Such guidelines should include reference to key features of the philanthropic donations: purposefulness, integration into programmes and the mobilisation of partnerships. The guidelines should also address the issue of how to develop such programmes when the donation involves the introduction of a new drug as in the case of ivermectin and malarone.

WHO has drawn up guidelines aimed at reducing inappropriate donations and to guard against abuse. (WHO, 1999). But these guidelines do not apply to the new philanthropic drug donation programmes. At the very least, the new guidelines should address the three characteristic features of drug philanthropy:

- **Purposeful**: defined public health goal; measurable and significant impact;
- **Programme**: strategic plan including chemotherapy as a component; and
- **Partnership**: public-private sector collaboration.

The new guidelines should also address some of the issues that have arisen from the experiences that have been derived from the operation of the four pioneer programmes.

- **Commitment**: the donor company should be willing to make a long-term commitment. (See Box 5) Such commitment may follow an initial pilot phase. (Box 6)

Box 6

GLOBAL ELIMINATION OF LYMPHATIC FILARIASIS

SmithKline Beecham's Commitment

"SmithKline Beecham will provide albendazole free of charge to WHO for use by governments, and those organisations working in association with (or with the permission of) these governments, for such duration as is reasonably designed to achieve the objective of WHO, expressed in resolution WHA50.29 adopted by the 50th World Health Assembly in 1997 and calling for the global elimination of lymphatic filariasis as a public health problem. (Since the strategy calls for treatment of all 'at risk' populations annually for 4-6 years, and since up to 1.1 billion people may be at risk of infection, this donation could comprise as many as 6 billion doses of albendazole over the lifetime of the elimination effort [estimated at 20-25 years])."

Source: The Collaborative Agreement between SmithKline Beecham and the World Health Organization Targeting the Global Elimination of Lymphatic Filariasis
See Also: WHO (1999)

[3] Churches' Action for Health of the World Council of Churches, the International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies, Médecins Sans Frontières, the Office of the United Nations High Commissioner for Refugees, OXFAM and the United Nations Children's Fund. In 1999 the number of co-sponsors expanded to include Caritas Internationalis, the International Pharmaceutical Federation, Pharmaciens Sans Frontières, UNAIDS, the United Nations Development Programme, the United Nations Population Fund and the World Bank.

- **Management:** Competent, effective management is required to deal with the various aspects of the programme including mobilisation of and collaboration with partners.

- **Conflict of Interest:** In order to guard against real and apparent conflicts of interest, the system should include an appropriate buffer between the donor company and the operational decisions. Each of the four programmes has endeavoured to achieve this objective by handing over the management to a third party, supported by an independent expert advisory committee. For the Mectizan Donation Program, Merck devolved decision making to the Mectizan Expert Committee, a group of scientists and public health practitioners. Merck provided the supplies of Mectizan as recommended by the expert committee. In order to provide direct charitable contributions, Merck operates a humanitarian programme from its Paris office; it provides gifts of Mectizan in response to requests from individual practitioners unrelated to the main programme. (Table 2)

Comments on Public/Private partnerships

The crisis in the health sector has induced governments in many developing countries to review the relationship between the public and the private sectors. Public-private partnerships will become increasingly more significant in the coming years as policy makers explore options for promoting complementary involvement of the private sector.

WHO now strongly supports the promotion of public/private partnerships with the caveat that such partnerships should be mutually beneficial and must always benefit health. (WHO 1998). This new policy of developing partnerships with the private sector has not gone unchallenged. Some of the activists who have vigorously campaigned against the private sector have expressed their unhappiness with WHO's new policy. (See Box 7) In spite of these criticisms and reservations, WHO under its new leadership has clearly indicated its commitment to work with the private sector. Dr. Gro Brundtland, the Director-General of WHO, has held roundtable consultations with representatives of the pharmaceutical industry. WHO is also engaging industry on research projects aimed at finding new medicines for developing countries, on mechanisms for strengthening the Essential Drug Programme, for combating the illegal traffic in fake medicines, etc. Several of WHO's new initiatives involve partnerships with the private sector:

- Roll Back Malaria
- Medicine for Malaria Venture
- Medicine for African Sleeping Sickness

Box 7
WHO'S NEW GUIDELINES

The industry agenda to co-opt the UN and work in partnership with agencies such as WHO continues to cause alarm amongst NGOs working to protect public health. With the stakes so high, WHO's new draft *Guidelines on Interaction with Commercial Enterprises*, could have an important role to play. The guidelines are, however, very disappointing and seem to be more an attempt to seek public approval for partnerships with corporations, than to ensure that WHO stays true to its mandate to improve health. Some good suggestions are made, but the language used is contradictory and confusing, stressing the need for such things as *"mutual respect, trust, transparency and shared benefit."* These concepts hold very different meaning for transnational corporations who have entirely different aims and values. Commercial enterprises are called on to abide by WHO policies on medicinal drugs, tobacco and chemical and food safety, but no mention is made of WHO's infant feeding policies.

SOURCE: The website of ***Baby Milk Action,*** *"a non-profit organisation which aims to save lives and to end the avoidable suffering caused by inappropriate infant feeding. Baby Milk Action works within a global network to strengthen independent, transparent and effective controls on the marketing of the baby feeding industry".*

UNDP/World Bank/WHO Special Programme for Research & Training in Tropical Diseases (1997) "Prospects for elimination: Chagas' disease, Leprosy, Lymphatic filariasis, Onchocerciasis" (TDR/GEN/97.1).

UNDP/World Bank/WHO Special Programme for Research & Training in Tropical Diseases (1998) "Tropical Disease Research: Progress 1997-98: Fourteenth Programme Report of the UNDP/World Bank/WHO Special Programme for Research & Training in Tropical Diseases", World Health Organization, Geneva, Switzerland.

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W.H.O. (1998) Health For All in the Twenty-First Century World Health Organization Document A51/5 Geneva.

World Health Organization. (1999a) "Building Partnerships for Lymphatic Filariasis": World Health Organization, Geneva.

World Health Organization. (1999b) "Guidelines for Drug Donations". (Revised): WHO/EDM/PAR/99.3; 1-23 World Health Organization, Geneva.

Selected web sites

Organisation	Internet Address
Baby Milk Action	http://www.inbc.org/
Global Forum for Health Research	http://www.globalforumhealth.org/
International Trachoma Initiative	http:/www.trachoma.org/abouttrachoma.html
Malarone Donation Programme	http://www.malaronedonation.org/
Mectizan Donation Programme	http://www.taskforce.org/MDP/
Task Force for Child Survival & Development	http://www.taskforce.org/
UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR)	http://www.who.int/tdr
World Health Organization	http://www.who.int/
WHO Control of Tropical Diseases (Filariasis)	http://www.who.int/

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TDR/BP/00.1
(Original: English)

Public- Private Partnerships in the Health Sectors:
--An assessment

The definitions:

Different persons use the terms public private partnership and state civil society partenership with different shades of meaning. Let us define what the way we use the terms private and civil society

Civil society we use in the sense of associations of people other than those in government In practice this often refers to registered societies and trusts involved in health and developmental work and peoples movements representing the interests of one or more sections. However the term also includes professional associations, the press, and local community based organisations like youth clubs, which are not formally registered. There is one important exclusion in this usage- local self government bodies . These are bodies of local governance and to be seen as part of the government/state. Due to their lack of powers and resources they may acquire activities and characteristics similar to a voluntary organisation- but indeed they should not be so confused. They just need more powers.

The other important exclusion is private companies working for profit. There is an important role for them and a need for partnership in certain areas which we discuss under public private partemships, but to prevent confusion we keep that section outside the way we are using civil society.

When we talk of private we are talking of commercially run organisations driven by the profit motive, displaying entrepreneurship and facing competition.

Not-for -profit service delivery organisations should also not for this discussion be seen as private – as they are not defined by the motive of private profit. Neoliberalism believes that private is better simply because market mechanisms always provide for the greatest efficiency in service delivery and therefore people would get better health care and cheaper health care too as long as the market can mediate. The state need only care for the indigent or better still pay their bills. The discussion below is only examining whether this contention is true.

In contrast to this many use a definition that all those which are not government run – are private. This confuses two entirely different approaches – it confuses all community based and voluntary and altruistic efforts with those which are part of corporate strategies of maximising returns on investment .

The Context of the rise of public private partnerships:

The Alma Ata declaration of 1978 was essentially a political declaration. It recognized the role of economics and politics, it recognised the role of the state and the need to address inequity and the need to let people play a central role in decision-making. Its immediate follow up on being translated into a number of national health policies was also a continuation on this process. In India for example the national health policy of 1983 was a far-reaching document that captured much of the spirit of the Alma Ata declaration. What should have followed in the next step was a greater allocation of funds to health sector, strengthening of district level health administration and health systems , local health planning efforts, revised health schemes based on locally identified priorities and schemes that would provide for adequate community involvement. But this was never to take place –not even at token levels. Instead what took place through the eighties was a reformulation of the policy into a set of targets and next evolving fragmented vertical approaches to meet each of these targets.

ಗರ್ಭಿಣಿಯರಿಗೆ ನೀಡಬೇಕಾದ ಪಾಲನೆಯ ಅವಕಾಶವಿದ್ದಾಗ್ಯೂ ಎ.ಎಸ್.ಎಂ.ಗಳಿದ್ದಾಗ್ಯೂ ವಿಶೇಷ ಗಂಡಾಂತರ ಸಂದರ್ಭದಲ್ಲಿ ಏನೂ ಮಾಡಲಾಗುತ್ತಿಲ್ಲ. ನಿರ್ದೇಶ್ಯ ಆಸ್ಪತ್ರೆಗಳು ಇಲ್ಲದಿದ್ದಾಗ ಗರ್ಭಿಣಿಯಿಂದ ಯೋಗಕ್ಷೇಮದ ಉದ್ದೇಶವೇ ನಷ್ಟವಾಗುತ್ತದೆ. ರಕ್ತ ಹೀನತೆಗೆ ಚಿಕಿತ್ಸೆ. ಧನುರ್ವಾಯು ತಡೆಗಟ್ಟುವಿಕೆಗಳನ್ನು ಹೊರತುಪಡಿಸಿದರೆ ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳು ಕುಟುಂಬ ಯೋಜನಾ ಫಲಾನುಭವಿಗಳಿಗೆ ಸೇವೆಗೈಯುತ್ತಿವೆ.

ಹೆರಿಗೆಯ ತೊಂದರೆಯ ಬಗ್ಗೆ ತಿಳಿದಾಗ ಖಾಸಗೀ ಸಂಸ್ಥೆಗಳಲ್ಲಿನ ಸೇವೆಯೇ ಸಹಾಯಕ್ಕೆ ಬಂದಿದೆ. ದ್ವಿತೀಯ ಮಟ್ಟದ ಆರೋಗ್ಯ ಪಾಲನೆ ಒಟ್ಟಾರೆ ಇಲ್ಲದೇ ಹೋಗಿರುವುದರಿಂದ ಖಾಸಗೀವಲಯಕ್ಕೆ ಪ್ರೋತ್ಸಾಹ ದೊರೆತು ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಪಾಲನೆಯ ಪರಿಕಲ್ಪನೆಯೇ ತಪ್ಪು ಗ್ರಹಿಕೆಗೆ ಒಳಗಾಗಿದೆ. ಭಾಗಶಃ ಮಧ್ಯಪ್ರವೇಶದಲ್ಲಿಯೇ ಐದನೆಯ ಅಂತರ ಈಗಲೂ ನಮಗೆ ವಿಶ್ವಾಸವಿದೆ.

ರಾಷ್ಟ್ರೀಯ ಆರೋಗ್ಯ ಪಾಲನಾ ಮಾಹಿತಿಯಲ್ಲೂ ಈ ತಪ್ಪು ಗ್ರಹಿಕೆ ಇದೆ.

ನ್ಯೂನ ಪೋಷಣೆ ತಪ್ಪಿಸದೆ ಅತಿಸಾರವನ್ನು ತಡೆಗಟ್ಟಲಾಗದು. ಅತಿಸಾರ ತಡೆಗಟ್ಟದೆ ನ್ಯೂನ ಪೋಷಣೆ ನಿರ್ಮೂಲನವಾಗದು. ಒಂದನ್ನು ಬೆಲೆ ದೃಷ್ಟಿಯಿಂದ ಕಾರ್ಯ ಸಾಧ್ಯ ಎಂದು ಹೇಳಿ ಇನ್ನೊಂದನ್ನು ಕಡೆಗಣಿಸುವುದು ಅರ್ಥಹೀನವಾದದ್ದು.

ಇನ್ನೊಂದು ಉದಾ: ಮಲೇರಿಯಾ ಹಾಗೂ ಆನೆ ಕಾಲು ರೋಗಕ್ಕೆ ಪ್ರತ್ಯೇಕ ಕಾರ್ಯಕ್ರಮ ಅರ್ಥ ಹೀನ. ಈ ಎರಡಕ್ಕೂ ಸೊಳ್ಳೆಗಳ ನಿಯಂತ್ರಣವೇ ಪರಿಹಾರ! ಸೊಳ್ಳೆಗಳನ್ನು ನಿಯಂತ್ರಿಸಲು ಅನೇಕ ವಲಯಗಳು ಸಹಕರಿಸಬೇಕೇ ವಿನಾ ಆರೋಗ್ಯ ವಲಯವೊಂದೇ ಸಾಲದು. ರಾಷ್ಟ್ರವ್ಯಾಪ್ತಿಯ ಅನೇಕ ರೋಗ ನಿಯಂತ್ರಣ ಕಾರ್ಯಕ್ರಮಗಳಲ್ಲಿಯೂ ಆರೆ ಬರೆಮಧ್ಯ ಪ್ರವೇಶವನ್ನು ಸರ್ಕಾರ ಕೈಗೊಳ್ಳುತ್ತಿದೆ.

ರೋಗ ನಿಯಂತ್ರಣದ 16 ಕಾರ್ಯಕ್ರಮಗಳಿವೆ. ಪ್ರತಿ ಖಾಯಿಲೆಗೂ ತನ್ನದೇ ಪರಿಣಾಮಕಾರಿ ಪರಿಹಾರವಿದೆಯೆಂದು ಊಹಿಸಲಾಗಿದೆ. ಈ ಪರಿಹಾರವನ್ನು ಅನ್ವಯಿಸಿದ ಸಮಸ್ಯೆ ಪರಿಹಾರವಾಗುವುದು.

ತಂತ್ರಜ್ಞಾನ ಮೂಲಕ ಈ ಬುಡಮೇಲು ಕ್ರಮವು ರೋಗ ನಿಯಂತ್ರಣ ಪ್ರಯತ್ನದ ಇತಿಮಿತಿಯಾದೀತು.

ಆಲ್ಮಾ ಆಟಾ ಘೋಷಣೆ ಮತ್ತು ರಾಷ್ಟ್ರೀಯ ಆರೋಗ್ಯ ನೀತಿಗಳೆರಡೂ 10 ವಲಯಗಳ ನಡುವೆ ಅಂತರ್ ಸಹಕಾರವನ್ನು ಒತ್ತಿ ಹೇಳಿವೆ. ಆದರೆ ವ್ಯಾವಹಾರಿಕವಾಗಿ ಕಾರ್ಯಕ್ರಮ ವಿನ್ಯಾಸಗೊಳಿಸುವ ಹಂತದಲ್ಲಿಯೇ ಈ ಸಹಕಾರವನ್ನು ಕೈ ಬಿಡಲಾಗಿದೆ.

ಆರೋಗ್ಯ ಯೋಜನೆಗೆ ಕೊಡುಗೆ ನೀಡುವ ವೈದ್ಯಕೀಯ ವೃತ್ತಿಪರರು ತಂತ್ರಜ್ಞಾನದ ಮಧ್ಯಪ್ರವೇಶ ಬಲ್ಲರೇ ವಿನಾ ಬಹುವಲಯ ಅಭಿವೃದ್ಧಿಯ ಅನುಭವ ಉಳ್ಳವರಲ್ಲ.

ಮಾರಾಟ ಸಾಮಗ್ರಿಯ ಲಾಬಿ ಇದೆಯೇ ವಿನಾ ಬಹುವಲಯ ವಿಧಾನಕ್ಕೆ ಲಾಬಿ ಇಲ್ಲ. (ಮಕ್ಕಳಿಗೆ ಹೆಪ ಟೈಟಸ್ ಬಿ ಲಸಿಕೆ ನೀಡಿಕೆಗೆ ಉತ್ತೇಜನವೇ ಉದಾಹರಣೆ)

ಸರ್ಕಾರಿ ಕಾರ್ಯಕ್ರಮವಾಗಿ ಇದು ಇನ್ನೂ ರೂಪುಗೊಂಡಿಲ್ಲ. ಒಮ್ಮೆ ರೂಪುಗೊಂಡರೆ ಉಪ್ಪಿನ ಆಯೋಡೀಕರಣದಂತೆ ಇಲ್ಲವೇ ಸೊಳ್ಳೆಪರದೆಯ ಕಾರ್ಯಕ್ರಮದಂತೆ ಅಥವಾ ವಿಟಮಿನ್ ನೀಡಿಕೆಯಂತೆ ಮುಂದುವರಿಯುವುದನ್ನು ಯಾರೂ ತಡೆಯಲಾರರು.

ಇಡೀ ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರವನ್ನು ಕುಟುಂಬ ಯೋಜನಾ ಕಾರ್ಯಕ್ರಮ ನುಂಗಿಹಾಕಿತು.

ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳು ಜನರ ಉತ್ಸಾಹವನ್ನು ಹೆಚ್ಚಿಸಿದವು. ಅವರ ಅಗತ್ಯಗಳಿಗೆ ಅಪ್ರಸ್ತುತವೆನಿಸುವುವು. ಇದರ ಪರಿಣಾಮವಾಗಿ ಉತ್ತಮ ಆರೋಗ್ಯ ಪಾಲನೆಯ ಬೇಡಿಕೆಯೂ ಮೂಲೆ ಗುಂಪಾಗುವುದು.

Enter the World Bank

By 1990 the World Bank had emerged on the scene as the major player and the world development report as its major expression. The 1990 World Development Report(2) was a strident advocacy for a greater role in health. Encouraged it went ahead with some serious work and in 1993 came out with its world development report titled "Investing in Health."(3) This report was completely focused on health care and in practice this became international health policy almost from the day it was published. We shall later examine the compulsions that caused this, but let us now examine the main features of this report- which was to henceforth inform almost all national health planning.

The main features of the world banks recommendations in "Investing in Health" were as follows:

1. There is a need to increase public investment in health. This is one of the few forms of transfer of resources to the poor that is acceptable both because it does not run foul of local power groups and because it does not increase state role in the economy.
2. It is not possible to do everything for every body. We (the world Bank) and national governments need to prioritise public health interventions. The mechanism of prioritization is to reduce all diseases to a single index based on the extent of disability it creates(Disability Adjusted Life Years) and calculate the expenditure it takes to prevent or cure that disease. Thus prioritization of public expenditure on health is to be based on "dollar spent per DALY saved."
3. At the global level the six interventions that emerge as major concerns are maternal care and child care services, population control, control of tuberculosis, control of sexually transmitted diseases and nutrition within which micronutrient intervention was rated the most feasible. Not only these priorities but even the exact programme design are to be accepted at national level, with some negotiation if need be before funds needed for building the infrastructure and implementing the programme could be extended by the World Bank, even then with strict monitoring and controls.
4. All other dimensions of health must be opened to the private sector and brought to conform to market forces as competition amongst private producers would encourage better services at lower costs.
5. Government must reduce its expenditure on other services through cost recovery mechanisms especially user fees and promote private sector in these areas. Promotion of health insurance would cover the needs of most sections.

It may also be noted that this World Bank document makes no note of the Alma Ata declaration. In contrast to the fate of the Alma Ata declaration the implementation of the new World Bank understanding was immediate. Country after country received a loan, which would be a small part of the recipient nation's total health budget but in return for which the health sector had to be reformed to bring it in conformity with the above principles – structural adjustment in healthcare!! It is indeed surprising that such a dramatic change did not excite more comment and opposition especially as many of its immediate implications were technically unsound, politically unacceptable and even undermined national sovereignty at points. But very soon after the flaws in this prescription became more and more obvious. Nor was resistance completely absent especially from more vocal people oriented NGO sections and peoples movements across the world. And the World bank was quick to respond.

The World Bank Course Correction

Responding to these factors the world bank came out with a modification of its polices which are set out in its document Nutrition, Health and Population in January 1997.(4).The main features of this report were as follows

ನೀವು ಹೇಳುವುದು ಸುಳ್ಳು. ಸಮುದಾಯ ಭಾಗವಹಿಸುವಿಕೆಯಲ್ಲಿ ನಮಗೆ ನಂಬಿಕೆ ಇದೆ. ಇದೇ ನಮ್ಮ ಆದರ್ಶ.

ಈ ವಿಮರ್ಶಕರು! ಸಮುದಾಯ ವಿಶ್ವಾಸಾರ್ಹವಲ್ಲ ಎಂಬುದನ್ನರಿಯರು.

ಸಮುದಾಯ ಭಾಗವಹಿಸುವಿಕೆ ಕಡಿಮೆ ಇರಲು ಮೂರು ಕಾರಣಗಳಿವೆ.

ಮೊದಲು ⇒ ಪೂರ್ವನಿರ್ಧರಿತ ಕಾರ್ಯಕ್ರಮಗಳ ಜಾರಿಗೆ ಸಮುದಾಯದ ಸಹಾಯ ಬೇಕು. ಇದು ಸಮುದಾಯದ ಪರಿವರ್ತನೆ; ಭಾಗವಹಿಸುವಿಕೆ ಅಲ್ಲ.

ಎರಡನೆಯದಾಗಿ ⇒ ಸಾಮರ್ಥ್ಯ ಹೆಚ್ಚಳಕ್ಕೆ ಸಂಪನ್ಮೂಲವಾಗಲೀ, ಯೋಜನೆ ಆಗಲೀ ಇಲ್ಲ. ಸಮುದಾಯ ಭಾಗವಹಿಸುವಿಕೆಯು ಸಮುದಾಯ ನಿಂದನೆಗೆಡೆ ಮಾಡಿಕೊಡುವುದು. ಪಂಚಾಯ್ತಿ ಒಳಗೊಳ್ಳುವಿಕೆಯಲ್ಲಿ ಇದು ನಿಜ.

ಮೂರನೆಯದಾಗಿ ⇒ ಆಯ್ಕೆಗೊಂಡ ಪಂಚಾಯ್ತಿ, ಜನ ಚಳುವಳಿ, ಸರ್ಕಾರೇತರ ಸಂಸ್ಥೆಗಳು - ಇವನ್ನು ಪ್ರೋತ್ಸಾಹಿಸಿ ಸಮುದಾಯ ಭಾಗವಹಿಸಿಕೆಯನ್ನು ಹೆಚ್ಚಳಗೊಳಿಸಬಹುದು. ಆಡಳಿತಾರೂಢರು ಒಂದು ಸಮಿತಿಯನ್ನು ಯಾಂತ್ರಿಕವಾಗಿ ನೇಮಿಸಿ ಸಮುದಾಯ ಭಾಗವಹಿಸಿಕೆಯೆಂದು ಹೇಳಲಾಗುತ್ತದೆ.

ನಿಜವಾದ ಸಮುದಾಯ ಭಾಗವಹಿಸುವಿಕೆ ಸಮುದಾಯ ಸಂಘಟನೆಯಿಂದ. ಇಂತಹ ಸಂಘಟನೆ ಆಡಳಿತ ವರ್ಗದ ಒತ್ತಾಯದಿಂದ ಅಲ್ಲ. ಅದು ತನ್ನ ಬೇಡಿಕೆಗಳನ್ನು ಸ್ಥಳೀಯ ಅಗತ್ಯಕ್ಕೆ ಅನುಗುಣವಾಗಿ ರೂಪಿಸುವುದು. ಇದೇ ನಿಜವಾದ ಭಾಗವಹಿಸುವಿಕೆ. ಸ್ಥಳೀಯ ಆಡಳಿತ ವರ್ಗ ರಾಜಕಾರಣಿ, ಗುತ್ತಿಗೆದಾರರು ಇದಕ್ಕೆ ಬೆದರಿದೆಹಲಿಯ ಪ್ರಯತ್ನವನ್ನು ಬೆಂಬಲಿಸುವರು.

ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳು ಜಿಲ್ಲಾ ಆಸ್ಪತ್ರೆಗೆ ನಿರ್ದೇಶಿಸಬಹುದು ಎಂಬುದು ಈಗಲೂ ನಿಜ. ಅಂದಾಕ್ಷಣ ನಿರ್ದೇಶ ವ್ಯವಸ್ಥೆ ಇದೆಯಂದಲ್ಲ. ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳು ಹಾಗೂ ಜಿಲ್ಲಾ ಆಸ್ಪತ್ರೆಗಳು ಒಂದೇ ತಂಡವಾಗಿ ಕೆಲಸ ಮಾಡಿದಾಗ ಮಾತ್ರ ಪರಿಣಾಮಕಾರಿ ವ್ಯವಸ್ಥೆಯಾಗಬಲ್ಲವು.

ಪರಿಣಾಮಕಾರಿ ನಿರ್ದೇಶ್ಯ ವ್ಯವಸ್ಥೆಯೆಂದರೆ ಇದು.

ಅತ್ಯಂತ ಗಂಡಾಂತರದ ಹೆರಿಗೆಯ ಗರ್ಭಿಣಿ ⇒ ಸ್ಥಳೀಯ ಮಟ್ಟದಲ್ಲಿ ತಪಾಸಣೆ ⇒ ದ್ವಿತೀಯ ತಪಾಸಣೆ

ದ್ವಿತೀಯ ಆಸ್ಪತ್ರೆ ನಿರ್ವಹಣೆ ⇐ ಸ್ಥಳೀಯವಾಗಿ ಹೆರಿಗೆ ⇐ ಪಿ.ಹೆಚ್.ಸಿ. ನಿರ್ದೇಶನ

ಹಾಗೆಯೇ ಸ್ಥಳೀಯವಾಗಿ ತಪಾಸಣೆಗೊಳಗಾದ ಸಕ್ಕರೆ ಖಾಯಿಲೆಯ ವ್ಯಕ್ತಿ ಪಿ.ಹೆಚ್.ಸಿ. ಯಿಂದ ದ್ವಿತೀಯಜ ಆಸ್ಪತ್ರೆಗಳೂ ಅನಂತರ ಮುಂದುವರಿಕೆ ಚಿಕಿತ್ಸೆಗಾಗಿ ಮತ್ತೆ ಪಿ.ಹೆಚ್.ಸಿಗೂ ನಿರ್ದೇಶನಾಗುವನು. ಹೀಗಾಗಿ ಅದು ಒಂದೇ ಘಟಕವಾಗಿ ವರ್ತಿಸುವುದು.

ಅಂತಹ ನಿರ್ದೇಶ ವ್ಯವಸ್ಥೆಯು ಪಿ.ಹೆಚ್.ಸಿಯ ಸಾಮರ್ಥ್ಯವನ್ನು ಹೆಚ್ಚಳಗೊಳಿಸಿ ವ್ಯಾಪಾರ ಆಗತ್ಯಗಳನ್ನು ಅದರಲ್ಲಿ ಚಿಕಿತ್ಸಾ ಆಗತ್ಯಗಳನ್ನು ಪೂರೈಸಬಲ್ಲದು. ಅನ್ಯಥಾ ಅಲ್ಲ.

100000 ಜನರಿಗೆ ಒಂದರಂತೆ ಇರಬೇಕಾದ ಸಮುದಾಯ ಈ ಕೊರತೆಯನ್ನು ನೀಗಬಲ್ಲದು. ಮೊದಲ ನಿರ್ದೇಶನ ಘಟಕ ತಪ್ಪಿಸಲು ಆಗತ್ಯ. ಈ ಪೈಕಿ 50% ಸ್ಥಾಪನೆಗೊಂಡಿಲ್ಲ. ಸ್ಥಾಪಿತವಾಗಿರುವ ಕೇಂದ್ರಗಳಲ್ಲೂ ಮೂಲ ಆಗತ್ಯಗಳು ಪೂರೈಕೆ ಆಗಿಲ್ಲ.

⇒ ವಿರುದ್ಧ ಆಶೆಗಳು ಪರಸ್ಪರ ಹೊಂದಾಣಿಕೆ ಆಗದಂತಹವು ಮತ್ತು ಎರಡನೇ ಹಂತದ ಆಸ್ಪತ್ರೆ ಸೇವೆಯ ಖಾಸಗೀಕರಣ.

1. Governments do have a major role to play in health care – especially to reach the poor. Partly because they(governments) are already there, and also because the private sector does not reach many of these sections nor include it as their priorities.
2. The public sector should be much better targeted on specific groups and specific problems .This needs a number of managerial reforms to improve their efficiency and the use of specific criteria to identify and define these groups. Even then the public sector is inherently difficult to reform very much.
3. The private sector is affected by "market imperfections," causing it to fail to reach the poor and fail to secure sustainable financing. Unless there is a strong government role in regulating , assisting and guiding the private sector health goals would not be achieved.
4. Private voluntary health insurance is particularly prone to market imperfections and are discouraged.(user fees are not specifically withdrawn but the report becomes silent on the issue. Subsequently the world Bank is to become vocal against being characterized as imposing user fees and claim that such characterization is an example of how it has been misunderstood)

The new mantra becomes "*Balanced Public Sector/Private Sector Mix.*" To quote-" Both economic principles and empirical evidence suggest that a mixture of public and private involvement leads to the best results in the HNP sector. Neither sector is effective by itself- each needs the other. Both too much and too little involvement by either sector are often associated with problems."(4) (As part of this course correction, the WHO was given a new role, that of a limited technical adviser and the Alma Ata declaration was acknowledged in the annexure of this report as a document that had set a number of goals and targets, which was in current need of updating!!!.)

This retreat from private sector only sort of approach is however not a retreat from neo-liberal doctrines. Only it is considered a better strategy to attain that goal. The bank advocates three "waves" of state reform. The first wave focuses on the privatization of commercial enterprises; the second wave privatizes public infrastructure and utilities; and the third wave continues with privatization of state assets and utilizes non-governmental and private management and investment in health, education, and pensions systems.(4) It is privatizing health care in the first round itself that is being questioned. Moreover the bank is no longer advocating in the health sector at least for now - the sale of public assets. What they are saying is the use of the public sector to build up the private sector, in a more viable and sustainable form. In this they see a long-term role for the state too with government having a greater role in the regulation of healthcare services. Though its health specialists might be eager to play down the bank's support of the private sector, the latest annual report is less reserved: "One of the bank's top priorities is to help stimulate the private sector. That's because the private sector is the main source of economic growth of jobs and higher incomes. The bank encourages the private sector by advocating stable economic policies, sound government finances, and open, honest, accountable, and consistent governance, and by offering guarantees."[5]

Stated Goals of public private partnerships:
Why is public private partnerships preferred? What are the projected benefits?
Broadly these are the following :-

- They bring in greater efficiency/greater quality in health care service delivery
- They cover areas/sectors where public sector/ cannot or is not efficient to reach.
- They bring in more investment in health.

ನಾನು ಕಂಡುಕೊಂಡರೂ ದೆಹಲಿ ಗುರುತಿಸಿದ ಪ್ರಧಾನ ಸಮಸ್ಯೆಗೆ ಹಣ ನೀಡಲಾಗುತ್ತಿದೆ.

ಸ್ಥಳೀಯ ಯೋಜನೆಗೆ ಪರಿಣಾಮಕಾರಿ ಆರೋಗ್ಯ ಮಾಹಿತಿ ಕೇಂದ್ರ, ವ್ಯವಸ್ಥೆ ಬೇಕು.

ಅನೇಕ ಜಿಲ್ಲೆಗಳು ಲಸಿಕೆ ಕಾರ್ಯಕ್ರಮ ಪೂರ್ಣಗೊಂಡಿರುವದಾಗಿ ಹೇಳುವವು. ಕೇವಲ 14% ರೋಗಿಗಳು ಸರ್ಕಾರಿ ಕೇಂದ್ರಗಳಿಗೂ ಹೋಗುವರು. ಹೀಗಾಗಿ ದಡಾರ, ನಾಯಿಕೆಮ್ಮುಗಳಿಲ್ಲವೆಂದು ಹೇಗೆ ಹೇಳಲು ಸಾಧ್ಯ? ಯಾವ ಜಿಲ್ಲೆಯಲ್ಲೂ ಕಾಮಾಲೆ ಪರಿಣಾಮವನ್ನು ಅಂದಾಜು ಮಾಡಲು ಕಠಿಣ. ಜಿಲ್ಲಾ ಅಧಿಕಾರಿಗಳು ಎಚ್ಚೆತ್ತುಕೊಳ್ಳದೆ ಪ್ರಮುಖ ಆರೋಗ್ಯ ಸಮಸ್ಯೆಗಳು ಹಾಗೆಯೇ ಉಳಿಯುವವು.

ಕ್ರಿಯಾತ್ಮಕ ಆರೋಗ್ಯ ಮಾಹಿತಿ ಯೋಜನಾರಹಿತ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮ ಏಕೆ ಬೇಕು?

ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ ಯೋಜನೆಯ ವಿಕೇಂದ್ರೀಕರಣವನ್ನು ರೂಪಿಸಿದೆಯೇ? ಇಲ್ಲ. ಸಮುದಾಯದ ಆರೋಗ್ಯವನ್ನು ಸ್ಥಳೀಯವಾಗಿ ರೂಪಿಸಬಲ್ಲ ವ್ಯವಸ್ಥೆಗೆ ಒತ್ತಡ ಹಾಕಬೇಕಾಗಿದೆ.

ಸಮೀಕ್ಷೆಗಳನ್ನು ನಿಯತಕಾಲಿಕವಾಗಿ ಅಥವಾ ಆಗಿಂದಾಗ್ಗೆ ನಡೆಸಿ ಅದರ ಆಧಾರದ ಮೇಲೆ ಯೋಜನೆ ರೂಪಿಸುವುದು.

ಈ ಮಾಹಿತಿ ನಿರ್ಮಿತಿಯಿಂದ ವಿಕೇಂದ್ರೀಕರಣ ಯೋಜನೆ ರೂಪುಗೊಳ್ಳುವುದೆಂದೇನೂ ಇಲ್ಲ! ಕೇಂದ್ರೀಯ ಯೋಜನೆಯೇ ಅವರ ಗುರಿ.

ಸಮುದಾಯ ಭಾಗವಹಿಸಿಕೆ ಇಲ್ಲ.

ಮೂರನೆ ಅಂತರ.

ಗ್ರಾಮೀಣ ನಾಯಕರನ್ನು ಹಾಗೂ ಮಾತೆಯರನ್ನು ನ್ಯೂನ ಪೋಷಣೆಯ ಮಕ್ಕಳನ್ನು ಗುರುತಿಸುವಂತೆ ರಾತ್ರಿಕುರುಡು ಇರುವ ಮಕ್ಕಳನ್ನು ಗುರುತಿಸಿ ವಿಟಮಿನ್ ಎ ನೀಡುವಂತೆ ಕೇಳಬೇಕೇ?

ಎಲ್ಲ ಕಾರ್ಯಕ್ರಮಗಳ ವಿನ್ಯಾಸವನ್ನು ಆರೋಗ್ಯ ಆಡಳಿತಶಾಹಿಯ ಕಿರಿಯ ಸಿಬ್ಬಂದಿ ಬಳಕೆಗೆ ಯೋಗ್ಯವಾಗುವಂತೆ ಮಾಡಿ ಸಮುದಾಯದ ಭಾಗವಹಿಸುವಿಕೆಯನ್ನು ಅಲಕ್ಷಿಸಲಾಗಿದೆ. ಈ ರೀತಿ ಆಡಳಿತ ಕೇಂದ್ರಿತ ವಿಧಾನ ಪರಿಣಾಮಕಾರಿಯಾಗದು.

ಯಶಸ್ವಿ.
ನಾವು 70% ಜನರಿಗೆ ವಿಟಮಿನ್ ಎ ನೀಡಿದ್ದೇವೆ.

ಎಚ್ಚರಿಕೆಯಿಂದ ಗಮನಿಸಿ. ಉಳಿದ 30% ಜನರಿಗೆಲ್ಲಾ ರಾತ್ರಿಕುರುಡು ಇದೆ.

ನೇರ ಚಿಕಿತ್ಸೆಯ ಅಲ್ಪಾವಧಿ ಕೋರ್ಸ್!

ಸ್. ಕ್ರಮದ ಮೂಲಕ ಕ್ಷಯ ನಿಯಂತ್ರಣದ ಕೈಗೊಂಡಿರುವುದನ್ನು ತೆಗೆದುಕೊಳ್ಳಿ. ಆರೋಗ್ಯ ಸಿಬ್ಬಂದಿಯು ರೋಗಿಯನ್ನು ತಮ್ಮ ಬಳಿಗೆ ಕರೆಸಿ ಆತ ಔಷಧಿ ತೆಗೆದುಕೊಳ್ಳುತ್ತಿರುವ ಬಗ್ಗೆ ಖಚಿತ ಮಾಡಿಕೊಳ್ಳುವುದು ವ್ಯವಹಾರ ಯೋಗ್ಯವೂ ಅಲ್ಲ. ಕಾರ್ಯಕ್ರಮದ ವ್ಯಾಪ್ತಿಯನ್ನು ಕುಂಠಿತಗೊಳಿಸುತ್ತದೆ. ಇಲ್ಲಿ ಸಮುದಾಯದ ಒಳಗೊಳ್ಳುವಿಕೆಯನ್ನು ಕಡೆಗಾಣಿಸಲಾಗಿದೆಯಲ್ಲದೆ ಹಾಗೆಯೇ ಯಶಸ್ಸನ್ನು ಘೋಷಿಸಲಾಗಿದೆ.

- They bring in more innovation.
- They provide more customer satisfaction..
- They are willing for philanthrophy-

We need to examine whether indeed the above contentions can be substantiated by the experiences of the last five to seven years , once this had become the main thrust of policy. Let us therefore examine each contention one by one and then look at case studies to see what public private partnerships are all about.

Better Quality of Care:

In a third world context regulatory frameworks are very weak. The private sector in health is often frankly unethical and irrational. Thus we know that normally about 10% of all pregnancies are high risk and about 4% would need a Cesarean section. Yet in many private clinics the Caesarean section rate is about 50%. of all pregnancies . even after accounting for a selection bias this would be unreasonably high. Unnecessary hysterectomies, appendices removed unnecessarily, CT scans ordered unnecessarily, laboratory investigations wastefully done and in so many other ways a supply side driven wasteful and costly consumption of health characterizes this segment.

The private sector for the poor is another dimension of problems altogether. About two thirds or more of all private sector care in rural areas are delivered by completely unqualified , illegal practitioners of allopathy. Many have had as little training as working informally as doctors assistant in his clinic for one or two months before setting up on their own.

Prescription analysis studies have shown high and dangerous irrationalities in their prescriptions . The cost of health care is now not only the second highest item of expenditure in all rural households it is also largely a wasteful drain providing little improvement and often endangering their health.

Does private sector health care increase outreach?

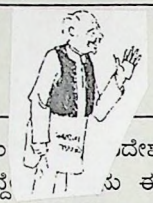
The state of Chhattisgarh is a good case study for this question. In almost no center where the public sector has not first penetrated and opened it up to allopathic care – does the private sector reach. Indeed given the fact that public sector doctors are allowed private practice – the private sector is embedded in it and spreads with it-never ever preceeding it. In almost a fourth of the blocks- the public sector doctor is the only qualified medical help available. If we see by sectors- units of 30,000 population, in over 50% the public sector doctor may be the only doctor available – even after accounting for a large degree of absenteeism and vacancies. The only other sector that does have an outreach are some mission hospitals and dispensaries- but they have nothing to do with all the arguments of privatisation on the world bank. They represent the strengths in civil society to resist market forces and their theoretical confusion with the former is a motivated one.

There are studies like Gita Sen's that have looked at access to health care figures in the nineties and come to the conclusion that about 35% of population getting excluded from any health care due to increasing cost of care!!

Public private partnerships are therefore become directed largely to contracting out public paid services to the private sector.

Let us look at a few case studies of such public- private partnerships:

ಎಲ್ಲವನ್ನೂ ನಾವು ಮಾಡಲಾರೆವು. ಬೆಲೆಗಿಟ್ಟುವ ಮಧ್ಯಸ್ಥಿಕೆ ಮಾತ್ರ ನಮ್ಮದು. ನೀವು ನಿಮ್ಮ ವೆಚ್ಚವನ್ನು ಕಡಿಮೆ ಮಾಡಿಕೊಳ್ಳಿ.

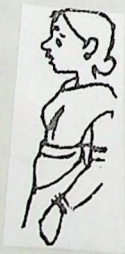


ಆರೋಗ್ಯ ಸೂಚಿಗಳಲ್ಲಿ ಪ್ರಗತಿಯನ್ನು ತೋರಿಸಬೇಕು.

ನನ್ನ ಮಾತನ್ನು ನಂ ದೇಶಗಳಲ್ಲಿ ನಾನು ಇದನ್ನು ಮಾಡಿದ್ದೆ ು ಈ ಕಾರ್ಯಕ್ರಮ ರೂಪಿಸಿದ್ದೇನೆ. ಬೆಲೆ ಆಧರಿಸಿ ಖಾಯಿಲೆಗಳನ್ನು ಪ್ರಥಮ, ಮಧ್ಯಮ ಮತ್ತು ಕನಿಷ್ಠ ಆದ್ಯತೆಯವನ್ನಾಗಿ ವರ್ಗೀಕರಿಸಿ ಪ್ರಥಮ ಆದ್ಯತೆಯವಕ್ಕೆ ಮಾತ್ರ ಪ್ರಯತ್ನಿಸಿ ಯಾರಾದರೂ ಕೇಳಿದರೆ ಪ್ರಥಮ ಆದ್ಯತೆಯನ್ನು ಮುಗಿಸಿದ ನಂತರ ನೋಡೋಣವೆನ್ನಿ. ಆಗ ನಿಮಗೆ ಸಮಸ್ಯೆ ಏನೂ ಬರದು.

ಅನಂತರ ಅವರು ಭಾರತದ ಆದ್ಯತಾ ಕ್ಷೇತ್ರವನ್ನು ಕುಟುಂಬ ಯೋಜನೆ ಎಂದು ಘೋಷಿಸಿದರು. ಅನಂತರದಲ್ಲಿ ಮಹಿಳೆ ಮತ್ತು ಮಕ್ಕಳ ಆರೋಗ್ಯ, ಪೋಷಕ ಆಹಾರ, ಕ್ಷಯ ಮತ್ತು ಲೈಂಗಿಕ ರೋಗಗಳು, ಅದರಲ್ಲಿ ಅವರು ಲಕ್ಷ್ಯವನ್ನು ಹುಡುಕತೊಡಗಿದರು.

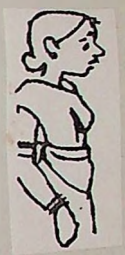
ಮಕ್ಕಳ ಆರೋಗ್ಯ



ಜೆ.ಓ.ಬಿ.ಐ. ಕ್ಷೇತ್ರದಲ್ಲಿ ಓ.ಆರ್.ಎಸ್. ಪೊಟ್ಟಣಗಳನ್ನು ವಿತರಿಸುವ ಮತ್ತು ಲಸಿಕೆ ಕಾರ್ಯಕ್ರಮಗಳು.

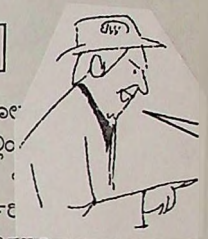
ಜೆ.ಓ.ಬಿ.ಐ. ಧೋರಣೆ ಬೆಳವಣಿಗೆಗೆ ನಿಯಂತ್ರಣ ಓ.ಆರ್.ಎಸ್. ಮೊಲೆಯೊಡುವಿಕೆ ಮತ್ತು ರೋಗ ನಿರೋಧಕತೆ. ಈ ಜೆ.ಓ.ಬಿ.ಐ. ಯು ಎಲ್ಲಾ ಮಕ್ಕಳು ತಿನ್ನುವ ಹೂ ಕೋಸಿನಲ್ಲಿ? ಕೋಸು? ಯಾರಿಗೆ ಗೊತ್ತು. ಅದನ್ನೇ ತಿನ್ನಬೇಕಾಗಬಹುದು.

ಮಹಿಳೆಯ ಆರೋಗ್ಯದಲ್ಲಿ ಮಾತೃ ಪಾಲನೆಗೆ ಆದ್ಯತೆ. ವಿಶೇಷವಾಗಿ ಗರ್ಭಿಣಿಯರ ಪಾಲನೆ. ಕುಟುಂಬ ಯೋಜನೆಗೆ ಇದು ಮುಖ್ಯವಾಗಿ ಬೇಕಾಗಿತ್ತು. ಅಯೋಡಿಕರಿಸಿದ ಉಪ್ಪು ಕಬ್ಬಿಣ ಹಾಗೂ ವಿಟಮಿನ್ ಎ ಪೂರೈಕೆ. ನಾವು ಉಪ್ಪನ್ನು ಅಯೋಡಿಕರಿಸಬೇಕೇ. ಈ ಪ್ರದೇಶದಲ್ಲಿ ಗಳಗಂಡ ರೋಗವಿಲ್ಲ. ಆದಾಗ್ಯೂ ಉಪ್ಪು ಅಯೋಡೀಕರಣದಿಂದ ದುಬಾರಿಯಾಗಿದೆ.



ಯಾರೂ ಆದ್ಯತೆ ನಿರ್ಧರಿಸುವರು?

ಎರಡನೇ ಅಂತರ.

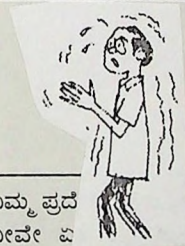


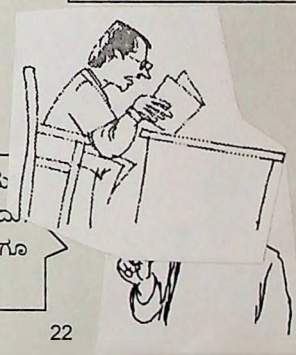
ಹೇ! ಇದು ವಿಶ್ವ ಆರೋಗ್ಯ ಸಂಸ್ಥೆ ಅಲ್ಲ. ಇದು ನಾವೇ ಮಾಡಿದ್ದು

ಆರೋಗ್ಯ ಆದ್ಯತೆಗಳನ್ನು ಸಮುದಾಯವು ನಿರ್ಧರಿಸುವ ಬದಲಿಗೆ ಆಲ್ಮಾ ಆಟಾ ಘೋ ಸಮುದಾಯವೇ ನಿರ್ಧರಿಸಲು ಸೂಚಿಸಿತ್ತು. ಆದ್ಯತೆಗಳನ್ನು ದೂರದ ರಾಜಧಾನಿಯಲ್ಲಿಂ ವಿಶ್ವ ಬ್ಯಾಂಕಿನಲ್ಲಿಯೋ ನಿರ್ಧರಿಸಿ, ಇಡೀ ಜನತೆಯ ಮೇಲೆ ಹೇರಲಾಗುತ್ತಿದೆ. ಕೇವಲ ಆಯ್ದ ಆರೋಗ್ಯ ಪಾಲನೆಯಲ್ಲ. ದೂರದ ಆರೋಗ್ಯ ಆಡಳಿತಶಾಹಿ ನಿರ್ಧ ಆರೋಗ್ಯ ಆದ್ಯತೆ. ಜನಗಳಿರಲಿ, ಈ ಆಯ್ಕೆ ಕೈಗೊಳ್ಳುವವರು ಆರೋಗ್ಯ ಅಧಿಕಾರಿಗಳೂ ಅಲ್ಲ. ಯಾವುದಾದರೂ ಪ್ರದೇಶದಲ್ಲಿ ಹಾವು ಕಡಿತ ಪದೇ ಪದೇ ಆದರೆ, ಅಥವಾ ಖಾಯಿಲೆಯಂತಹ ರೋಗವಿದ್ದರೆ ಪಿ.ಹೆಚ್.ಸಿ. ಇವುಗಳಿಗೆ ಸ್ಪಂದಿಸಲು ಅವಕಾಶವಿಲ್ಲ. ಆವರಿಗೆ ಈ ಅರಿವು ಇಲ್ಲ.

ವೈದ್ಯರೇ ನನಗೆ ಹಾವು ಕಚ್ಚಿದೆ.

ಕ್ಷಮಿಸು, ಇದು ಪಿ.ಹೆಚ್.ಸಿ. ಪಟ್ಟಿಯಲ್ಲಿಲ್ಲ.





ನಿಮ್ಮ ಪ್ರದೆ ಗ್ಯ ಸಮ
ನೀವೇ ಏ ಚ್ಚಾರಮ.
ಹೇಗೆ? ನಮ್ಮ ಹಿರಿಯ ಜಿಲ್ಲಾಧಿಕಾರಿಗೂ ಈ ಸ್ವಾತಂತ್ರ್ಯವಿಲ್ಲ.

Tertiary Care Public Private Partnership
Case Study:
Escorts Hospital and government of Chhattisgarh:
The government of Chhattisgarh signed an MOU with a leading corporate hospital Escorts to open up a state of the art cardiology center in Raipur , the state capital. The terms were that the entire infrastructure and equipment and start up costs for this 20 bed facility , which amounts to 115 million rupees would be paid by the state out of its budget. The equipment purchase and building design and supervision of construction would all be by Escorts. Escorts would further be allowed to run the hospital, hiring staff of its choice and charging market rates. The running costs would be all borne by Escorts. Escort would however provide a 15% concession in rates to government employees and if there are cases the government has to refer the reimbursement of their fees at this rate would be by the government.
The justification for this is that to bring up such a center within the public sector would be time consuming and of insufficient quality and would take a lot of effot. But within six months such a center could be created with this partnership.
While this is true we need to note that we are now talking of good quality in the corporate sense and what is more important at corporate rates. Is this sort of PPP an argument for better patient satisfaction we only need note that the state has invested Rs 50 lakh per bed as compared to one third this amount for an entire 30 bed hospital at the block level catering to one lakh persons with an outpatient attendance of over 200 persons a day . Such quality care moreover would be accessible to only a very small section of the elite. The private party has risked very little, brought in no investment, and it is not very clear how or even whether any transfer of skills would happen. The moot question is that if we are catering to the most affluent sections why not let the market forces take care of it. Why bring in the state – especially a state which has desperate levels of poverty and where a large community health worker programme to cover the entire state cost about the same as a 20 bed hospital and the latter struggles for funds. Or this same budgetary outlay applied annually to the rural public health system can take care of all gaps in staffing at all levels of paramedicals for the entire state.

This munificence towards the corporate hospital sector has a rich history. Most corporate hospitals have benefited from special policies meant for its growth. Thus most of them have land in prime urban areas acquired for them by the government -as a public good – paying for it well below market rates or not at all. Most of the investment comes in the form of loans from public sector financial institutions given at terms more favorable then the market rates. They have been given handsome exemptions from customs duties and tariffs for costly equipment imported. For all these concessions they were asked to in return provide 10 to 40% of patient care free or nominally charged so that the poor could benefit. When the Supreme Court was seized of this issue and ordered an independent investigation by its appointed commissioner Mr. Chandramouli, the report showed that not a single hospital had honored these commitments. Some of them had admitted hospital staff family members or occasionally for political patronage perhaps a few cases. Nothing beyond that.

As the competition hots up it is more than likely that soon many of them would seek and get counter guarantees. That the state commits to sending a number of patients and paying their bills in case they find inadequate clientiele through market mechanisms- and in anyway pays them whether or not they are able to send. In the next iteration there would be a preference to anyway pay the counter guarantee and not even send patients! If this seems unfair speculation- let us consider the case of Sheonath river.

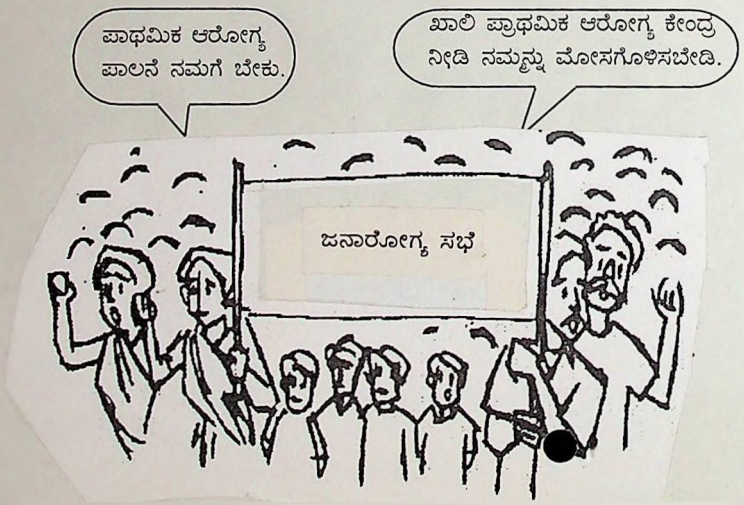
The Sheonath River Case study .

ನಿಮ್ಮ ಊಹೆ ಸರಿಯಾದದ್ದೇ. ಆರೋಗ್ಯ ಸ್ಥಿತಿಗತಿಗಳು ಎಲ್ಲಿ ದುಸ್ತರವಾಗಿದೆಯೋ ಅದೇ ರಾಜ್ಯಗಳಲ್ಲಿಯೇ ಆರೋಗ್ಯ ವ್ಯವಸ್ಥೆಯೂ ಇಲ್ಲವಾಗಿದೆ.

ಕನಿಷ್ಠ ಅಗತ್ಯಗಳು

1. ಪಿ.ಎಚ್.ಸಿ ಇಬ್ಬರು ವೈದ್ಯರು - ಕನಿಷ್ಠ ಒಬ್ಬರು ಅಲ್ಲೇ ಇರಬೇಕು. ಅನೇಕ ರಾಜ್ಯಗಳಲ್ಲಿ ಏಕ ವೈದ್ಯ ಪಿ.ಎಚ್.ಸಿ. ಗಳಿವೆ.
2. ಉಪಕೇಂದ್ರಗಳು. ಇಬ್ಬರು ಬಹು ಉದ್ದೇಶ ಕಾರ್ಯಕರ್ತರು, 12 ಎಂ.ಪಿ.ಡಬ್ಲ್ಯು ತಲಾ ಪಿ.ಎಚ್.ಸಿ.ಗೆ. ಅನೇಕ ಕಡೆ ಪುರುಷ ಕಾರ್ಯಕರ್ತರು ಮಂಜೂರಾತಿ ಇಲ್ಲವೆ ಇಲ್ಲ. ಕಾರ್ಯಪ್ರವೃತ್ತವಲ್ಲ.
3. ಸೌಲಭ್ಯಗಳು ದಿನದ ಯಾವ ವೇಳೆಯಲ್ಲಿಯಾಗಲಿ ಹೆರಿಗೆ ಮಾಡಿಸುವು ಸೌಲಭ್ಯ ಮತ್ತು ವೈದ್ಯ ನಿರ್ವಹಣೆಯ ಎಲ್ಲ ಕಾಯಿಲೆಗಳಿಗೆ ಚಿಕಿತ್ಸೆ.
4. ಔಷಧಿಗಳು: ಪ್ರತಿ ಪಿ.ಎಚ್.ಸಿ.ಗೆ 50 ಔಷಧಿಗಳು ಮತ್ತು ಪ್ರತಿ ಉಪ ಕೇಂದ್ರಕ್ಕೆ 25 ಔಷಧಿಗಳು.
5. ಸಾರಿಗೆ ಮತ್ತು ಸಂವಹನ ಸೌಲಭ್ಯಗಳು ಪಿ.ಎಚ್.ಸಿ. ಮತ್ತು ಉಪಕೇಂದ್ರಗಳಲ್ಲಿ ಲಭ್ಯವಿದ್ದು ಜಿಲ್ಲಾ ತಂಡದ ನಿರಂತರ ಸಂಪರ್ಕ ಸಾಧಿತವಾಬೇಕು.

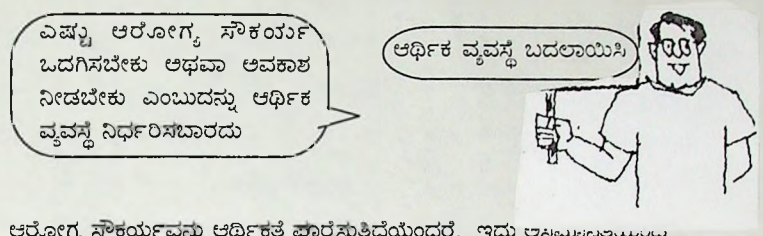
ಈ ಮೂಲ ಅಗತ್ಯ ಪೂರೈಕೆ ಇಲ್ಲದೇ ಅವುಗಳನ್ನು ನಿಷ್ಕ್ರಿಯವೆಂದು ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರ ಕಲ್ಪನೆ ತಳ್ಳಿ ಹಾಕುವುದು ಒಪ್ಪತಕ್ಕದ್ದಲ್ಲ.



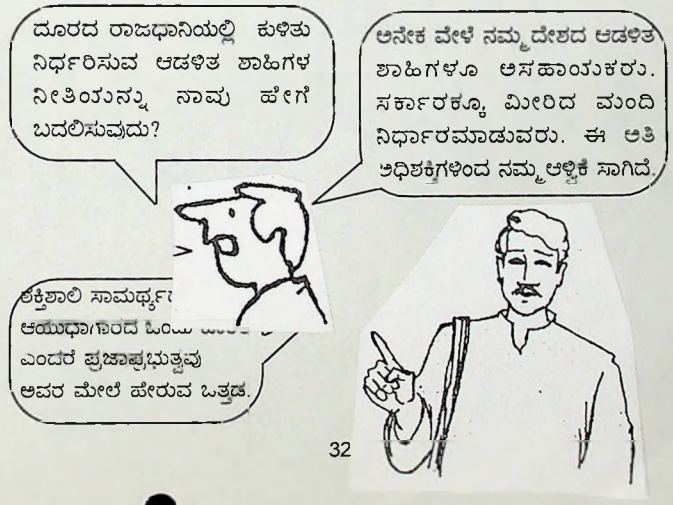
ಅಧ್ಯಾಯ - 4

ಮಾಡಬೇಕೇನು?

ಆರೋಗ್ಯವು ಮೂಲಭೂತ ಹಕ್ಕು - ಒಳ್ಳೆಯ ಆರೋಗ್ಯ ಬದುಕಿನಷ್ಟೇ ಅತ್ಯಗತ್ಯವಾದದ್ದು ಆರ್ಥಿಕ ಮತ್ತು ಸಾಮಾಜಿಕ ವ್ಯವಸ್ಥೆಗಳು ಈ ಆಧಾರದಿಂದಲೇ ರೂಪುಗೊಳ್ಳಬೇಕು.



ಆರೋಗ್ಯ ಸೌಕರ್ಯವನ್ನು ಆರ್ಥಿಕತೆ ಪೂರೈಸುತ್ತಿದೆಯೆಂದರೆ, ಇದು [illegible] ಕೂಡಿದ ಹಾಗೂ ಬಹುತೇಕ ಜನರ ಬದುಕನ್ನು ಕೆಲವೇ ಜನರು ನಿಯಂತ್ರಿಸುವ ಜಗತ್ತು ಇರುವುದೇ ಕಾರಣ. ಜನರು ತಮ್ಮನ್ನು ತಾವೇ ಸಮರ್ಥಿಸಿಕೊಂಡು ಬಹಳ ಜನರ ಅಭಿಪ್ರಾಯವು ನಿರ್ಣಾಯಗಳಲ್ಲಿ ಬಿಂಬಿತವಾಗುವಂತೆ ನೋಡಿಕೊಳ್ಳಬೇಕು. ಕ್ರಿಶ. 2000ಕ್ಕೆ ಎಲ್ಲರಿಗೂ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮ ಕೆಲವು ಕಾಲದ ನಂತರ ಸರ್ಕಾರಗಳು ಮರೆಯುವ ಕಾರ್ಯಕ್ರಮವಲ್ಲ. ಸರ್ಕಾರವು ಮರೆತರೂ ಜನರು ಹಾಗೆ ಮರೆಯಗೊಡಬಾರದು.



An entire 23.6 km stretch of Sheonath river in a 19 km radius near Durg township had been leased out to Radius Water Limited (RWL), giving the Company the monopoly rights on the supply of water. This was a 22-years renewable concession . The water was to be sold to the Chhattisgarh State Industrial Development Corporation. This was done by the depratmen of industries without consultation of legal government stateholders -forests departemnt, water resources departments, agriculture department or local governments. Farmers in this stretch of the river were refused the right to irrigation water, the right to domestic water and fishing nets put in were cut by henchmenof the new owners of the river moving around in motor boats. The economics of the deal was that three fourths of the money was put up by the state government. And whether this accounted for all the money put in due to inflated estimates is open to question. The company was provided power at special subsidised rates: All that the company did wa build a small barrage across the river a tone point.

Since there was a counter guarantee stipulating that a minimum amount of water would be purchases by the government over Rs 12 million paid for water not used- for no industry developed there. And thoughtfully a ten year tax holiday had been provided for. When public protest forced its reconsideration it emerges for cancellation of the agreement a sum of over 1200 m. rupees would need to be paid!!!! With promise of more contracts.

We may protest that the above is a scam and not a legitimate case to argue about- for the problems of governance need to be seen separately. But then what did undermine the public sector in the first place – if not the very same problems of governance. If these wer handled would private sector prove most cost effective or even quality effective?
Indeed it seems more than likely that public private partner ships are used by larger corporates with deeper pockets to leverage themselves ahead of their competition usig the mechanisms of the state. So not only does it not obey the mythical rules of the market , it actually undermines them:

The Central American Case Study: Selling Soap

One example recently published(6) titled" the story of a successful public-private partnership in Central America" is worth quoting in length. The programme objective is diarrhoeal disease control and the immediate objective is promotion of handwashing. The approach is for the state to identify leading manufacturers of soap ,provide them with good market analysis and support for advertisement campaigns, and then evaluate to see whether the desired effect was gained. The private soap manufacturers were to integrate health messages as part of their soap promotion campaign in which they promote their brand of soap, utilize all the resources and technical knowhow being provided to them, expand their distribution network and watch the profit roll in. The project identified 10 soap producers and of them two were multinationals, both of whom joined in and benefited. The report states that they expanded the programme to cover all school children popularized their brands, were very positive about the out comes and planned to extend the idea to other areas and commodities. Two of the ten companies were regional of which one joined in only to drop out later and still later be acquired by the multinational. The remaining six were local of which two joined in "out of fear of staying out" and the report is strangely silent on how they benefited from it and whether all they were keen on or able to follow up. The report notes that the large multinational manufacturers had sought an exclusive relationship and this was refused. However in the course of everyone being allowed in and the market allowed to play its role, to no ones surprise the multinationals have come out of it with huge gains. Smaller producers could certainly not have matched the large number of free soaps that Colgate is stated to have made available!! And unstated in the report is the probability that the public expenditures were in the form of World Bank loans, which shall indebt the state into the indefinite future!!

	ಕ್ಷಯ
1947 -	5 ಲಕ್ಷ ಮರಣ
2000 -	5 ಲಕ್ಷ ಮರಣ
1947 -	20 ಲಕ್ಷ ಪ್ರಕರಣ
2000 -	120 ಲಕ್ಷ ಪ್ರಕರಣ

ಕ್ಷಯಕ್ಕೆ ಏಕೈಕ ಧೋರಣೆ ಬೇಕಿಲ್ಲ.
ಸಮಗ್ರ ಆರೋಗ್ಯ ಪಾಲನೆ ಬೇಕು.
ಅದು ಲಭ್ಯವೇ ಇಲ್ಲ.

ಮಲೇರಿಯಾ ರೋಗಿಗಳು ವಾರ್ಷಿಕ 700 ಲಕ್ಷ ಸಂಖ್ಯೆಯ ಪ್ರಕರಣಗಳಿವೆ. 1960ರ ಅವಧಿಯಲ್ಲಿ ಕೇವಲ ಡಿ.ಡಿ.ಟಿ. ಸಿಂಪಡಿಕೆಯಿಂದಲೇ 1 ಲಕ್ಷಕ್ಕೂ ಕಡಿಮೆ ಪ್ರಕರಣಗಳನ್ನು ತಗ್ಗಿಸಿತ್ತು. 90ರ ದಶಕದ ವೇಳೆಗೆ ಇದು 70 ಲಕ್ಷಕ್ಕೆ ಏರಿತು. ಆನಂತರ ಸ್ಥಿರವಾಗಿ 20 ಲಕ್ಷ ಪ್ರಕರಣಗಳು ಆದವು. ಈಗ ಚಿಕಿತ್ಸಾ ನಿರೋಧಕ ಮಲೇರಿಯಾ ಕಾರಣಗಳಿವೆ. ಮಲೇರಿಯಾ ನಿಯಂತ್ರಣಕ್ಕೂ ಈಗ ಸಮಗ್ರ ಇದ್ದು ಆರೋಗ್ಯ ಪಾಲನೆಯೇ ಬೇಕು. ಇಷ್ಟೆಲ್ಲಾ ತಳರಚನೆ ಇದ್ದು, ಆರೋಗ್ಯ ಸ್ಥಿತಿ ಗತಿ ಇದ್ದು ಏಕೆ ಕಡಿಮೆ?

ಇಷ್ಟೆಲ್ಲಾ ತಳರಚನೆ ಇದ್ದೂ ಆರೋಗ್ಯ ಸ್ಥಿತಿ ಗತಿ ಏಕೆ ಕಡಿಮೆ? ಎಲ್ಲಾ ಪಿ.ಹೆಚ್.ಸಿ.ಗಳೇಕೆ ಸಾಕಷ್ಟು ಔಷಧಿಗಳಿಂದ ಸಜ್ಜಾಗಿಲ್ಲ? ವೈದ್ಯರು ಮತ್ತು ದಾದಿಯರು ಕೆಲಸ ಮಾಡುತ್ತಿಲ್ಲವೇ?

ಇದು ಭಾಗಶಃ ನಿಜಾ ಅಷ್ಟೇ

ಬಹಳಷ್ಟು ರಾಜ್ಯಗಳಲ್ಲಿ ಹುದ್ದೆ ಭರ್ತಿ 15%ಗೂ ಕಡಿಮೆ. ಸರ್ಕಾರದ ವರದಿಯನ್ನೇ ಮಾನ್ಯ ಮಾಡಿದರೂ 1/3 ಭಾಗ ಸಿಬ್ಬಂದಿ ಪಿ.ಹೆಚ್.ಸಿ ಯನ್ನು ತುಂಬಬೇಕು.

ಔಷಧಿ ಪೂರೈಕೆ ಅಸಮರ್ಪಕ ಮತ್ತು ಯದ್ವಾತದ್ವಾ ಆಗಿದೆ. ಇದರಿಂದ ಕ್ಷಯದ ಏರಿಕೆ ಅರ್ಧ ಬಾಗುತ್ತದೆ. ಆದರೆ ಗರ್ಭಿಣಿ ಆರೈಕೆ, ಅತಿಸಾರ ಚಿಕಿತ್ಸೆ ಮೊದಲಾದವುದಕ್ಕೆ ಅನ್ವಯಿಸದು.

ಉಪಕೇಂದ್ರಗಳು ಹಾಗೂ ಪಿ.ಹೆಚ್.ಸಿ. ಕಾರ್ಯಶೀಲವಾಗಿರುವೆಡೆಗಳಲ್ಲೂ ಕೆಲವು ಜನರು ಮಾತ್ರ ಆ ಸೌಲಭ್ಯ ಪಡೆದುಕೊಳ್ಳುವರು. ಸಾಕಷ್ಟು ತಳ ರಚನೆ ಉಳ್ಳ ಗ್ರಾಮಗಳಲ್ಲೂ ಸಾರ್ವಜನಿಕ ಆರೋಗ್ಯ ಗುರಿ ಸಾಧಿಸಲು ಸಾಧ್ಯವಾಗಿಲ್ಲ.

ಇದು ನಮ್ಮ ತಪ್ಪಲ್ಲ. ನಾವು ಕೈಲಾಗುವಷ್ಟು ಮಾಡಿದ್ದೇವೆ. ಜನರಿಗೆ, ಅವರಿಗೆ ಏನು ಒಳ್ಳೆಯದೆಂಬುದು ತಿಳಿಯದು. ಈಗಾಗಲೇ ಸಾಕಷ್ಟು ಆರೋಗ್ಯ ಪಾಲನೆ ಇದೆ. ಜನರನ್ನು ಅವುಗಳ ಬಳಕೆ ಮಾಡುವಂತೆ ಮನವೊಲಿಸಬೇಕು.

ಇದು ಅತ್ಯಂತ ಸುಲಭವಾದ ವಿವರಣೆ. ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರ ಜಾಲವನ್ನು ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಪಾಲನೆಗೆ ಸಮೀಕರಿಸಲಾಗಿದೆ. ಈ ಎರಡು ಪಿ.ಹೆಚ್.ಸಿ. ಗಳಿಗೂ ಆಜಗಜಾಂತರವಿದೆ. ಈ ಅಂತರಗಳೇನೆಂದು ನೋಡುವ. ಅವೆಂದರೆ.....

1. ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರದ ಗುರಿ ಆಯ್ದ ಆರೋಗ್ಯ ಪಾಲನೆಯೇ ವಿನಃ ಸಮಗ್ರ ಆರೋಗ್ಯ ಪಾಲನೆಯಲ್ಲ.
2. ಆರೋಗ್ಯ ಅದ್ಯತೆಗಳ ಆಯ್ಕೆಯನ್ನು ದೂರದ ಆಡಳಿತ ಶಾಹಿಗಳೂ ಕೈಗೊಳ್ಳುವರೇ ವಿನಃ ಸ್ಥಳೀಯ ಯೋಜನೆಗಳ ಮೂಲಕ ಅಲ್ಲ.
3. ಇಲ್ಲಿ ಸಮುದಾಯದ ಭಾಗವಹಿಸುವಿಕೆ ಇಲ್ಲ. ಭಾಗವಹಿಸಿದರೆ ಹೇಗೆಂಬ ಆಂಜಿಕೆ.
4. ಪರಿಣಾಮಕಾರಿ ನಿರ್ದೇಶ್ಯ ಆಸ್ಪತ್ರೆಗಳಿಲ್ಲ.
5. ಲಕ್ಷವೂ ಆರೋಗ್ಯ ವಲಯದ ಖಂಡ ಪೂರ್ಣಕೆಯತ್ತ ಸಮಗ್ರ ಹಾಗೂ ಅಂತರ ವಲಯ ಧೋರಣೆ ಅಲ್ಲ. ಲಕ್ಷವೂ ಪ್ರಕ್ರಿಯೆಗಳಿಗಿಂತ ಭಿನ್ನವಾದದ್ದು.

ಮೇಲಿನ ವ್ಯತ್ಯಾಸಗಳು ಬಹಳ ಮುಖ್ಯ. ಎರಡು ಪಿ.ಹೆಚ್.ಸಿ. ಗಳ ಅಂತರ ಆರೋಗ್ಯ ಮತ್ತು ರೋಗದ ಅಂತರ. ಈ ಐದು ಅಂತರಗಳನ್ನು ವಿಸ್ತಾರವಾಗಿ ತಿಳಿಯೋಣ.

ಮೊದಲ ಅಂತರ ಆಯ್ದ ಆರೋಗ್ಯ ಪಾಲನೆ.
ಹೌದು ಅದೇ ಸರಿ.

ವಿಶ್ವ ಬ್ಯಾಂಕ್ ಅವೆರಡನ್ನೇ ಬದಲಾಯಿಸಿ ಆಲ್ಮಾ ಆಟಾದ ಜನರು ಮೂರ್ಖರು. ಎಲ್ಲವನ್ನೂ ಎಲ್ಲರಿಗೂ ನೀಡಲು ಹಣವೆಲ್ಲಿ ಬರಬೇಕು. ಆಲ್ಮಾ ಆಟಾ ಘೋಷಣೆಯ ಸಹಿಯ ಮಸಿಯು ಆರುವ ಮೊದಲೇ ಶ್ರೀಮಂತ ಸಂಸ್ಥೆಗಳಾದ ರಾಕ್ ಫೆಲ್ಲರ್ ಸಂಸ್ಥೆಯಂತಹವುಗಳ ಬೆಂಬಲದೊಂದಿಗೆ ವಿಶ್ವಬ್ಯಾಂಕ್ ಕಾರ್ಯ ಪ್ರವತ್ತವಾಯಿತು. 1985ರ ವೇಳೆಗೆ ಆಯ್ದ ಸಮಗ್ರ ಆರೋಗ್ಯ ಪಾಲನೆಯನ್ನು ಕೈಬಿಟ್ಟು ಆಯ್ದ ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಪಾಲನೆಯತ್ತ ವಾಲಿದರು.

Though no where is private sector stated to be synonymous with corporate sector, we need to examine how many success stories of private-public mix are stories of the multinational corporate sector expanding its influence, possibly in the process marginalizing local industry, with liberal assistance from the public funds. It remains a question that if indeed the magic of the market place is valid why a giant like unilever did not make the additional investment needed to define a health related soap market ? Why was the state's support needed? And what is there to have us belief that an equal investment in locally manufactured soaps would not have generated both health and local employment.

This case study has relevance in the Indian context also for a similar public private partnership was sought to be launched in Kerala. This state has a rich tradition of soap manufacture and an alert public raised such a debate on it that it was shelved. There are moves to revive this campaign with local soaps.

We need to explore whether these liberal grants of drugs to major international health campaigns by leading MNCs is a variant of this strategy. Thus if Smith Kline and Beecham decided to supply all the drugs needed for the national campaign against filariasis free – it is also managing to put out of business a number of competitiors who are local producers who can produce these drugs at rates that they could hardly have matched. Yet these small companies cannot diversify into newer products so fast as a MNC and if meanwhile the small are run out of the marker by free drugs then the future market of the transnational is secured against such competition. So is this just a form of dumping ? We do not know whether such a contention can be sustained. However different presentations of the issue never raised this dimension to discussion or scrutiny. So much for the free market.

Does Private Sector partnership improve innovation?

Again there is no reason to believe this. A very small part of R&D private budget goes into new drugs. Choice of research is governed largely by profitability- Priorities for the poor and tropical diseases get little if no inputs. Often all the basic research on disease mechanisms and even the discovery of the active molecule is done in state supported university laboratories –with only the commercialisation being done by the manufacturer.
Even in clinical methods there is no evidence to say that the private sector is more

Then what really drives the move to public private partnerships:

First and foremost the most important fuel is the very poor state of the public health system. Not only does it have a lack of investment and a lack of manpower, even where these are adequate the system is so dysfunctional that it is easy to conclude that there is a problem with any public system as such. The problem if image is further compounded by the public sector constantly needing to attract more funds and justify its growth by showing that " things are bad and if not... a crisis would result". In contrast private sector justifies its growth and attracts investments by proclaiming success irrespective of the real situation. Individuals blame private sector failures on individual companies/owners whereas the failure of any faciltity is blamed on the public sector system as a whole -on policy.

But the truth is that except for a top 0.1% who can afford corporate private care, on the rest of the private care sector – the jury is still out – even on customer satisfaction. Currently only 22% of all health care expenditure is borne by the state in India as against an OECD average of over 75% . Even this OECD average excluding US is much higher- almost 90%. US figures of 44% are

ಮಾತೃ ಮರಣ ಇದಕ್ಕೂ ಮೀರಿ ಗಾಬರಿಯಾಗುವಂತಹದು.

ಪ್ರತಿ ಲಕ್ಷಕ್ಕೆ 200ಕ್ಕೆ ಮೀರದಂತೆ ಮಾತೃ ಮರಣವನ್ನು ನಿಯಂತ್ರಿಸಬೇಕೆಂಬುದು ಸರ್ಕಾರದ ಇರಾದೆ. 1976ರಲ್ಲಿ ಈ ಸಂಖ್ಯೆ 450. ಈಗ ಇದು 410ಕ್ಕೆ ಇಳಿಮುಖವಾಗಿದೆ. ಅಭಿವೃದ್ಧಿಗೊಂಡ ದೇಶಗಳಲ್ಲಿ ಈ ಸಂಖ್ಯೆ 25 ಮಾತ್ರ ಆಕರ.

ನಾವು ಸರಕಾರಿ ಗುರಿಗಳಿಗೆ ಸೀಮಿತಗೊಳ್ಳಬೇಕೆ? ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಪಾಲನೆಯ ಗುರಿ ಸಾಧನೆಯಲ್ಲಿ ಒಂದು ಪ್ರಕ್ರಿಯೆಯನ್ನು ಸ್ಥಾಪಿಸುವ ಕೆಲಸ. ಇಲ್ಲಿ ಪ್ರತಿಫಲವನ್ನು ಅಳೆಯಲು ಸೂಚ್ಯಂಕಗಳು ಬೇಕೇ ವಿನಃ ಕಾರ್ಯ ನಿರ್ದೇಶಿಸಲು ಗುರಿಯಿಲ್ಲ. ವ್ಯತ್ಯಾಸವೇನೆಂದರೆ ಸೂಚ್ಯಂಕಗಳ ಗುರಿಗಳಾದರೆ ಪ್ರಕೃತಿಯ ಹುಸಿಭಾವನೆ ಮೂಡುತ್ತಿದೆ.

ಮಕ್ಕಳ ಮರಣವನ್ನು ಆರೋಗ್ಯ ಪಾಲನೆ ಸೂಚ್ಯಂಕವಾಗಿ ನೆನೆದರೆ
ನೀವು ಗುರಿ ಸಾಧಿಸಿದ್ದೀರಿ.

ಮಕ್ಕಳ ಆರೋಗ್ಯ ಸ್ಥಿತಿ ಗತಿ ಇಳಿಮುಖ. ಈ ಮಕ್ಕಳನ್ನು
ಸಾವಿನಂಚಿನಲ್ಲಿಯಾಗಿದೆ. ಸಾವನ್ನು ತಪ್ಪಿಸಿದರೂ ಆರೋಗ್ಯ
ಸ್ಥಿತಿ ಸುಧಾರಿಸಿಲ್ಲ.
ಮಕ್ಕಳ ಆರೋಗ್ಯ ಸ್ಥಿತಿ ಇಳಿಮುಖ. ಸಾವು.

ಗುರಿಯಿಲ್ಲದೇ ಹೋದಲ್ಲಿ ಸೂಚ್ಯಂಕ ಸೂಚ್ಯಂಕವೇ. ಸೂಚ್ಯಂಕವನ್ನು ಗುರಿಯಾಗಿಸಿದರೆ ಹುಸಿ ಚಿತ್ರ ಮೂಡುತ್ತದೆ.

ಸರ್ಕಾರದ ಗುರಿಯನ್ನು ಶಿಶುಮರಣ ಸಂಖ್ಯೆ ಮತ್ತು ಮಾತೃ ಮರಣ ಸಂಖ್ಯೆಯಲ್ಲಿ ನಿರ್ಣಯಿಸಲಾಗುತ್ತದೆ. ಬೇರೆ ಸೂಚ್ಯಂಕಗಳನ್ನು ಪರಿಗಣಿಸಿ ಈ ಸಾಧನೆಗಳ ವ್ಯತ್ಯಾಸತ್ಯತೆಯನ್ನು ನೋಡೋಣ.

ರೋಗ ಸೂಚ್ಯಂಕಗಳನ್ನು ನಿರ್ಧರಿಸುವುದು ಕಠಿಣ. ವಿದ್ಯಾವಂತನು ದಡಾರವಾದಾಗ ವೈದ್ಯರ ಸಹಾಯ ಪಡೆಯಬಹುದು. ಆದರೆ ಗ್ರಾಮೀಣರು ಹಾಗೆ ಮಾಡುವುದೇ ಇಲ್ಲ. ಬಿಳಿ ಸೆರಗು ವಿಸರ್ಜನೆಯನ್ನು ಕೆಲವು ಸಂಸ್ಕೃತಿಯವರು ರೋಗವೆಂದು ಭಾವಿಸುವರು. ಆದರೆ ಇನ್ನು ಕೆಲವರು ಆ ಬಗ್ಗೆ ಹೇಳಲಾರರೆಂದು ಸಮೀಕ್ಷೆ ತಿಳಿಸುವುದು. ಆರೋಗ್ಯಕ್ಕೆ ಬೇರೊಂದು ಸೂಚ್ಯಂಕವೇ ಬೇಕು.

ಮಕ್ಕಳಲ್ಲಿ ನನ್ಯೂನ ಪೋಷಣೆಯು ಆರೋಗ್ಯದ ಮತ್ತೊಂದು ಒಳ್ಳೆಯ ಸೂಚ್ಯಂಕ. ಇದರ ಮಾಪನ ಸುಲಭ. ಮಗುವಿನ ತೂಕವನ್ನು ಕುರಿತ ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸಿದರಾಯಿತು. ಆಹಾರದ ಕೊರತೆಯೇ ನ್ಯೂನ ಪೋಷಣೆಗೆ ಕಾರಣ. ಇದರಿಂದಾಗಿಯೇ ಖಾಯಿಲೆಯೇ ಮರುಕಳಿಸುತ್ತದೆ. ದೈಹಿಕವಾಗಿ ಹಾಗೂ ಮಾನಸಿಕವಾಗಿ ತನ್ನ ಸಾಮರ್ಥ್ಯವನ್ನು ಬೆಳೆಸಿಕೊಳ್ಳದೇ ಕುಂಠಿತಗೊಳ್ಳುವುದು. ಆರೋಗ್ಯಗ ವ್ಯಾಖ್ಯೆಯಲ್ಲಿ ಬೌದ್ಧಿಕ ಹಾಗೂ ಸಾಮಾಜಿಕ ಸುಸ್ಥಿತ ಅಡಕವಾಗಿರುವ ಕಾರಣ ನ್ಯೂನ ಪೋಷಣೆಯು ಆರೋಗ್ಯದ ಸೂಚಿ ಆಗಬಲ್ಲದು.

ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಪಾಲನೆಯ ಪ್ರಕ್ರಿಯೆ ನ್ಯೂನ ಪೋಷಣೆಯನ್ನೂ ಗಣನೀಯವಾಗಿ ತಗ್ಗಿಸಬಹುದಾಗಿತ್ತು. ಇದರ ಪರಿಣಾಮವಾಗಿ ಶಿಶುಮರಣ ಸಂಖ್ಯೆಯು ಇಳಿಮುಖವಾಗುತ್ತಿತ್ತು. ನಾವು ಇತ್ತ ಗಮನಿಸಿದ್ದೇವೇಯೇ?

ಭಾರತ : 53% ಮಂದಿ ನ್ಯೂನ ಪೋಷಣೆಯವರು. 22% ತೀವ್ರ ನ್ಯೂನ ಪೋಷಣೆಯವರು.
ಬ್ರೆಜಿಲ್ : ಕೇವಲ 6% ಮಕ್ಕಳು ನ್ಯೂನ ಪೋಷಣೆಯವರು. ನ್ಯೂನ ಪೋಷಣೆಯನ್ನು ತಲಾವಾರು ಆದಾಯಕ್ಕೆ ಹೋಲಿಸಿದಾಗ ಭಾರತ ಮತ್ತು ಬಾಂಗ್ಲಾದೇಶಗಳು ಜಗತ್ತಿನಲ್ಲೇ ಅತ್ಯಂತ ದಾರುಣ ಸ್ಥಿತಿಯಲ್ಲಿವೆ. **ನಮ್ಮ ಸಾಧನೆ ತೀರಾ ಕಳಪೆ.**

ಇನ್ನೂ ಹೇಳುವೆ. ನಾವು ವಿಕರೀತಿ ಇದ್ದೇವೆ. ನ್ಯೂನ ಪೋಷಣೆಯೇ ಅಲ್ಲದೇ, ಮಲೇರಿಯಾ ಮತ್ತು ಕ್ಷಯ ರೋಗಗಳಲ್ಲೂ ಸುಧಾರಣೆ ಇಲ್ಲ.

considered low. Most developing countries have higher contribution from private sector and it is consistently less than the figures for the developed world.

- *In this context – the first goal should be to strengthen the public sector and regulate the private sector rather than encourage further an already overgrown and almost completely unregulated private sector.*

The case of State - Civil society partnerships:

One recent trend under the umbrella of the term public private partnerships is the contracting out of urban health care directed at poor areas and primary health care in remote rural area to NGOs. Both in Andhra Pradesh and in Assam this has been tried out in a major way.
We already noted that these are not private in the sense of being either corporate or profit driven. We also note that most of them at least in the start up phase are driven by a notion of service and altruism. Even if for all the employees and even much of their managements it is primarily also an employment opportunities at a time of considerable stagnation in employment it still retains a high degree of service –mindedness largely as they are not professional and share the lay persons viewpoint of health and disease. Since hiring on such contract terms has less commitments and less expenditure for the state and since many, especially young women, become available for the low wages that these jobs offer it seems a win win situation all around.
The catch in it is the issue of governance. The very same reasons why the public sector fared so poorly rise their head again in the entire process of selecting, costing, monitoring and paying for the NGOs. Over time except for a very few who are good and adept, most of them would either get corrupted or drop out, till eventually they have as bad a reputation as the public system, and become as bureaucratic and corrupt. One hears frequently of how NGOs are a fraud and of how they are corrupt, just as frequently a sone hears of corruption and sloth in the public employee. Both charges are right in part and grossly inadequate as they fail to see the relationship with governance.
In third world contexts ruling sections often see the public exchequer as a source of revenue to sustain and build their political and personal strengths. A Marcos or an Idi Amin is only an extreme variant of a general situation where it has almost become acceptable for a politician to dip into the treasury – if it is done for the party. The economically powerful do not support (or cannot) the politicians campaigns unlike what happens in the advanced countries. Looting the public exchequer becomes then a form of primitive accumulation of capital in the developing context.The public health system too is beset with corruption at its highest levels- and this can be sustained only is the entire purposes of administration are made to extract this sum out – thereby pervading the system from top to bottom with a parallel and perverse system of values.

When because of this the public system is discredited- largely attributed to the recalcitrance of the public sector employee – this section moves on the new idiom – PPP carrying along with it the same problems of governance. To no ones surprise then PPP fairs no better – and if the public health system was dysfunctional the PPPs become a series of scams. And Public civil society cooperation is also pushed by these same issues of governance -slowly in the same direction. One cannot therefore look to these strategies as ever being able to get around the central issues of governance and the oppressive and exploitative nature of current ruling systems.

How then does one build up resistance to this retreat of the state?

First and foremost is developing awareness amongst the people, especially the poorest that health is a fundamental right and health care services is an entitlement to secure which one mobilize for collective action.

ಅಧ್ಯಾಯ 3

ಎರಡು ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳ ಕಥೆ

ಈಗಿರುವ ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳ ಜಾಲಕ್ಕೂ, ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಪಾಲನೆಗೂ ವಿಶಾಲ ಕಂದರವಿದೆ. ಈ ಅಂತರವೇ ಜನಾರೋಗ್ಯದ ಬಗ್ಗೆ ಕುರಿತು ಈ ಪುಸ್ತಕ ರಚನೆಗೆ ಕಾರಣ. ವ್ಯತ್ಯಾಸಗಳನ್ನು ನಾವು ಸ್ಪಷ್ಟಪಡಿಸಿಕೊಳ್ಳಬೇಕು.

ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಪಾಲನೆಯ ಬದ್ಧತೆ ಎಂದರೇನು?

ನಾವು ಅನೇಕ ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳನ್ನು ಪ್ರಾರಂಭಿಸಿದ್ದೇವೆ. ಆರೋಗ್ಯ ಕಾರ್ಯಕರ್ತರ ನಿಯೋಜಿತ ಪ್ರತಿ ವರ್ಷವೂ ಹೆಚ್ಚಿಸಿದ್ದೇವೆ. ವಿಶ್ವ ಬ್ಯಾಂಕಿನಿಂದ ವಿದೇಶಿ ನೆರವು ಬರುತ್ತದೆ. ಶಿಶು ಮರಣ ಸಂಖ್ಯೆಯೇ ಬಹಳವಾಗಿ ತಗ್ಗಿದೆ. ಭಾರತೀಯರ ಸಾವು ಇಳಿಮುಖವಾಗಿದೆ. ಕುಟುಂಬ ಯೋಜನೆ ಜಾರಿ ಯಶಸ್ವಿಯಾಗಿದೆ. ಅಲ್ಮ ಆಟ ಒಪ್ಪಂದ ಭಗ್ನವಾಗಿದೆ ಎಂದು ಹೇಳುವಿರಲ್ಲಾ, ನಿಮಗೆ ಬುದ್ದಿಯಿದೆಯೇ?

ಅಲ್ಮ ಆಟ ಉಪಯುಕ್ತ ಎಂಬುದು ನಿಜ. ಕೆಲವು ಸಾಧನೆಗಳು ಆಗಿರಬಹುದು. ಪ್ರಶ್ನೆಯೊಂದೇ ಅದೇ ಸಾಕೇ? ಭರವಸೆ ಈಡೇರಿತೇ? ಇನ್ನಷ್ಟು ವಿವರವಾಗಿ ನೋಡೋಣ.

ಅಲ್ಮ ಆಟಾಗೆ ಧನ್ಯವಾದಗಳು. P.H.C.ಗಳ ಸಂಖ್ಯೆ ಗಣನೀಯವಾಗಿ ಹೆಚ್ಚಿದೆ.

	ಉಪಕೇಂದ್ರಗಳು	P.H.C. ಗಳು
1980	47,112	5,484
1998	1,36,818	
22,997		
	ಮೂರು ಪಟ್ಟು ಹೆಚ್ಚು	1985-90 ರಲ್ಲಿ ಎರಡು ಪಟ್ಟು ಹೆಚ್ಚು. ಅನಂತರದಲ್ಲಿ ಇಲ್ಲ.

P.H.C. ಜಾಲದ ದೃಷ್ಟಿಯಿಂದ ಪ್ರಗತಿಯಾಗಿರುವುದು ನಿಜ. ಆರೋಗ್ಯ ಬಜೆಟ್

ವಿದೇಶಿ ಸಹಾಯ : ಸರ್ಕಾರದ ಆರೋಗ್ಯ ವೆಚ್ಚದ 9% ಮಾತ್ರ ವಿದೇಶ ಸಹಾಯದ್ದು. ಈ ಸಹಾಯವನ್ನು ಸರ್ಕಾರದ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ದಿಕ್ಕುಗೆಡಿಸಲು, ಗಮನಾರ್ಹವಾಗಿ ಬದಲಾಯಿಸಲು ಬಳಕೆ ಮಾಡಿಕೊಳ್ಳಲಾಗುತ್ತಿದೆ. ರಾಷ್ಟ್ರೀಯ ಆರೋಗ್ಯ ನೀತಿಗಿಂತ ಭಿನ್ನವಾಗಿ ವಿಶ್ವ ಬ್ಯಾಂಕಿನ ನಿರ್ದೇಶನದಂತೆ ನಡೆಸಲು ಒತ್ತಡ ತರಲಾಗುತ್ತಿದೆ.

ಆರೋಗ್ಯ ಸ್ಥಿತಿಗತಿಯ ಹೆಚ್ಚಳ : ಆರೋಗ್ಯ ಸ್ಥಿತಿಗತಿಯ ಹೆಚ್ಚಳವಾಗಿರುವ ಸೂಚನೆಗಳಿವೆ. ಈ ಮಟ್ಟಿಗೆ ಅಲ್ಮಾ ಆಟಾ ಘೋಷಣೆಗಳು ಉಪಯುಕ್ತ. ಈ ಸಾಧನೆಗಳು ಸಾಧಿಸಬಹುದಾದ್ದಕ್ಕಿಂತ ಅಥವಾ ನಿರೀಕ್ಷೆಗಿಂತ ಕಡಿಮೆಯೇ.

ಶಿಶುಮರಣ ಹಾಗೂ 5 ವರ್ಷಕ್ಕಿಂತ ಕಡಿಮೆ ವಯಸ್ಸಿನ ಮಕ್ಕಳ ಮರಣದಲ್ಲಿ ಇಳಿಮುಖವಾಗಿದೆ. ಆದಾಗ್ಯೂ ಇತರ ದೇಶಗಳಿಗೆ ಹೋಲಿಸಿದರೆ ಇದು ಗಣನೀಯ ಸಂಖ್ಯೆಯ ಇಳಿಮುಖ ಅಲ್ಲ.

1980ರ ದಶಕದಲ್ಲಿ ಸಾಧಿಸಿದ ಗುರಿಯ ಐದು ವರ್ಷ ಹಾಗೂ ಅದಕ್ಕೂ ಕಡಿಮೆ ವಯಸ್ಸಿನ ಮಕ್ಕಳು ಮೃತರಾಗುತ್ತಿದ್ದ ಅಂಕಿ ಅಂಶವನ್ನು ಗಮನಿಸಿದಾಗ 1960ರಲ್ಲಿ 236 ಇದ್ದದ್ದು 1998ರಲ್ಲಿ 105ಕ್ಕೆ ಇಳಿಮುಖವಾಯಿತು. 180 ರಾಷ್ಟ್ರಗಳ ಪೈಕಿ ಭಾರತವು 49ನೆಯ ಸ್ಥಾನದಲ್ಲಿದೆ. ಕೆಳಗಿನಿಂದ ಆಫ್ರಿಕಾ ಹಾಗೂ ಬಡ ಏಷಿಯಾ ರಾಷ್ಟ್ರಗಳು ಇದಕ್ಕಿಂತಲೂ ಕೆಳಗಿವೆ. ಭಾರತದ ಸಂಖ್ಯೆ 105 ಇರುವಾಗಲೇ ಶ್ರೀಲಂಕಾದಲ್ಲಿ ಈ ಸಂಖ್ಯೆ 18, ಮಲೇಷಿಯಾದಲ್ಲಿ 10, ಚೀನಾದಲ್ಲಿ 47, ವಿಯಟ್ನಾಂನಲ್ಲಿ 42, ಮೆಕ್ಸಿಕೋದಲ್ಲಿ 34 ಇದೆ. ನಮೀಬಿಯಾ, ಗಯಾನದಂತಹ ಬಡದೇಶಗಳಲ್ಲಿ ಈ ಬೆಲೆ ಅನುಕ್ರಮವಾಗಿ 74 ಮತ್ತು 79 ಇದೆ.

ಭಾರತ ಸರ್ಕಾರವೂ ಈ ಸಂಖ್ಯೆಯನ್ನು 70ಕ್ಕೆ ಇಳಿಸುವ ಗುರಿ ಇರಿಸಿಕೊಂಡಿತ್ತಾದರೂ, ಈ ಗುರಿಯನ್ನು ಸಾಧಿಸಲಾಗಿಲ್ಲ. ಈ ಅಂಕಿ ಅಂಶವು 25,90,000.00 ಶಿಶು ಮರಣಕ್ಕೆ ಸಮನಾದೆಂಬುದನ್ನು ಮರೆಯಬಾರದು. ಇವುಗಳಲ್ಲಿ ಅನೇಕವು ತಪ್ಪಿಸಬಹುದಾಗಿದೆ.

(ಆಕರ: State of World Children Unicef 2000 ಇದು 1998 ಅಂಕಿ ಅಂಶ)

ಈ ವಿವೇಚನೆ ತಪ್ಪು! ಇದು ಎಲ್ಲ ಸಾಮಾಜಿಕ ಸಮೂಹಗಳೂ ಶಿಕ್ಷಣದ ಮಾರುಕಟ್ಟೆಗೆ ಸಮಸ್ಪರ್ಧಿಗಳಾಗಿ ಬರುತ್ತವೆ ಎಂದು ಕಲ್ಪಿಸಿಕೊಳ್ಳುತ್ತದೆ. ಜಾತಿ, ವರ್ಗ ಮತ್ತು ಲಿಂಗಾಧಾರಿತ ಅಸಮಾನತೆಯು ಅನಿಯಂತ್ರಿತರಾಗಿರುವಂಥ ಕಡೆಯಲ್ಲಿ ಆಯ್ಕೆ ಮತ್ತು ಪೈಪೋಟಿಯಂಥ ಮಾನದಂಡಗಳು ಕೇವಲ ಮಧ್ಯಮ ಮರ್ಗಗಳಿಗೆ ಮಾತ್ರ ಲಾಭವಾಗುವಂಥ ಕಾರ್ಯವಿದಾನವನ್ನು ಒದಗಿಸುತ್ತವೆ. ಇದು ಈಗಾಗಲೇ ಇರುವ ಸಮಾನತೆಯನ್ನು ಆಳವಾಗಿಸಲು ಸಹಾಯಮಾಡುತ್ತದೆ.

ಪರಿಣಾಮಗಳು

ಸಾಮಾಜಿಕ ವರ್ಗ ಸಂಪನ್ಮೂಲಗಳಿಗೆ ಮಾತ್ರ ಸೀಮಿತವಾದಂತೆ ಶಾಲಾವ್ಯವಸ್ಥೆಯು ಇನ್ನು ಧ್ರುವೀಕೃತವಾಗುತ್ತಿದೆ.

ಮೂಲಭೂತ ಶಿಕ್ಷಣವನ್ನು ಬಾಹ್ಯ ಸಹಾಯಕ್ಕೆ ತೆರೆದಿಟ್ಟಿದ್ದು. 1998ರಲ್ಲಿ ಭಾರತವು ತನ್ನ ಸ್ಥೂಲ ದೇಶೀಯ ಉತ್ಪನ್ನದ ಶೇಕಡಾ 3ರಷ್ಟನ್ನು ಶಿಕ್ಷಣಕ್ಕಾಗಿ ಖರ್ಚು ಮಾಡುತ್ತಿತ್ತು. 1968ರ ಕೊಠಾರಿ ಆಯೋಗದ ವರದಿಯು ಕನಿಷ್ಠ ತನ್ನ ಸ್ಥೂಲ ದೇಶೀಯ ಉತ್ಪನ್ನದ ಶೇಕಡಾ 6 ರಷ್ಟನ್ನಾದರೂ ಶಿಕ್ಷಣಕ್ಕಾಗಿ ವ್ಯಯ ಮಾಡಬೇಕೆಂದು ಶಿಫಾರಸ್ಸು ಮಾಡಿದ್ದರೂ ಭಾರತದ ಪ್ರಭುತ್ವವು ಮತ್ತೆ ಮತ್ತೆ ಅದನ್ನು ದೃಢೀಕರಿಸಿದರೂ ವಾಸ್ತವ ಸ್ಥಿತಿ ಹೀಗಿದೆ.

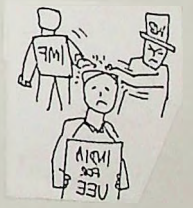
> 1992ರಷ್ಟು ಇತ್ತೀಚೆಗೆ, ಉದಾರೀಕರಣ ಪ್ರಕ್ರಿಯೆಯ ಪ್ರಾರಂಭದ ಸಮಕಾಲದಲ್ಲಿಯೇ ನವದೆಹಲಿಯಲ್ಲಿ ನಡೆದ ಒಂಭತ್ತು ರಾಷ್ಟ್ರಗಳ ಶಿಕ್ಷಣ ಶೃಂಗಸಭೆಯಲ್ಲಿ 2000 ಇಸವಿಯ ಹೊತ್ತಿಗೆ ಶಿಕ್ಷಣಕ್ಕಾಗಿ ನಿಗದಿಪಡಿಸಲಾದ ಮೊತ್ತದ ಬಡತಿಯ ಹೆಚ್ಚಳವು ಶೇಕಡಾ 6ರ ಅಂಕಿಯನ್ನು ತಲುಪಲಿದೆಯೆಂಬ ದೃಢನಿರ್ಧಾರವನ್ನು ಒತ್ತು ಕೊಟ್ಟು ಮತ್ತೆ ಮತ್ತೆ ಹೇಳಲಾಯಿತು.

ಆದರೆ ಇನ್ನೂ ಕೇವಲ 3% ರಷ್ಟನ್ನು ವ್ಯಯಿಸಲಾಗುತ್ತಿದೆ.

> IMF ಸಾಲದ ಮೂಲಕ ವಿದಿಸಲಾದ ರಚನಾತ್ಮಕ ಹೊಂದಾಣಿಕೆಯ ನೀತಿ (SAP) ಸಾಮಾಜಿಕ ಕ್ಷೇತ್ರಕ್ಕಾಗಿನ ವೆಚ್ಚವನ್ನು ಕಡಿತ ಮಾಡುತ್ತದೆಂದು ನನಗೆ ಗೊತ್ತು. ನಾನು ನಿಮಗೆ ಸಾಮಾಜಿಕ ಸುರಕ್ಷಾ ಜಾಲ ಎಂಬ ಅದ್ಭುತ ಯೋಜನೆಯನ್ನು ಪುಂಜುವಾರು ಮಾಡಬಲ್ಲೆ. ಈ ಯೋಜನೆಯಿಂದಾಗಿದೊರೆಯುವ ಮೃದುಸಾಲವನ್ನು ನೀವು ಜಿಲ್ಲಾ ಪ್ರಾಥಮಿಕ ಶಿಕ್ಷಣ ಕಾರ್ಯಕ್ರಮಕ್ಕಾಗಿ ಬಳಸಬಹುದು.

ಕೇಂದ್ರ ಸರ್ಕಾರವು 1992ರಲ್ಲಿ ಈ ಹಣವನ್ನು ತೆಗೆದುಕೊಂಡು ವಿವಾದಾತ್ಮಕ DPEP ಕಾರ್ಯಕ್ರಮವನ್ನು ಸ್ಥಾಪಿಸಿತು. ಈ ನಿಧಿಯು ಪ್ರಾಥಮಿಕ ಶಿಕ್ಷಣಕ್ಕಾಗಿ ಮೂಲಭೂತ ಶಿಕ್ಷಣಕ್ಕಾಗಿ ಕಾರ್ಯಸೂಚಿಯನ್ನು ಸಿದ್ಧಪಡಿಸುವ ನಿಟ್ಟಿನಲ್ಲಿ ಯಜಮಾನಿಕೆ ವಹಿಸುತ್ತಿದೆ.

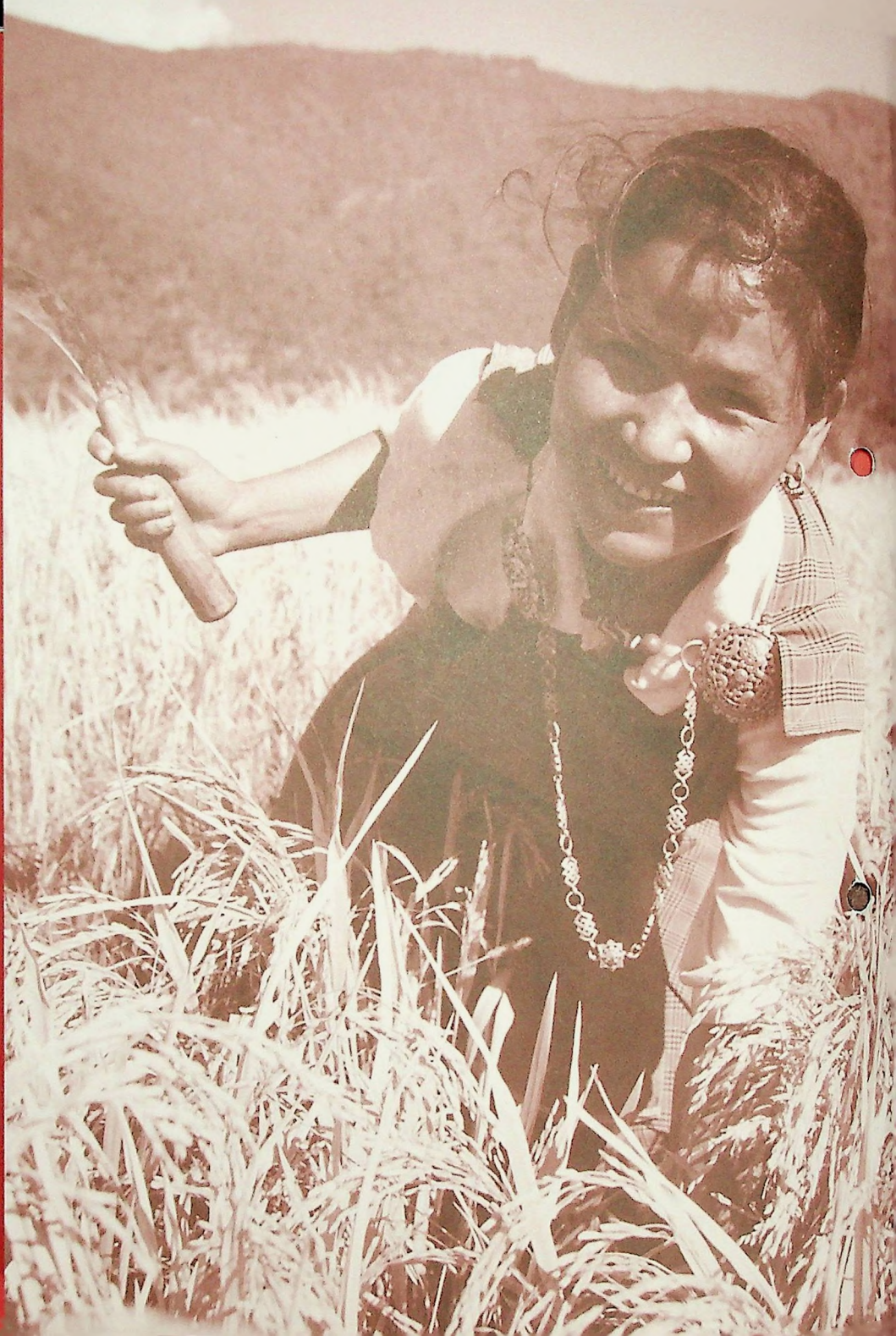
ಉದಾರೀಕರಣದ ಪ್ರಕ್ರಿಯೆ ಪ್ರಾರಂಭವಾದಾಗಿನಿಂದ ಭಾರತೀಯ ಪ್ರಭುತ್ವದ ಕಾರ್ಯನೀತಿ ಅಥವಾ ಧೋರಣೆಯನ್ನು ಅಂತರಾಷ್ಟ್ರೀಯ ಹಣಕಾಸು ನಿಧಿಯ / ಜಾಗತಿಕ ಬ್ಯಾಂಕಿನ ಷರತ್ತುಗಳು ಸ್ಪಷ್ಟವಾಗಿ ಮೂಲೆಗುಂಪು ಮಾಡಿವೆ. ಪ್ರಾಥಮಿಕ ಶಿಕ್ಷಣದ



WEMOS
GEZONDHEID WERELDWIJD
HEALTH FOR ALL

Good Intentions with Side-Effects

Information on Global Public Private Initiatives in Health: GPPIs



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1. Introduction and highlights

The health situation of poor people in low and lower middle income countries is a matter of great concern. Millions of people do not have access to sufficient food, safe drinking water, adequate housing and health care. Large numbers of people die every day of preventable and treatable illnesses. As a response to the present health crisis, UN health related agencies are increasingly appealing to companies and rich individuals to provide funds and other resources for the improvement of people's health in poor countries. Together with UN bodies such as the World Health Organisation (WHO) and governments, they are engaging in a growing number of so-called Global Public Private Initiatives or Partnerships (GPPIs). Partnerships between the public and the private sector are not new; its international dimension has, however, created a relatively new phenomenon.

At this moment, there are around 80 GPPIs working in the field of health, and new partnerships are launched regularly. In Tanzania, 28 partnerships are implementing activities. In Uganda 25 partnerships are active, in Mali 24 and Zambia, Mozambique and Senegal count 23 global partnerships. Most of them focus on the development of a product (e.g. development of a vaccine) or the improvement of access to health products (e.g. access to medicines for leprosy). 13 of these partnerships are focussed on different aspects of malaria, 12 on HIV/AIDS and 9 on tuberculosis.

This booklet has been compiled within the framework of the Wemos project 'Health and the Private Sector'. Wemos is of the opinion that an integrated approach to health is needed to ensure the fulfilment of the right to health for all. This implies, amongst other things, the need for strengthening of health systems that guarantee accessible health services for all and are based upon the needs of the people they are meant to serve. That large companies and rich individuals are willing to take responsibility for fighting the ill-health of millions of people is a positive development. The question is whether the present GPPIs are an effective way to improve people's health.

As part of this project, a series of case studies is being carried out by Southern partner organisations in order to shed light on the performance of some GPPIs programmes at country level and the consequences of these programmes for local health systems. In Uganda, Tanzania and Zambia, Roll Back Malaria is investigated. In South Africa, one of Wemos' partners is looking at Stop TB. A Kenyan partner organisation is doing research on the Global Alliance to Eliminate Lymphatic Filariasis and in India the Global Polio Eradication Initiative and the Global Alliance to Eliminate Lymphatic Filariasis are being investigated. The results of these studies will be available in the summer of 2004.

This booklet is based on a study carried out in 2003 on behalf of Wemos. 79 GPPIs were studied, most involving the WHO.
The researchers used information available on the websites of GPPIs themselves, their partners, non-governmental institutions (NGOs) and independent reports. Out of the 79, 10 were selected to be studied in more detail, looking at aspects such as their objectives, which public and private institutions are involved and how decisions are made and implemented.

'In India, 40 percent of the population lives below the poverty line. We welcome new partnerships, but they will have to work. They have to work for the people.'
Mr. Poddar, West Bengal Voluntary Health Association, India

Good intentions with side-effects, drawing on the results of the research, is aimed at giving an idea of what exactly partnerships are and what their side-effects might be. The booklet includes a close look at one of the largest and most influential GPPI, the Global Alliance for Vaccines and Immunisation (GAVI). Also, an overview is given of the 79 GPPIs that were studied, and 10 partnerships are described in more detail.

2. GPPIs

What are they?
Objectives, strategies and activities

Looking at the objectives, activities and strategies of 79 GPPIs reveals an overriding emphasis on a specific disease, linked to the access to, or development of a specific drug or vaccine. Typical too will be a clearly expressed target like '50 percent reduction' or 'eradication'. Diseases commonly targeted are malaria, tuberculosis (TB), HIV/AIDS and other infectious diseases. Almost half concern development or access to drugs, vaccines and other health products. By contrast little more than one in ten states strengthening health services as one of their objectives.

Who are they? Main participants

Public

WHO and UNICEF are the principal international governmental or multilateral organisations, having a stake in respectively 62 percent and 33 percent of all global partnerships in health. Typically the WHO takes responsibility for high-level technical decisions while UNICEF plays a more operational role driven by the number of vaccine-related GPPIs and the high burden of disease borne by children. GPPIs are seen as an important way for UN organisations to increase access to funding. UN secretary general Kofi Annan told the World Economic Forum in 1999 that prosperity could not be achieved without partnerships involving the business community. The World Health Organisation's ex-director Gro Harlem Brundtland argued too that the complexity of today's health requires all sectors to pull together, including business. In this context, the WHO developed 'Guidelines on working with the private sector'. These guidelines were intended primarily to help WHO staff interact appropriately with commercial enterprises and avoid conflict of interest.

The World Bank is also an important multilateral player, mostly acting as a custodian of funds managed by a GPPI. For governments of low income countries, GPPIs represent another source of financial and technical support for their activities in health. Health budgets often amount to less than 13 US dollar per person per year (1) and many governments argue that any outside funding is welcome to fight the present health crisis. The WHO Commission on Macro-economics and Health estimates that at least 30 to 40 US dollar per person per year is needed to cover essential interventions, including those needed to fight the AIDS pandemic.

Private

The most common philanthropic foundations are the Bill and Melinda Gates Foundation and the Rockefeller Foundation, with Gates by far the most involved. The pharmaceutical companies GlaxoSmithKline (GSK) and Merck are the most common of a concentrated group of six commercial pharmaceutical companies. Private capital's involvement may be both socially responsible and purely economic. Transnational companies have become so

WHO and Unicef have a stake in respectively 62 percent and 33 percent of all global partnerships in health

large and powerful that it is almost inevitable they will touch on larger social questions such as AIDS/HIV and malaria. Shareholders will demand an increased sense of social responsibility and businesses would rather not operate in the global insecurity posed by the threat of diseases such as HIV/AIDS. But unlike previous "donations", "partnerships" suggest a degree of leverage. All partners, including private capital, have a say in decisions and have interests, which should be addressed. And companies have much to gain. GPPIs can carve out new markets for the future; vaccines can be introduced to the business potential of the developing world. GPPIs can also boost the public image of a company, becoming a part of its whole corporate planning.

NGOs are typically being involved in GPPIs because of their presence in a particular target country. Médecins Sans Frontières (MSF) and the Programme for Appropriate Technology in Health (PATH) are the most common, playing a role in GPPIs they themselves have launched. Other participants include developed country government departments such as USAID and academic institutions such as the London School of Hygiene and Tropical Medicine.

And How?

Organisational arrangements

The research of ten GPPIs showed most were organised through an international board that usually meets infrequently to consider large funding allocations, strategic direction and changes in objectives. Typically the GPPI boards take funding decisions in response to proposals from recipient countries. These have been made according to a set framework previously established by the donors.

Other research on GPPIs governing structure reveals that certain groups are systematically under-represented in governing bodies of GPPIs, particularly Southern governments and civil society organisations (2). The Global Alliance to Improve Nutrition (GAIN) is an exception in this respect. GAIN gives poor countries a 40 percent stake, while the rest including private industry, private foundations, NGOs, bi-and multi-lateral agencies such as the UN and scientific agencies have 10 percent each. However, the voting rights structure does not provide the full picture of the power structure within GPPIs. While drug companies may not have a majority of votes on a GPPI board, they exercise huge influence over decision making, because without their continued and voluntary donations many GPPIs would simply collapse.

GPPIs are almost always based in Western countries: their headquarters are close to those of the private company or multilateral agency that launched them. Of the 79 GPPIs studied, only four had a headquarter based in a recipient country. Due to the costs of travel, some authors suggest that partners or potential partners from poor countries may be at a disadvantage to participate in decision making processes.

How much money is involved?

Though it is quite difficult to obtain information on the exact budget of GPPIs, it is possible to make a rough estimate using different sources. For example, the Global Polio Eradication Initiative has spent 2 billion US dollar since 1985. Her budget for 2002 until 2007 is about 1 billion US dollar. The Global Alliance for the Elimination of Lymphatic Filariasis has an annual budget of about 100 million US dollar. Roll Back Malaria could spend 165 million US dollar in 2002. The Stop TB partnership has a budget of around 600 million US dollar per year. The Global Alliance for Vaccines and Immunisation has had about 1,14 billion US dollar to spend since 2001. In comparison: the total budget of the WHO for 2004-2005 is 2,8 billion US dollar.

Which information is available?

The amount of information published on the GPPI's websites depends partly on the size and public profile of the GPPI. For example, the collaboration between Japanese pharmaceuticals, the ministry of health and the WHO's malaria venture, a relatively small GPPI, appeared to be hardly documented on the web.

By contrast the Global Alliance for Vaccines and Immunisation (GAVI) publishes extensive information on its website including its objectives, a progress report, and the names and roles of board and secretariat members.

The researchers conclude that GPPIs rarely publish much information on finances and progress towards their aims. What they do publish is an overriding focus on easy to measure targets, such as the number of persons covered by immunisation or receiving a specific treatment.

GPPIs are almost always based in Western countries


Polio
Also called 'Poliomyelitis'
Polio is a Sickness
which begins with a
Mild Cold,
Arms or Legs
become Lame,
thin wasted with
normal sense to touch

3. Good intentions with side-effects

This study and earlier studies on GPPIs show that some have had positive outcomes. They deliver funding, draw attention to largely unknown health threats such as river blindness, and some have been very successful in achieving their goals. For example, one of the earliest GPPIs, the Global Polio Eradication Initiative has made great gains in eradicating the disease in almost every region of the world.
But there are risks too. The main risks associated with GPPIs concern their sustainability, governance and accountability.

Sustainability

In discussions about the increasing importance of GPPIs, questions are often raised about the sustainability of the funding and of the health improvements. GPPIs rarely include explicit financial commitments of the commercial sector beyond five years. Merck's donation of the drug Mectizan, in the framework of the Mectizan Donation Programme, is remarkable for explicitly stating that the donation is indefinite. With other GPPIs, this is not the case. If, for example, in the framework of the Global Alliance for the Elimination of Lymphatic Filariasis, the pharmaceutical company GSK decided to withdraw its commitment to donate the drug albendazole to a specific country, then the initiative would stop. Poor countries cannot insist on the support of GSK. A commitment to donate is not enshrined within any governance documents available. Without it the GPPI, invested in by the country's health system and requiring a commitment over many years, would collapse.
Dependency on new, sometimes more expensive drugs or vaccines, also affects the sustainability of the partnership. In the case of the Global Alliance for Vaccines and Immunisation, Ghana has accepted a more expensive vaccine (pentavalent) because the cheaper quadravalent version was not available at that moment. If the GPPI would stop and the government would have to continue the programme, they have to spend a large part of their budget on these vaccines and other health priorities could suffer.

Another example is the Accelerating Access Initiative (AAI), which aims to reduce the prices of HIV/AIDS medicines. According to Act Up Paris, the pharmaceutical companies working in the AAI let countries sign confidential agreements that aim to prevent competition with generic HIV/AIDS medicines (3). The absence of generic medicines makes countries fully dependent on the willingness of international pharmaceutical companies to offer their medicines at a lower price. If these companies decide to increase their prices, governments have no alternative and are forced to purchase these more expensive patented medicines.

Finally, the number of GPPIs operating in one single country and the number of these GPPI programmes directed to the same health

problem might pose questions about sustainability and efficiency.
Especially because each partnership works with a different perspective and with a different approach, but makes use of the same health system to implement their plans.
When these programmes are not well coordinated, it might lead to overuse of the already weak health system. Then the situation could arise that a country does have access to the medicines it needs, but lacks the infrastructure to deliver it to the patients.

Governance and accountability

Another 'hot item' is the way in which GPPIs are governed. This whole question of "governance" is attracting attention as it is breaking new ground. For the first time on a global scale, public, commercial and civil society are being brought together through partnerships to achieve shared health goals. Related to this is the issue of transparency and information about the operational structure, decision making processes and accountability mechanisms for GPPIs.

Though a sufficiently wide group of stakeholders is normally in place to make decisions (for example, the Stop TB partnership counts more than 200 partners), this does not guarantee democratic decision making.
So far, research concludes a gross underrepresentation of stakeholders from poor countries and a lack of specific criteria for defining the "rights, privileges and obligations associated with partners status"(4). Most decision-making power sits in the hands of multilateral institutions and the commercial sector. By contrast, poor countries' governments have less of a voice in the formation and design of GPPIs.

Some researches state that accountability in partnerships is complex and contested. Complex, because it involves the accountability of the executive staff to the governing body of the GPPI, of the governing body to its stakeholders, and of the partners of the GPPI to the GPPI itself. Contested, because opinions differ whether these partnerships need to be accountable only to the donors and main stakeholders or need to be accountable to any social group affected or involved in the GPPIs' programmes. The lack of representation of the target population in decision making mechanisms makes these partnerships very low accountable to populations to whom they are directed.

The main risks associated with GPPIs concern their sustainability, governance and accountability

4. An example: The Global Alliance for Vaccines and Immunisation (GAVI)

GAVI was launched in January 2000 at the World Economic Forum in response to international concern over a decade of declining childhood immunisation rates. This decline had had a devastating effect on child mortality. GAVI brought together an alliance of national governments, the WHO, UNICEF, the World Bank, the Bill and Melinda Gates Foundation and industry, represented by the International Federation of Pharmaceutical Manufacturers' Associations. It aimed to provide a new mechanism for coordinating partner organisations' efforts to revitalise international support for immunisation.

Turning back the tide on childhood disease

In 1974 the World Health Assembly had launched The Expanded Programme on Immunisation (EPI) which achieved real successes. By 1980 UNICEF could report that immunisation rates against the six major childhood diseases, diphtheria, tetanus, whooping cough, polio, measles and tuberculosis, had leapt from 5 percent to 80 percent. It then stalled and began to fail. This was caused by a variety of inter-related reasons including war, HIV/AIDS, donor fatigue and a change of leadership at the WHO. By 2000, global coverage on immunisation had dropped to 75 percent. In 19, mostly African countries, immunisation rates against diphtheria, tetanus and polio had dropped below 50 percent. Yet as early as September 2003, GAVI could claim that 30 million of the world's poorest children had benefited in just three years. 250 million US dollar had been distributed among 60 countries and an estimated "300,000 deaths had been prevented" (5).

As early as September 2003 GAVI could claim that 300,000 deaths had been prevented

New initiative, new methods, new money

GAVI is significant as one of the first of the new GPPIs launched in the last five years. It is also one of the biggest and is mostly funded by the largest private donor, the Bill and Melinda Gates Foundation, that committed US$ 750 million. There was also support from national governments, ranging from the United States (US$ 159 million over three years), the Netherlands (US$ 85 million over five years), to Ireland (US$ 0.5 for one year). While a board sets its overall objectives, structures and recommendations for funding, a separate and mutually interdependent Vaccine Fund has the final say on applications to the GAVI. A stated additional aim of this Fund is to "demonstrate to vaccine manufacturers that a developing country market exists for newer vaccines".

Unlike many GPPIs, it spelt out clear objectives. These include expanding the use of existing under-utilised vaccines in 74 countries, supporting the development of new vaccines, improving access to sustainable immunisation services, expanding the use of existing cost-effective vaccines and promoting the delivery of other appropriate interventions at immunisation centres. It also spelt out clear goals. These included that 80 percent of poor countries would have at least 80 percent routine immunisation coverage by 2005. Also specific targets were added for hepatitis B (hep B) and haemophilus influenzae type b (Hib) vaccination.

GAVI is significant as one of the first of the new GPPIs launched in the last five years

Return to immunisation

A report by UK-based NGO Save the Children looked in 2001 at how GAVI actually worked on the ground in four countries: Ghana, Mozambique, Tanzania and Lesotho.
In general they welcomed the renewed focus on immunisation, the strengthening of countries' immunisation coordinating committees, the introduction of safe injections and equipment for hepatitis B vaccine, and the provision of technical support. Countries particularly welcomed the freedom GAVI allowed, in contrast to other donors, in the way money was spent on supporting health systems. Welcome too was the chance GAVI offered to provide hepatitis B vaccine, which countries had previously wanted but found too expensive.

There was also evidence that GAVI was getting feedback and learning from individual country's experience. The "evolutionary" aspect of GAVI has been praised.

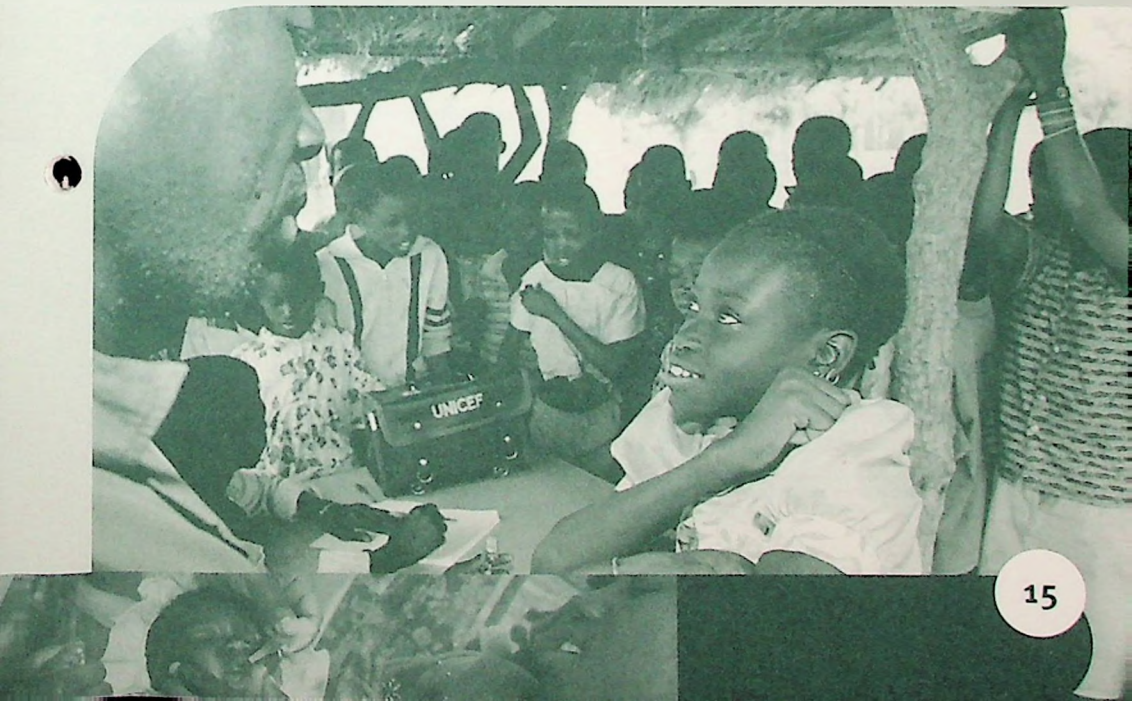
One example is the decision to provide auto-disposable syringes for all vaccines in the expanded programme and not just for new vaccines. This helped allay fears that re-usable syringes could put their children at risk from HIV.

However, critical remarks have been made about the limited attention paid to strengthening the infrastructure needed to vaccinate children. Health Action International Europe, for example, noted that among the first awards in 2000/2001 only 10 percent were for strengthening immunisation services while 90 percent were for developing and introducing new vaccines, mainly hep B (6). A good sign is that in the proposals for 2002 this percentage had increased: 28 percent of the total budget was awarded to strengthening of immunisation delivery systems (7).

Risks

All the benefits of the GAVI programme could be jeopardised by its over dependence on the inadequate systems currently operating. Because it is incorporated into routine immunisation services it may suffer from the same chronic under-investment. Examples from the Save the Children report speak of broken fridges and thermostats, a lack of fuel for transport, staff shortages and inadequate facilities for disposing of syringes. Much of rural Mozambique, for example, has no adequate cold chain equipment to store the vaccines. With these crippling problems, efforts to extend immunisation coverage and ensure supervision and monitoring, an important aim of GAVI, are threatened. GAVI's system support funds alone cannot hope to redress such structural weaknesses and attention should be paid to more sustainable health system improvements in order to achieve the GAVI objectives.

The Save the Children study raises serious concerns about sustaining funding for the GAVI after its initial lifespan of five years. A notable finding, it concludes, is a lack of discussion and co-ordination about future financing. It sees little evidence that individual agencies will meet future costs especially, for example, where countries have opted for expensive combination vaccines. The current cost of Ghana's expanded programme on immunisation is $US 3.7 million a year. This will treble with the introduction of the pentavalent vaccine, which is part of the GAVI programme in Ghana. If GAVI would decide to stop its activities in Ghana, it may be politically damaging for the government to withdraw from costly programmes such as the pentavalent vaccine programme. As a result, other greater health priorities could suffer.



5. Concluding remarks

In this booklet, a brief introduction to GPPIs in health has been provided. It is too early to have in-depth insight into the effects of GPPIs. More research on the performance of GPPIs at country level is needed in order to decide whether the present GPPIs are an effective way to improve people's health in poor countries and if not, what should be done to improve their effectiveness. The Wemos' case studies, available this summer, will provide more information.

In the mean time, based on the available information, Wemos proposes a series of clear criteria that can be used to assess whether GPPIs are an effective instrument in improving people's health:

- Participation – Is the strategy and approach of the GPPI the result of consultation with the recipient country? Does it reflect their main priorities?
- Sustainability – Does the GPPI strengthen local health system structures, enabling people to help themselves in the future? Does the GPPI look beyond its set time frame? Does the GPPI give attention to prevention and the cause of the targeted disease?
- Accountability – Is the GPPI accountable to the public? Is the decision making process transparent? Are the WHO guidelines on interaction with the private sector being followed?

When these criteria are met, GPPIs will be able to make a contribution to sustainable improvements in people's health. Without attention for participation, sustainability and accountability the good intentions of all partners involved may be jeopardised. GPPIs might then at best make a contribution to fighting an illness for a set period of time, but will not lead to the sustainable health improvements, that GPPIs are created for.

It is too early to have in-depth insight into the effects of GPPIs

6. Annexes

Annex 1: List of the analysed GPPIs, with their targeted diseases/risk factors

Full Name	Disease / Risk Factor
Global Alliance to Eliminate Leprosy (GAEL)	Leprosy
Accelerating Access Initiative to HIV Care (AAI)	HIV/AIDS
Global Polio Eradication Initiative (GPEI)	Polio
Int'l. Partnership Against Aids in Africa (IPAAA)	HIV/AIDS
The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund)	HIV/AIDS, Malaria, Tuberculosis (TB)
Global Alliance for the Elimination of Lymphatic Filariasis (GAELF)	Lymphatic Filariasis (LF)
Global Alliance for Improved Nutrition (GAIN)	Micronutrient deficiency
Global Alliance for Vaccines and Immunisation (GAVI)	Vaccine-preventable diseases of the poor
Roll Back Malaria Global Partnership (RBM)	Malaria
Stop TB Partnership (Stop TB)	Tuberculosis (TB)
WHO-Pharmaceutical Industry Associations-NGO Anti-Counterfeit Drug Initiatives	Counterfeit and substandard drugs
African programme for Onchocerciasis Control (APOC)	Onchocerciasis (river blindness)
Meningitis Vaccine Project at WHO/PATH (MVP)	Meningitis
WHO programme to Eliminate Sleeping Sickness (WPESS)	Human African trypanosomiasis
Japanese Pharmaceutical, Ministry of Health, WHO Malaria Drug Partnership (JPMW)	Malaria
Mectizan Donation programme (Mectizan)	Lymphatic Filariasis (LF), Onchocerciasis (river blindness)
Partnership for the use of social sciences in malaria control	Malaria
Global Elimination of Trachoma (GET 2020)	Blindness, Trachoma
WHO/Novartis Coartem®	Malaria
Action TB programme	Tuberculosis (TB)
African Comprehensive HIV/AIDS Partnerships (ACHAP)	HIV/AIDS
Alliance for Microbicide Development (AMD)	HIV/AIDS, Sexually transmitted infections
Concept Foundation	Reproductive health
CONRAD	Reproductive health
Corporate Council on Africa (CCA)	HIV/AIDS
Diflucan Partnership programme	HIV/AIDS
Foundation for Innovative New Diagnostics (FIND)	Diagnostics, Tuberculosis (TB)
Global Alliance for TB Drug Development (TB Alliance)	Tuberculosis (TB)
Global Business Coalition on HIV & AIDS (GBC)	HIV/AIDS
Global Guinea Worm Eradication programme (GWEP)	Guinea worm (dracunculiasis) disease

Global Microbicide Project (GMP)	Sexually transmitted infections
Global Public-Private Partnership for Hand Washing with Soap (GPHW)	Communicable diseases
Global Reporting Initiative (GRI)	HIV/AIDS
Hope for African Children Initiative (HACI)	HIV/AIDS
Intercompany Collaboration for AIDS Drug Development (ICCADD)	HIV/AIDS
International AIDS Vaccine Initiative (IAVI)	HIV/AIDS
International Partnership for Microbicides (IPM)	Sexually transmitted infections
International programme on Chemical Safety (IPCS)	Chemical safety information
Lilly Multi-Drug Resistant Tuberculosis Partnership	Tuberculosis (TB)
Maternal and Neonatal Tetanus, Global Elimination of (MNT)	Tetanus, maternal and neonatal
Microbicides Development programme (MDP)	HIV/AIDS, Sexually transmitted infections
MTCT-Plus Initiative	HIV/AIDS
Safe Injection Global Network (SIGN)	Injection safety, syringes
Secure the Future	HIV/AIDS, Sexually transmitted infections
Sequella Global Tuberculosis Foundation (SGTBF)	Tuberculosis (TB)
Step Forward programme	HIV/AIDS
Strategies for Enhancing Access to Medicines (SEAM) at Management Sciences for Health (MSH)	Diseases of the poor
Tuberculosis Diagnostics Initiative (TBDI)	Tuberculosis (TB)
UNFPA Contraceptives Access Project (UNFPA/Industry) (Profile in Progress)	Reproductive health
Viramune® Donation programme (VDP)	HIV/AIDS
Alliance for Health Policy and Systems Research (AHPSR)	Health policies and health systems
Artesunate Suppository for Emergency Treatment of Severe Malaria	Malaria
Children's Vaccine programme at PATH (CVP at PATH)	Vaccine-preventable diseases of the poor
Consortium for Industrial Collaboration in Contraceptive Research (CICCR)	Sexually transmitted infections
Dengue Vaccine Project (DVP)	Dengue
Drugs for Neglected Diseases Initiative (DNDi)	Chagas, Leishmaniasis, Human African trypanosomiasis
European Malaria Vaccine Initiative (EMVI)	Malaria
Gates Foundation/U. of North Carolina Partnership for the Development of New Drugs (GFUNC)	Leishmaniasis, Human African trypanosomiasis
Health InterNetwork (HIN)	Digital divide
Hookworm Vaccine Initiative (HVI)	Hookworm
Infectious Disease Research Institute (IDRI)	Chagas, Leishmaniasis, Leprosy, Malaria, Tuberculosis (TB)
Institute for OneWorld Health (IOWH)	Parasitic and other neglected infectious diseases
Lapdap Antimalarial Product Development (LAPDAP)	Malaria
Lassa Fever Initiative (LFI)	Lassa fever
Malaria Vaccine Initiative (MVI)	Malaria
Medecins Sans Frontieres Drugs for Neglected Diseases Working Group (MSF DND)	Neglected diseases

Medicines for Malaria Venture (MMV)	Malaria
International Trachoma Initiative (ITI)	Blindness, Trachoma
Int'l. Conf. on Harmonisation of Technical Reqs for Registration of Pharmaceuticals Human Use (ICH)	Harmonisation of drug applications
Micronutrient Initiative (MI)	Micronutrient deficiency
Multilateral Initiative on Malaria (MIM)	Malaria
NetMark PLUS, a Regional Partnership for Sustainable Malaria Prevention	Malaria
Pediatric Dengue Vaccine Initiative (PDVI)	Dengue
Pharmaceutical Security Institute (PSI)	Counterfeit and substandard drugs
Single Nucleotide Polymorphisms Consortium Ltd (SNP)	All human diseases and medical conditions
Vaccine Fund (VF)	Vaccine-preventable diseases of the poor
Vaccine Vial Monitors (VVMs), Development of	Vaccine vial monitors
Vision 2020	Blindness, Cataract, Onchocerciasis (river blindness), Trachoma
Vitamin A Global Initiative (VITA)	Vitamin A deficiency
Children's Vaccine Initiative (CVI) - HISTORICAL*	Vaccine-preventable diseases of the poor
Malarone Donation programme - HISTORICAL	Malaria
Meningitis C Vaccine Development and Supply in UK - HISTORICAL	Meningitis
Norplant, Development of - HISTORICAL	Reproductive health
Onchocerciasis Control programme in West Africa (OCP) - HISTORICAL	Onchocerciasis (river blindness)
Oral Rehydration Salts (ORS) Commercialisation in Bolivia - HISTORICAL	Diarrhea dehydration
Praziquantel Manufacturing Project - HISTORICAL	Schistosomiasis
Syringes - Autodestruct Development - HISTORICAL	Injection safety, syringes

*HISTORICAL means the GPPI has ended.

Annex 2: Overview of 10 GPPIs

Name	**Accelerating Access Initiative to HIV Care (AAI)**
Disease or risk factor focus	HIV/AIDS
Brief description	Announced in May 2000, the initiative involves a dialogue between the UN and the pharmaceutical industry with the intention of making HIV/AIDS medicines and diagnostic equipment more available and affordable in the hardest hit regions of the world. It is a cooperative endeavour involving five UN organisations and six pharmaceutical companies. AAI is involved in negotiating deeply discounted drug prices for countries that can provide proof they have the health services to handle the complicated HIV/AIDS medicines. Facilitated by UNAIDS, governments negotiate with the pharmaceutical companies about ARV- prices.
Objectives	• To increase access to HIV/AIDS care, treatment and support in resource-poor settings • To improve access to care, including treatments for opportunistic infections and antiretroviral therapy, in the hardest-hit regions of the world
Approach	Improvement of access to health products
Main participants	**Public sector**: WHO, World Bank, UNICEF, UNAIDS, etc. **Private sector**: GlaxoSmithKline, Merck, Bristol-Myers Squibb, Abbott, Boehringer Ingelheim, Hoffman La Roche, etc.
Target countries	Bahamas, Barbados, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Chile, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Gabon, Honduras, Jamaica, Mali, Malawi, Marocco, Romania, Rwanda, Senegal, Trinidad and Tobago, Uganda, South Africa
Website	www.unaids.org

Name	Global Alliance for Elimination of Leprosy (GAEL)
Disease or risk factor focus	Leprosy
Brief description	The Global Alliance was initiated by WHO in 1999 to ensure that a common strategy based on experience of past leprosy elimination efforts was adopted, intensively implemented and effectively monitored. GAEL is a partnership dedicated to ensuring that all leprosy patients, wherever they may live, and however poor, have free and equal access to the most modern of treatment available. Multi-drug therapy (MDT) has been made available free of charge from WHO, thanks to a donation by Novartis which make the drugs and financial support by the Nippon and Sasakawa Foundations. MDT provides a simple yet highly effective cure for all types of leprosy in just six to twelve months. The goal of GAEL is to eliminate leprosy as a public health problem from every country by the year 2005 and to detect and cure all the remaining leprosy cases currently estimates at over 2.5 million. GAEL includes WHO, governments of endemic countries, the International Federation of Anti-Leprosy Associations, NGOs, DANIDA, the World Bank, the Nippon Foundation and the Sasakawa Memorial Health Foundation.
Objectives	To detect and cure all remaining leprosy cases (estimated at 2.8 million), in order to eliminate it from every country by 2005 (elimination as attaining a level of prevalence below one case per 10 000 population)
Approach	Improvement of access to health products
Main participants	**Public sector:** WHO, World Bank, Ministries of Health in target countries, DANIDA, etc. **Private for-profit sector:**, GlaxoSmithKline, Merck, Novartis, Binax, etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, Sasakawa Memorial Health Foundation, Nippon Foundation, International Leprosy Association (ILA), International Federation of Anti-Leprosy Associations (ILEP), The Leprosy Mission (TLM), etc.
Target countries	Angola, Brazil, Guinea, India, Madagascar, Mozambique, Myanmar, Nepal
Website	www.who.int/lep

Name	Global Alliance for the Elimination of Lymphatic Filariasis (GAELF)
Disease or risk factor focus	Lymphatic Filariasis (also known as elephantiasis) Onchocerciasis (river blindness) in countries where the diseases co-exist
Brief description	GAELF exists to eliminate lymphatic filarisasis worldwide. LF is a dehabilitating condition caused by two types of parasite, spread by mosquitoes, that occupy the lymph nodes and which in conjunction with secondary bacterial & fungal infections may cause swelling of the limbs and genitals causing social stigma and restricting the ability to work and travel. In 1995 the WHR identified LF as the second leading cause of disability in the world. WHO is the secretariat for this partnership forum for the exchange of ideas & coordination of activities; with membership open to all interested parties. GAELF members include governments of endemic countries, plus 39 organisations from public and private sectors, academia, government bodies & NGOs. It was founded in May 2000. Its cornerstones are the WHO which directs and coordinates activities, the Gates Foundation, which donated $20m in 2000, and GSK which has made a $1.6bn commitment to supply drugs until the disease is eliminated.
Objectives	• To eradicate LF by 2020 • To interrupt transmission of infection • To alleviate and prevent the suffering and disability caused by the disease identified in more than 20m people worldwide
Approach	Improvement of access to health products
Main participants	**Public sector:** WHO, UNICEF, World Bank, US Centres for Disease Control & Prevention (CDC), Ministries of Health in target countries, USAID, UK Department for International Development (DFID), government of Belgium, Spain, Italy, Japan, Netherlands, etc. **Private for-profit sector:** GlaxoSmithKline, Merck, Binax, etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, Carter Center, Arab Fund for Economic and Social Development, Caribbean Epidemiological Centre (CAREC), Secretariat for the Pacific Community, South East Asian Ministers of Education Organisation (SEAMEO), etc.
Target countries	79 countries
Website	www.filariasis.org

Name	**Global Polio Eradication Initiative (GPEI)**
Disease or risk factor focus	Poliomyelitis
Brief description	A multi-partner, informal coalition supporting the WHO goal and strategies for eradication of poliomyelitis. Partners include others UN Agencies, other NGOs, national development assistance and technical agencies. The spearheading partners are the WHO, Rotary International, The CDC and UNICEF. Industry has donated polio vaccine and funds to support surveillance.
Objectives	• To interrupt transmission of the wild poliovirus globally and certify all WHO regions polio-free by the end of 2005 • To achieve global certification of polio eradication, including containment of the wild poliovirus, and the development of a post-eradication immunisation policy • To contribute to health systems development by strengthening routine immunisation and surveillance for communicable diseases
Approach	Improvement of access to health products
Main participants	**Public sector:** WHO, UNICEF, World Bank, US Centres for Disease Control & Prevention (CDC), USAID, UK Department for International Development (DFID), Canadian International Development Agency, government of Finland, Germany, Netherlands, Japan, Italy, Belgium, Denmark, EU, etc. **Private for-profit sector:** Aventis Pharmaceuticals, De Beers, Wyeth, Rotary International, and Vaccine Manufacturers Network, etc. **Private not-for-profit sector:** UN Foundation, GAVI, Bill and Melinda Gates Foundation, Australian International Health Institute, Red Cross, etc.
Target countries	Afghanistan, Angola, Egypt, Ethiopia, India, Niger, Nigeria, Pakistan, Somalia, Sudan
Website	www.polioeradication.org

Name	Global Alliance to Improve Nutrition (GAIN)
Disease or risk factor focus	Micronutrients deficiencies
Brief description	GAIN was launched in May 2002 during the United Nations General Assemby Special Session on Children and is a collaboration between the diverse stakeholders: public sector, commercial sector, non-profit sector, bilaterals, multilaterals & academic institutions, with the emphasis on including public and private sector partners with the aim of reducing ill-health caused by malnutrition, especially deficiencies of micronutrients. It has an independent non-profit legal status. Their focus is on the promotion of food fortification programmes by food producers in collaboration with the public sector. They also promote nutrition awareness at strategic and consumer levels. They specifically exclude consideration of micronutrient supplements, leaving this to other agencies. Various activities include policy formulation, setting standards, capacity building, advocacy, marketing & operational research. As the alliance is relatively young there is no sustained period of operation during which performance can be analysed. They recognise that malnutrition is driven by social and economic factors and therefore target poor communities. GAIN is governed by a Board and administerd by a Secretariat and was incorporated as a Swiss Foundation in March 2003.
Objectives	• GAIN is an alliance of public, private and civil society organisations committed to saving lives and improving health through the elimination of vitamin and mineral deficiency. This is targeted primarily through facilitating fortification of commonly available and consumed local foods. • By contributing to the reduction of micronutrient deficiencies, GAIN aims to decrease child and maternal morbidity and mortality, lessen health care costs, improve productivity, & promote the ability of populations to achieve their physical and intellectual potential • A particular emphasis on children; poor communities; and vitamin A, iodine, folic acid and iron
Approach	Global coordination mechanism, public advocacy, education and research, regulation and quality assurance
Main participants	**Public sector:** WHO, Unicef, World Bank, US Centres for Disease Control & Prevention (CDC), UN Food and Agriculture Organisation (FAO), World Food Programme, USAID, Canadian International Development Agency, government of Germany, national food fortification associations, etc. **Private for-profit sector:** Procter & Gamble, Heinz, Unilever, Roche, International Life Sciences Institute, Salt Institute, etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, Helen Keller International, Program for Appropriate Technology in Health (PATH), SUSTAIN, Micronutrient Initiative, PAHO, International Union of Nutritional Sciences, International Food Policy Research Institute, etc.
Target countries	Bolivia, China, Côte d'Ivoire, Dominican Republic, Indonesia, Iran, Jordan, Kazakhstan, Morocco, Nigeria, Philippines, South Africa, Thailand, Uzbekistan, Vietnam, Zambia
Website	www.gainhealth.org

Name	Global Alliance for Vaccines & Immunisation (GAVI)
Disease or risk factor focus	Vaccine-preventable diseases of the poor
Brief description	GAVI was established in 1999. It partners private and public sector to improve health and "save children's lives" through the widespread use of vaccines - full vaccine coverage would save 3m lives a year. International organisations, governments, vaccine industry, research institutions, and foundations have formed a partnership to develop and push GAVI objectives. They work with the governments of target countries which are listed below and must have a GNP of less than $1000 pppa. GAVI directs the Vaccine Fund to "fuel poorer countries' long-term efforts to provide children with basic access to life saving vaccines". At the end of 2002, the Vaccine Fund had committed $905 million over five years to 64 countries in immunisation programme financing. GAVI also proposes to stimulate the vaccine industry to develop and supply vaccines vital to low-income countries. The main driver for its inception was the Gates Foundation.
Objectives	• Improve access to existing vaccine services • Promote research and development into new vaccines • Raise profile of vaccine-preventable diseases of the poor
Approach	Improvement of access to health products , global coordination mechanism
Main participants	**Public sector:** WHO, Unicef, World Bank, US Centres for Disease Control & Prevention (CDC), Ministries of Health in target countries, USAID, UK Department for International Development (DFID), Canadian International Development Agency, governments of The Netherlands, Norway, etc. **Private for-profit sector:** GlaxoSmithKline, Aventis, International Federation of Pharmaceutical Manufacturing Association (IFPMA), American Home Products, Chiron Vaccines, BERNA Swiss Serum & Vaccine Institute Berne, CVP at PATH, etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, United Nations Foundation, Sierra Leone Red Cross Society, Institut Pasteur, etc.
Target countries	75 countries
Website	www.vaccinealliance.org

Name	The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund)
Disease or risk factor focus	HIV/AIDS, tuberculosis, malaria
Brief description	The Fund aims to rapidly disburse grants to increase existing spending on the prevention and treatment of these three diseases while building on, complement, and coordinate with existing regional and national programs in support of national policies, priorities and partnerships.
Objectives	In order to fight AIDS, tuberculosis and malaria: • To attract, manage and disburse additional monies with less bureaucracy for recipient countries, allowing more effective use of donor resources, and fewer transaction costs for all • To direct financial resources where they are needed most and ensure that they are used effectively • Reduced death rates, reduced disease transmission rates, increased survival rate, and control of multi-drug resistance
Approach	Global coordination mechanism
Main participants	**Public sector:** WHO, World Bank, UNAIDS, USAID, governments of Thailand, Brazil, Japan, Italy, France, Ukraine, Uganda, Pakistan, China, European Union **Private for-profit sector:** may private companies e.g. McKinsey, Eni S.p.A., Statoil, Winterthur, KPMG (Thailand), Pricewaterhouse Coopers (Zambia), etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, Uganda Health Rights Action Group, Harvard University, GAVI, AIDES, Academy for Educational Development, Aids Fund, International HIV/AIDS Alliance, Int. Couincil of AIDS Service organisations, Global Network of People Living with HIV/AIDS, etc.
Target countries	-
Website	www.globalfundatm.org

Name	International Partnership Against Aids in Africa (IPAAA)
Disease or risk factor focus	HIV/AIDS
Brief description	Established in 1999, the IPAAA is a coalition housed in UNAIDS, that works under the leadership of African countries to save and improve lives. It is made up of African governments, the United Nations, donors, and the private and community sectors. The Partnership's mission is to reduce the number of new HIV infections in Africa, promote care for those who suffer from the virus, and mobilise society to stop the advance of AIDS.
Objectives	• reduce the number of new HIV infections in Africa • promote care for those who suffer from the virus, and mobilise society to stop the advance of AIDS • reduce human, social and economic erosion due to AIDS in Africa
Approach	Global coordination mechanism
Main participants	**Public sector:** WHO, UNAIDS, FAO, UNDP, UNFPA, ILO (International Labour Organisation), EU, Canada, European governments (e.g. Belgium, Italy, Finland, France, Ireland, Netherlands, Norway, Sweden, UK), Japan, US, African governments, etc. **Private for-profit sector:** Boehringer-Ingelheim, Bristol Myers Squibb, Glaxo Smith Kline, Merck, F. Hoffman, Chevron Oil, Eskom, Rio Tinto etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, Rockefeller Foundation, McArthur Foundation, Packard Foundation, Ted Turner, African Council of AIDS Service Organisations, Network of people living with HIV/AIDS (NAP+), Society of women with AIDS in Africa (SWAA), etc.
Target countries	-
Website	www.unaids.org

Name	Roll Back Malaria (RBM)
Disease or risk factor focus	Malaria
Brief description	RBM is a WHO-led programme - a 'global partnership' - that aims to act as global coordinator for malaria prevention & treatment efforts: specifically, "aims to provide global leadership, strategy, and overall coordinating mechanisms ". It proposes to "halve the world's malaria burden by 2010" and acknowledges the profound economic and human impact that malaria has on the poor, especially in sub-Saharan Africa. It was founded in 1998 by four multilateral institutions: WHO, UNICEF, UNDP & the World Bank, possibly in a reaction to the perceived failure of the WHO's previous malaria control strategies from the last 40 years. It is not a fund. It coordinates other stakeholders, other alliances, and funds. From inception in 1998 its aim has been to apply a new type of management structure to the application of disease-specific programmes at WHO: more flexible, less top-heavy, faster at making decisions.
Objectives	• Increase global political commitment to tackle malaria more effectively through coordinated action • Assist the health sector to focus resources on high disease burdens such as malaria and cost-effective intervention packages and increase commitment among the research community and private sector • Discover new products and cost effective control tools
Approach	Global coordination mechanism, health services strengthening
Main participants	**Public sector:** WHO, Unicef, World Bank, US Centres for Disease Control & Prevention (CDC), UNDP, Ministries of Health in target countries, USAID, UK Department for International Development (DFID), Canadian International Development Agency, governments of Australia, Denmark, Ireland, Norway, Sweden, The Netherlands, etc. **Private for-profit sector:** GlaxoSmithKline, Novartis, Eni, ExxonMobil, Procter & Gamble, World Alliance for Community Health (founder members are mining companies), etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, Medecins Sans Frontieres, Child Survival Collaborations and Resources Group, Red Cross, Oxfam, MERLIN, Netmark, Malaria Consortium UK, Multilateral Initiative on Malaria, Medicines for Malaria Venture, Malaria Vaccines Initiative, Royal Tropical Institute, Netherlands, London School of Tropical Medicine, etc.
Target countries	103 countries
Website	www.rbm.who.int

Name	Stop TB Partnership
Disease or risk factor focus	Tuberculosis
Brief description	Stop TB is a partnership that is hosted by the WHO with the aim of eradicating TB worldwide within the next 50 years or so. Its function is to lead, coordinate, strategise and plan interventions worldwide. DOTS is the central plank of its strategy. It recognises the social, political and economic factors that lie behind the disease TB. It has a strong focus on the link between HIV and TB. Countries include target countries, bilaterals and multilaterals, academic institutions (teaching & research), TB associations, NGOs & commercial pharmaceutical companies. Governance is addressed by the Stop TB Framework and plans and activities are coordinated by the Stop TB Coordinating Board. Founded in 1998.
Objectives	Build partnerships to accelerate social and political action to stop the unnecessary spread of tuberculosis around the world
Approach	Global coordination mechanism
Main participants	**Public sector:** WHO, Unicef, World Bank, US Centres for Disease Control & Prevention (CDC), TDR, Ministries of Health in target countries, USAID, UK Department for International Development (DFID), Canadian International Development Agency, US National Institutes of Health (NIH), governments of Japan, Netherlands, UK, etc. **Private for-profit sector:** Pan American Institute of Highways, Soros Foundation, Wyeth, Ryder-Cheshire, etc. **Private not-for-profit sector:** Management Sciences for Health, Royal Netherlands Chemical Society, International Union Against Tuberculosis And Lung Disease, American Lung Association, Royal Netherlands TB Association, Tuberculosis Research Centre, India, Research Institute of Tuberculosis, Japan, Sao Paolo University, etc.
Target countries	Afghanistan, Bangladesh, Brazil, Cambodia, China, The democratic republic of the Congo, Enthiopia, India, Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Pakistan, Philipines, Russian Federation, South Africa, Tanzania, Thailand, Uganda, Vietnam, Zimbabwe
Website	www.stoptb.org

7. Interesting websites

www.wemos.nl/english
www.ippph.org
www.haiweb.org
www.gatesfoundation.org
www.who.int

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9. Explanation of words and abbreviations

Accountability	Providing an explanation for or justification of one's actions.
Civil society	Civil society covers the space between the activities of the state and the market. Organisations within civil society range from church groups to environmental pressure groups to local credit collectives and trade unions.
Cold chain	The equipment and people that keep vaccines cold, from the manufacturer to the child. This includes vaccine refrigerators and vaccine carriers. A cold chain failure, where vaccines have not been kept at specified temperature, can result in vaccines losing their potency.
Empowerment	The conferment of a sense of self-actualization or authority to an individual, group of individuals or an organisation
Generics	Drugs not protected by trademark (Example:`Acetaminophen' is the generic form of
the	proprietary drug`Tylenol')
GPPI	Global Public Private Initiative: a collaborative relationship that transcends national boundaries and brings together at least three parties – among them a corporation and/or industry association and an intergovernmental organisation – so as to achieve a shared health creating goal on the basis of mutual agreed and explicitly defined division of labour
Health systems	The combination of a set of cultural beliefs about health and illness that forms the basis for health seeking and health promoting behaviour, the institutional arrangements within which that behaviour occurs, and the socio-economic, political and physical context for those beliefs and institutions. Or: all activities whose primary purpose is to promote, restore or maintain health (WHO 2000).
Low and lower middle income countries	A country having an annual gross national product (GNP) per capita equivalent between 735 US dollar and 2935 US dollar in 2002. At that time, there were about 64 low-income countries and 54 lower middle income countries.
Multilateral organisations	International institutions with governmental membership,spanning several regions, including financial institutions such as the World Bank and IMF, UN agencies and regional groupings.

NGO	Non-Governmental Organisation: not belonging to orassociated with a government
Pentavalent	A pentavalent vaccine combines 5 different vaccine antigens that can be given as a single shot; in this case it is the addition of Hepatitis B vaccine and Haemophilus influenzae type b vaccine to the existing Diphtheria-Tetanus-Pertussis (DTP) vaccine
Private sector	The private sector is composed of all the organisations and individuals outside the direct control of the state, including both those working for-profit and not-for-profit
Quadravalent	A quadravalent vaccine combines 4 different vaccine antigens that can be given as a single shot; in this case it is the addition of Hepatitis B vaccine to the existing Diphtheria-Tetanus-Pertussis (DTP) vaccine
Public health	The general health of a community and the practice and study of ways to preserve and improve this. It includes health education, sanitation, control of diseases, and regulation of pollution.
Sustainability	The ability to autonomously continue an intervention after external financial and technical assistance ceases
TB	Tuberculosis
Transnational Corporations (TNCs):	Companies which operate in more than one country but retain ownership and control in their home countries
Transparency	In the case of GPPIs, it means that information is open and accessible to everyone and that decisions are taken democratically
UN	United Nations
WHO	World Health Organisation
WHO guidelines on working with the private sector	Guidelines intended primarily to help WHO staff interact appropriately with commercial enterprises and avoid conflict of interest

10. About this publication

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The highest attainable standard of health is a fundamental Human Right. Wemos Foundation has been working since 1981 to improve people's health in developing countries through influencing international policy.

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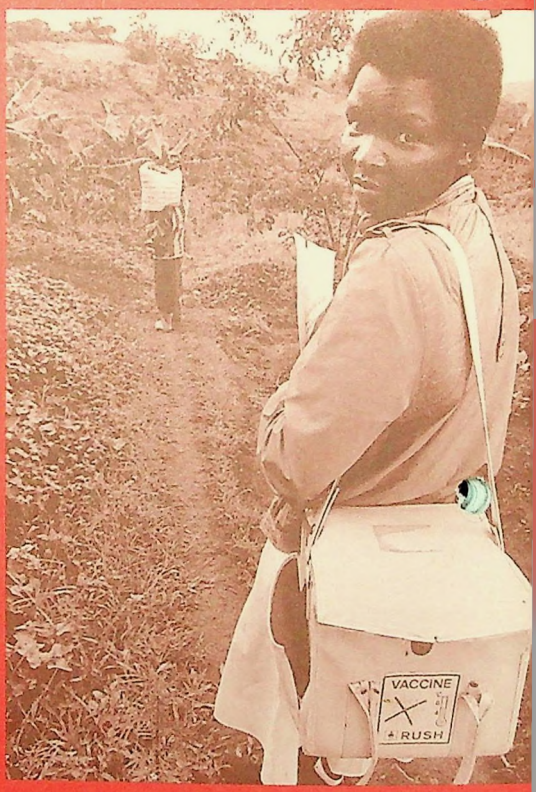
GEZONDHEID WERELDWIJD

HEALTH FOR ALL

This booklet provides information on the background and working of Global Public Private Initiatives in health – GPPIs, which aim to improve the health situation in poor countries. It also contains some critical remarks of the Wemos Foundation.



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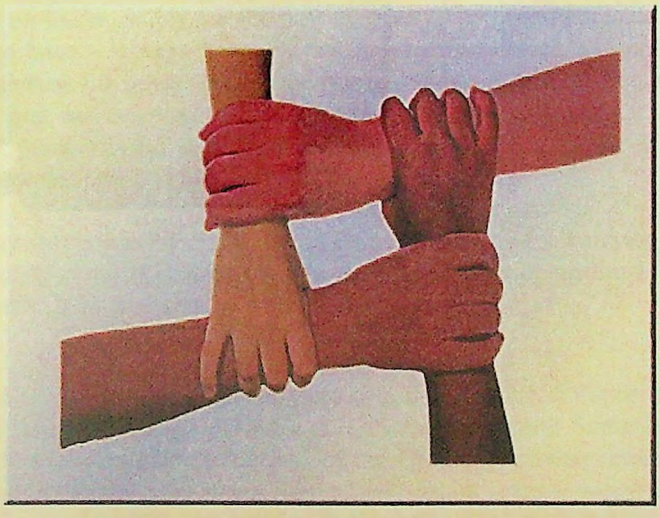

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EUROPEAN COMMISSION
RESEARCH DIRECTORATE-GENERAL

International scientific cooperation
Acting Director

Brussels, 8 November 2004
D(2004) 33904

Dear Participant,

I am pleased to provide you with a copy of the summary version of a report entitled "*North South Partnership for Health Systems Research: 20 years of experience of European Commission support*".

International Cooperation (INCO) has funded more than 70 projects on health system research and on health policy for the past 20 years. The need expressed by the research community to have a linkage between health systems research and policy making and research initiatives on health system research and health policy triggered the idea of looking into past and ongoing research in the field, and analysing the work funded for more than 20 years. The EC convened 10 independent experts from the EU and from the South to review this work.

This summary report will be diffused and discussed during the working session that the EC will organise at the Ministerial Health Summit in Mexico on the 17th of November. The full report will be available after the Summit.

The intention is that this report contributes to a constructive dialogue on health system research and future challenges. The Mexico Ministerial Health Summit is an important platform both to disseminate the outputs of the EC health system research of the INCO programme and to explore the issues particular to health systems research that have been identified in the course of its involvement in this area.

L. Bellemin

European Commission

NORTH SOUTH PARTNERSHIP FOR HEALTH SYSTEMS RESEARCH:

20 YEARS OF EXPERIENCE OF EUROPEAN COMMISSION SUPPORT

Summary version

A report to the European Commission by independent experts

Wim Van Damme (Belgium)
Hans-Jochen Diesfeld (Germany)
Andrew Green (United Kingdom)
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This report has been prepared under contract with independent external experts and paid from funds provided by the European Commission. Its findings are solely those of its authors and does not engage the European Commission

Directorate-General for Research
International Scientific Cooperation Policy

2004

The publication can be found at:
http://europa.eu.int/comm/research/iscp/index_en.cfm?page=Publications&type=other

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Acronyms

ACP	African, Caribbean and Pacific countries
AIDCO	European Aid Office (of EC)
AHPSR	Alliance for Health Policy and Systems Research
COHRED	Council on Health Research for Development
DC	Developing Country
EC	European Commission
ERA	European Research Area
EU	European Union
FP	Framework Programme
GAVI	Global Alliance for Vaccines and Immunisation
GRIPP	Getting Research into Policy and Practice
GTZ	German Technical Cooperation
HSD	Health System Development
HSR	Health System and Policy Research
IHPP	International Health Policy Programme
INCO-DEV	International Co-operation and Development
INCO-DC	International Co-operation with Developing Countries
MDG	Millennium Development Goals
NIS	Newly Independent States
RTD	Research and Technology Development
STD	Scientific and Technology for Development Programmes
SWAp	Sector Wide Approaches
TDR	UNDP/World Bank/WHO Special Programme for Training in Tropical Diseases
TRIPS	Trade-related aspects of intellectual property rights
WHO	World Health Organisation

1 Executive Summary and Recommendations

Health systems

Health systems have been undergoing significant changes in recent years yet these changes are often not based on robust evidence.

A greater understanding of how health systems do, and do not, function is a fundamental prerequisite to improving health in developing countries. Policies to scale up add a further dimension to the need to understand health systems.

Global factors are increasingly influencing the functioning of the health sector and require policy attention.

Health systems research (HSR)

Health system research is a relatively new field of research which examines the interactions between functions, elements and actors in the health system. There have been a number of initiatives in recent years to strengthen HSR, yet there remain important challenges.

There is a need for increased levels of research funding for HSR.

Clear and transparent processes for identifying and prioritising health system issues for research are required.

An appropriate balance between applied and theoretical research and also between mainstream and risk-taking HSR is needed. Adequate provision for longer-term and conceptual and methodological research is also required. The relative youth and complexity of HSR suggests the need for continued attention to strengthening of its methods basis.

Greater research leadership and ownership by developing country institutions is needed. This requires investment in capacity-building activities.

Urgent attention is needed to find ways of addressing the Know-Do gap including seeking early interest in the research by policy-makers and identifying ways of sharing research findings appropriately through Getting Research into Policy and Practice (GRIPP).

European Union policies

Health systems in the European Union (EU) are based on values including solidarity and universal access to services, which provide a basis for EU external action on health.

European States are diverse and include a number sharing similar problems and health system characteristics with developing countries. Important insights in both directions can be gained especially from analysis of health policies, pharmaceutical policies, decentralisation and the impact of globalisation on health systems.

European Commission (EC) policies support international health systems research. However, specific support will be required to ensure that this is not compromised by narrowly oriented research needs and policy priorities addressing only specific problems.

The challenge facing EU policies in development and health is to ensure that priorities are not compromised on the basis of increasing focus on internal markets and policies on trade and security. This challenge of coherence and capacity warrants more, rather than less, emphasis on analytical skills and knowledge on health systems within the EU.

European Commission support to health systems research in developing countries

The EC has, over the 20 years of HSR support in INCO-DEV, made a significant contribution to funding HSR and building the capacity of institutions and individuals in both Europe and developing countries and has contributed to the creation of solid partnerships.

There are, however, areas in which such support could be made more effective through improved prioritisation and administrative procedures.

There is potential for further HSR learning and capacity development and transfer of existing knowledge through equitable North-South, South-South and South-North partnerships which should be further encouraged.

Capacities, both for research and for using research findings particularly in developing countries, need further strengthening requiring greater investment by the EC in this area.

Inevitable tensions between competing priorities for funding remain and this reflects a lack of a current clear prioritisation mechanism.

Further efforts are needed to promote Getting Research into Policy and Practice (GRIPP) in the INCO-DEV programme. This suggests the need for more understanding of the constraints and resultant strategies to overcome the Know-Do gap.

The Mexico summit provides an important opportunity for exploration of the general issues explored in this report and their interrelationships as part of a health system research system

Recommendations

General recommendations

1. **The research community and other key actors should engage more closely with funding agencies and policy-makers to convince them of the benefits of increased investment in HSR and capacity-building and help them to understand the context within which research institutions operate.**

2. **International agencies including the EC must urgently and significantly scale up their funding for HSR.**

3. **Support should be given by international agencies, including the EC, to the development and maintenance of Regional Health System Observatories to collect and disseminate regionally based evidence.**

Recommendations to the EC

4. **The EC should develop a more structured and open approach to prioritising health systems research calls involving both the research community and key southern stakeholders. This should include specific ring-fenced funding for methods development in HSR and support to conceptual and long-term research alongside support for medium-term research and capacity development.**

5. **The EC should continue to support capacity-building of institutions both through INCO-DEV and development funds in both the South and the North. This should include:**
   - ***A requirement that capacity-building is seen as a key component of every project***
   - ***Capacity-building support for policy-makers to use and interpret research findings.***

6. **The EC should, in INCO-DEV, give greater emphasis to GRIPP, through:**
   - ***commissioning work to understand better the process, by sharing experiences in this field, or by requiring specific attention to it in project design***
   - ***enhancing the capacity of policy-makers to use research findings***
   - ***widening the current criterion of 'dissemination' to 'GRIPP'***
   - ***fostering national partnerships involving researchers, practitioners and policy makers as it has fostered international research partnerships***
   - ***involvement of key parties in the identification of research topics and in the development of the research***
   - ***greater attention and investment in dissemination methods***
   - ***links to development resources to implement findings***

7. **The EC should build on the values of universal access and solidarity in European health systems through:**
   - ***encouraging comparative study (North-South, South-South and South-North directions) of health systems based on similar values***
   - ***explicit extension of these values to the global stage through increased support for developing country health systems***

8. **The EC must seek ways of strengthening collaboration between INCO-DEV and AIDCO to ensure cost-effective use of research data and GRIPP in the EC context. Both Directorates need to strengthen their analytical capacity and develop linkages which will also serve as an example of good practice for national health systems.**

9. **The EC INCO-DEV needs to find ways for optimal coordination with other key actors at the global and national levels. The Mexico summit meeting is a platform for strengthening that, capitalising on the presence of high level policy-makers enabling instant feedback and recommendations.**

10. **The EC should use a variety of instruments to support HSR, some allowing for long-term funding of larger endeavours, but others more appropriate for exploratory, innovative or more reactive research, which may thrive better in smaller projects, with shorter time-frames and with simplified approval mechanisms.**

11. **The EC should simplify its application (including web pages) and project management and reporting procedures, making them more transparent and streamlined, and strengthening**

its support to, and training for, administrative coordinators. It should develop further its electronic database as a means of monitoring research projects.

12. The EC should, in the interest of fostering equitable participation, encourage the submission of more proposals from co-ordinators in Southern institutions and should consider improving the instruments to create national networks through platforms and the possibility of granting 'seed money' to allow prospective research partners to meet to compile a full proposal.

13. The EC should give greater encouragement to the use by researchers of pre-proposal checks and feedback on outline proposals.

14. The EC should support a regular forum of EC funded researchers, policy-makers and practitioners to share ideas, methodologies, and research priority concerns and to provide a means of dialogue with the EC on issues related to project management. Other forms of information sharing such as web-sites could also be considered.

2 Background to the report

This document is a summary of a more extensive report[1][2] commissioned by the EC Research Directorate into the experiences of its research programme on health systems in developing countries over the last 20 years. The EC has, in recent years, put significant effort into supporting research into health system questions. It has recognized however that greater efforts are needed to identify the appropriate knowledge gaps on health systems, and find answers to these in ways that will be implemented. The EC has also developed a particular way of funding research which, for example, lays stress on collaboration in research endeavour between Northern and Southern partners. The report should be seen as a case-study of one international agency's response to the need for HSR which has wider lessons for other such agencies.

The report was commissioned in recognition of the key role that health systems play in promoting health objectives. It is expected that the report will serve two complementary purposes. Firstly the EC itself will use the results in considering improvements to its future INCO-DEV research programmes. Secondly the report will provide an input to the 2004 Mexico summit allowing ministers to learn from the successes and failures of one particular approach as they seek means of strengthening the health systems research processes. It is one of a number of activities within this area at this time such as the Independent Task Force convened by WHO and the Activities of the Alliance for Health Policy and Systems Research including an recent evaluation.

The full report has drawn on a number of sources. These include secondary data, which included a review of final reports related to a sample of specific projects, and a limited number of interviews with key informants as well as a literature review. An important part of the process has included peer review and validation by a separate reference group who joined the team for a workshop in Brussels as part of the drafting process.

Within the report, the term Health System Research is used to include Policy-focused research, and the acronym HSR to cover the wide inclusive interpretation.

3 Health systems

Health systems throughout the world are facing an increasingly urgent set of challenges. Gross inequities in health at the global (and frequently national) level – illustrated for example by the fact that the lifetime risk of maternal death is over 100 times greater in Africa than in high income regions of the world - are being exacerbated. For many countries health systems are failing to deliver improvements in health. Whilst this is particularly the case in sub-Saharan countries where AIDS, coupled with the other major killers of malaria and TB, are having devastating effects, these failures to achieve health improvements can be found in vulnerable populations throughout the world where such vulnerability is caused by a combination of social, economic and political factors. The particular socio-economic and other contextual differences of countries lead to different patterns of ill-health and the need for different health system responses. Despite goals that range from the Health for All by 2000 objectives of the Primary Health Care movement through the ICPD charter to the most recent Millennium Development Goals (MDGs), there remains a widespread sense of health system failure.

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[1] The full report is obtainable from Dr Anna Karaoglou, (anna.karaoglou@cec.eu.int), European Commission – DG Research, International Scientific Cooperation, SDME 1/17 B-1049 Brussels, Belgium

[2] The full report also contains the full references referred to in this summary.

Clearly if there is to be a serious attempt to meet the MDGs, the performance of the health system must be improved, and as a matter of urgency. This is particularly the case if health systems are to act effectively as a platform for scaling up efforts such as WHO's 3 x 5 initiative.

Yet for this to occur, the critical question of how must be answered. The last 15 years has witnessed an unprecedented set of serious attempts to re-engineer the health systems of many countries both low and high income. Against the background of wider structural adjustment policies which sought to reduce the role of the public sector in developing countries, the World Bank led a set of health sector reform policies in the 90s which were rooted in neo-liberal market based policies. In particular the public sector reforms included a changing role in the public sector from service provision to policy direction and regulation and greater reliance on the provision of health services by the private sector which was perceived as more efficient. Linked to this was the concept of the purchaser-provider split and the introduction of public sector quasi-markets as part of general "marketization" of the health sector. Inefficiencies were also seen to result from over-centralisation. As such, reforms included attempts to decentralise decision-making to district levels and semi-autonomy for (particularly tertiary) hospitals and movement from vertical programs towards more integrated approaches. Reforms also frequently included the introduction of new health financing methods and in particular user fees and more recently, social insurance. The financing crisis put new emphasis on the need for priority setting and new forms of resource allocation, and reforms often included essential health packages and new processes of priority-setting based on cost-effectiveness techniques.

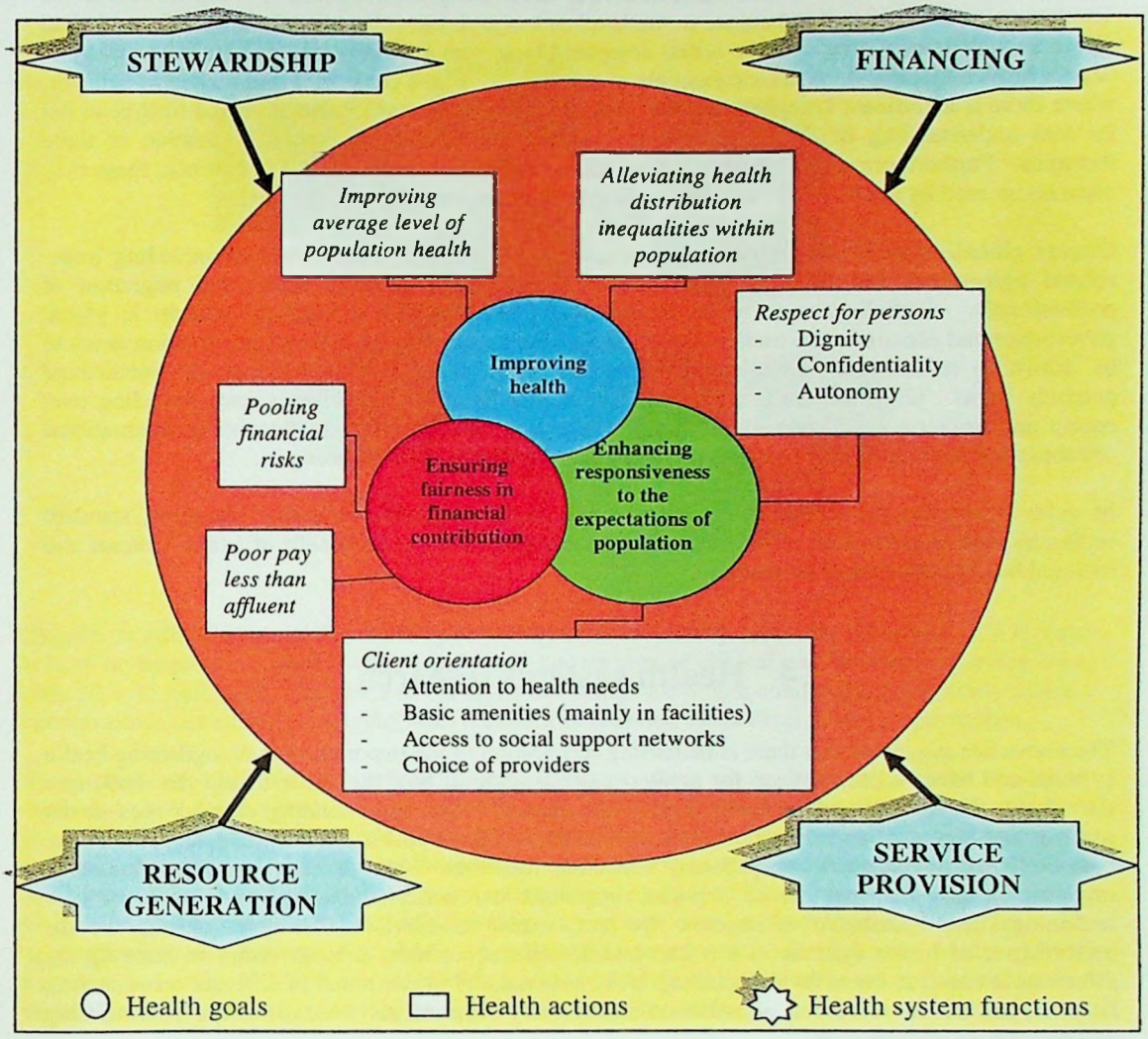
Health reform initiatives focused on introducing structural and financing changes in health systems. This focus led to the neglect of a number of issues. In particular reforms have been criticised for placing insufficient emphasis on staff issues, demand-side issues such as community involvement and needs assessment, and ignoring the overall low levels of available resources as *the* major constraint facing such health systems. The latter was highlighted by the Commission on Macro Economics and Health report which suggests that the funding gaps are so large as to require significant international financing (potentially through new mechanisms such as SWAps). The reforms were also criticised for a focus on health services rather than the broader objectives of health, thus neglecting the potential for inter-sectoral health promoting activities.

The manner in which reforms were introduced was also criticised as being top-down, internationally imposed and, most importantly in the context of this report, evidence-poor.

The above does, however, suggest that the last 15 years has witnessed increasing interest in health systems and their internal workings. This has been shown in both greater conceptual thinking about health systems (such as evidenced by the WHO framework which is elaborated on in Figure 1), and recognition of the importance of understanding the challenges they face and the opportunities they provide to improving health. It has also seen controversial attempts to measure and indeed compare the performance of health systems.

Figure 1: Function/action-based view on health system

Source: based on Murray *and* Frenk, 2000



This period has also seen an unprecedented rise in global influences on health. These range from global political and economic initiatives to those that are more health specific. The implications of some of these are still to emerge clearly. However within the health sector, growth of Public Private Partnerships (such as GAVI – the Global Alliance for Vaccines and Immunisation and the more recent Global Fund for AIDS, Malaria and TB) are seen by some analysts as major new forces. Whilst set up as mechanisms for tapping funding, they are also viewed in some quarters as the birth of a new form of international verticalisation, and criticised for diverting resources away from the broader health system which is seen as a necessary platform from which to scale up responses to these major diseases. Who for example, given the human resource crisis in Sub-Saharan health systems, will be available to scale up access to ARV treatment? Their governance and accountability back to national health systems is also questioned raising issues as to where policy power now lies.

The health system changes described above were, however, often based on, at best poor evidence of what works, and at worst, crude ideology. Despite calls for greater evidence-based decision-making,

led by agencies such as WHO, the reality is that there are huge gaps in our understanding of how health systems operate, and what policies could feasibly be deployed to improve them. In particular at present there are no international mechanisms for sharing experiences between countries or regions. There remains a significant imbalance in the level of research effort between the search for technical answers (such as new drug developments) compared to system answers (such as how successfully to deliver proven therapies). A classic example of this lies in TB, the cause of 2 million deaths per year, where there is significant knowledge of the clinical requirements for TB detection and treatment, but far less understanding of the constraints to ensuring appropriate access and utilization of these therapies. Furthermore, even where there are robust answers to health system questions, these may often be ignored by health policy makers, leading to the infamous 'Know – Do' gap.

Greater globalisation is also bringing new challenges to national health systems including trade-related agreements and trade in health services, intellectual property rights and migration of professionals. Globalisation is based on political processes with a need for change in global governance and economic and trade policies. In the context of trade policies special attention needs to be drawn to multilateral and bilateral agreements concerning trade in services and intellectual property rights. Globalisation brings opportunities, but these are not without costs including over equity and universal provision of services. There is a need for further attention to international collaboration and regulatory measures including those related to human resources.

In order to support national health systems a new focus on global regulatory measures, standard setting as well as evaluation of new technologies and products for the benefit of health systems and national health policies will be required.

4 Health systems research

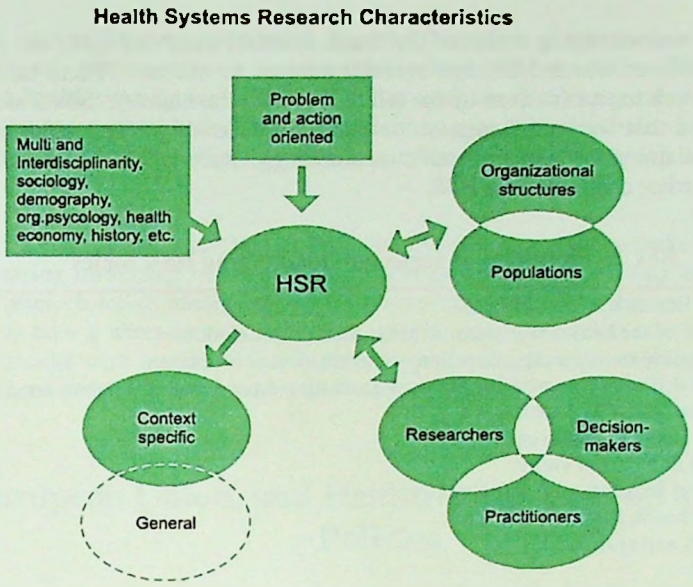
The above has suggested that there is increasing recognition of the importance of strengthening health systems and hence a critical need for greater understanding of how they operate and the challenges they face. Health systems research (HSR) has improved our understanding of who uses health services and why, challenged medical claims about the value of specific interventions, helped shift the balance from practitioners' to patients' concerns, identified ways of improving the financing, organisation and management of services, improved our understanding of the impact of new technology and contributed to improve the performance of services. However to improve the performance of health systems in low and middle-income countries it is necessary to scale up the efforts in research at every level, including local, national and international in different areas such as financial and human resources, organisation and delivery of health services, governance, stewardship and knowledge management.

Whilst there are a number of definitions we define Health Systems Research (HSR) as:

> *'the production of new knowledge and applications to improve how societies organize themselves to achieve health goals, including how they plan, manage and finance activities to improve health, as well as the roles, perspectives and interests of different actors in this effort' (AHPSR 20000)*

Figure 2 sets out graphically the characteristics of HSR.

Figure 2: Health Systems Research Characteristics



Despite its critical importance, health systems research is relatively new with its origins as a separate area of investigation distinct from the more well-known area of clinical and laboratory research being only 20 – 30 years ago. The youth of the discipline brings inevitable challenges, particularly where it is contrasted, and indeed competing, with the more established biomedical research approaches.

Such challenges are firstly methodological. Whilst there have been significant strides in methodological development over the last 25 years, challenges remain. The nature of the questions investigated in health systems research requires contributions from many disciplines including, for example, economics, sociology, anthropology, epidemiology, operational research, and political science, and the use of both qualitative and quantitative research methods. How such disciplines can be combined in a genuinely multidisciplinary way poses new methodological challenges. The appropriate balance between disciplinary specialism and broader multi-disciplinarity is also difficult to gauge and achieve. Furthermore, breaking new methodological ground poses risks to researchers which funding agencies need to recognise and be prepared to accept

Related to the above, is the importance of context in health system research. Each health system is unique in terms of the range and combination of factors affecting it. This raises issues in terms of how to interpret HSR and in particular its generalisability versus its context-specificity.

Furthermore, many HSR questions require significant time periods to answer. Changes in health systems can be slow and not identifiable within the short time frame available to many research projects, or acceptable to funding agencies. Health system research needs to find an appropriate and acceptable balance between short-term and long-term research.

There are also ethical issues in health systems research. 'Each research domain has its own ethical challenges – with those of biomedical and laboratory research being well-known. Health system research faces a number of challenges including those of confidentiality, treatment of values (such as equity), and approaches to socially sensitive areas such as corruption. It also raises questions as to the use and ownership of findings (for example between communities and researchers) and the need for greater participation by the subjects of the research in the actual conduct of research. Underpinning

these concerns is the recognition that HSR deals with issues that relate to relative power between different actors within the health system.

The complexity and ever-changing nature of the health system means that there are, and always will be, a myriad of questions which HSR can usefully attempt to answer. There have been various attempts to identify such topics (such as by the Alliance and in the Lancet). Box 1 sets out a number of examples of topics that we would suggest are currently under-researched. However such list is personal and has no claim to basis in a scientific methodology. Rather, it is an illustrative list. It does raise however two further challenges for HSR.

Box 1: Examples of neglected or emerging HSR topics

Importance of the Health System to MDGs
Prevention and role of the health care sector in cross-sectoral promotion
a. Role of public policy measures in prevention and promotion of health;
b. Effectiveness of different incentive leverages in promoting cross-sectoral collaboration.
Community/Demand side/Civil society
- a. User involvement in health care;
- b. Community and citizen views;
- c. Gender issues in health and health care.

Governance in the health system
- a. Mechanisms and systems;
- b. Corruption;
- c. Regulatory measures in health systems;

Global aid and trade policies and health systems
Globalisations including the need for regulation and pressures of commercialisation in health care.
Non-financial incentives in health systems.
Scaling up.
Integration of essential vertical programme into health system.
Human resources issues including international migration
Accreditation.
Private sector
How to make effective links between Evidence, policies and practice.

Firstly, it is clear, and has been acknowledged in a number of quarters, that insufficient resources are put into HSR. Whilst funding levels have increased significantly in recent years, not least in agencies such as the EC, HSR is still the poor cousin when compared to biomedical research. In the recent publication from The Alliance for Health Policy and Systems Research (2004) *Strengthening health systems: the role and promise of policy and systems research,* it is estimated for example, that 0.02% of total health expenditure is allocated to health systems research. Yet many of the challenges facing developing country health systems are system-based rather than biomedical. For many health problems, technical solutions exist, but are not (effectively) applied through weaknesses in the health system.

Related to the above are concerns as to the availability of research capacity. Research institutions face particular pressures. For example within Europe core support to research institutes is declining and there are pressures on researchers which may conflict with their mainstream research work. In many developing countries there is currently very little HSR capacity. Building research capacity may not always be viewed as high priority by health policy-makers either at the national or international level and yet, without such capacity, HSR of an appropriate quality is impossible to achieve.

Secondly, it is also clear that, even if budgets for HSR doubled tomorrow, there would still be a massive shortfall between research questions and available research funding to answer such questions. This raises questions as to how priorities are, and should be, set, and in particular by whom, and using which criteria. HSR needs transparent priority-setting mechanisms at the relevant levels. It remains

to be shown whether the CAM model is adaptable to fit this purpose for HSR or if other models should be developed.

The above issues are well-known to the health system researcher. However less well-recognised is the gap between health system research and resultant evidence-based action. The Know-Do gap is still wide and both health system researchers and policy-makers need to pay more attention to how it can be bridged. The gap appears both at national and international levels. Indeed within the EC itself there is little interaction between the directorates responsible for *developing* knowledge and for *applying* it.

Strategies such as giving greater emphasis to HSR commissioned by policy-makers appear attractive as means of increasing ownership of the resultant findings, but raise questions as to the need for a balance between research topics identified by other including researchers themselves who may have fewer pressures to take a short-term policy view. Other strategies relate to the mechanisms for dissemination of results with less focus on traditional academic dissemination means and more on those likely to be accessible by policy-makers and users of services.

5 The European Union, and Health Systems and Development Policies

The division of European Community health policies between public health policies and health services has meant that health systems issues as a whole have not been the subject of EU policies. There has not been substantial accumulation of expertise and knowledge on health systems. The unclear mandate has also led to fragmented approaches between two DGs: Health and Consumer Affairs and Social Affairs and Employment. European health policies have become increasingly influenced by decisions and processes outside the health sector. European Court of Justice decisions, the quest for competitiveness of the European economy, industrial policies and protection of interests of European industry and the developments of internal markets have all set the context for health services, pharmaceutical policies and public health policies, leading to consideration of health systems increasingly as part of the economic and commercial interests.

The EU involvement in research and development intersects EU health policies at various levels. The commitment to ensure a high level of health protection in all policies is of relevance to research and development efforts. Furthermore the EU has also been actively supporting research efforts concerning health services.

Policies in other sectors may impose substantial cost implications to health systems. The aim of ensuring consideration of health in other policies has been a challenge for the EU and also is important in development policies.

EU development aid is substantial and in the field of health carries weight. Therefore it is particularly important that the EC ensures a strong and *analytically based* set of health development policies which includes support to health systems research.

Various European health systems (and in particular those based on Beveridge and Bismarck principles) embody key values and approaches to health systems development, such as solidarity and equity of access to health services. The lack of sufficient analytical capacity within the EC to underpin development strategies carries the danger of the adoption of policies that are not consonant with these values.

INCO-DEV research[3] on health systems fits and supports the core development policy efforts on poverty and health as well as the overall research policy priorities. However there is also a risk that more targeted measures with respect to poverty-related diseases, HIV/AIDS and research and development in pharmaceuticals may restrict EU support to health systems development into vertical programmes and specific diseases.

The international role of the EU is changing. In future the European Commission may play a greater role in representing member states in international organisations such as WHO. The new strategic partnership with WHO strengthens their relationship. This highlights the importance research within the EU on health systems and health policy to ensure that European positions are empowered with knowledge, analytical capacity and a genuine European approach based on dialogue, research and analysis and are grounded in European academic and institutional networks and collaboration with developing countries. However, there needs to be an improvement in transfer of knowledge on research and programming between the EC directorates. In particular, it is unclear to what extent INCO-DEV links and resources have been used, and recognised, in the European Community aid policies.

International exchange is of crucial importance in the context of health sector reform. While it is necessary to view European solidarity as part of broader European values, it is also important to recognise the potential for mutual learning and exchange in the context of health policies. In terms of the INCO-DEV work this suggests more dialogue and exchange between health managers and researchers involved in research within Europe and developing countries in a context of comparative studies and analysis.

Finally, globalisation and increasing economic integration create new challenges to health systems in Europe and the developing world. There is a need and opportunity to further expand and exchange analysis of health policy priorities and regulatory matters to ensure universal access, cost-containment and solidarity in health systems. This is important both to articulate concerns about common trade and intellectual property rights in the sphere of health policies, and to minimise human resource shortages in developing countries. Research and understanding of health policies in this area needs to be expanded within the EU. This raises a challenge both in the context of European external and aid policies and it is important to ensure policy coherence is not sought predominantly on the basis of trade interests.

6 EC support to Health Systems Research and Capacity-Building

The EC has been a key funder of HSR over the last 20 years. This review of these experiences may help both the EC and other agencies to address the above challenges for Health System Development (HSD) and HSR.

Programme overview

Research co-operation on health with developing countries has been part of the EC's overall research agenda under its regular research budget since 1983 and continues to be one of the main priority areas with co-operation programmes in ACP, Asian and Latin American countries, and Mediterranean Partner countries, Western Balkans, Russia and the other NIS. The EC's scientific co-operation for development has gone through a number of phases as set out in Table 1. While RTD for collaboration with Developing Countries is only a small fraction (around 0.01 - 0.017%) of the total Framework Programme research budget it has benefited from the overall increasing research budget (42M€ to

[3] Within this report this term is used generically to cover STD1-3/INCO-DC

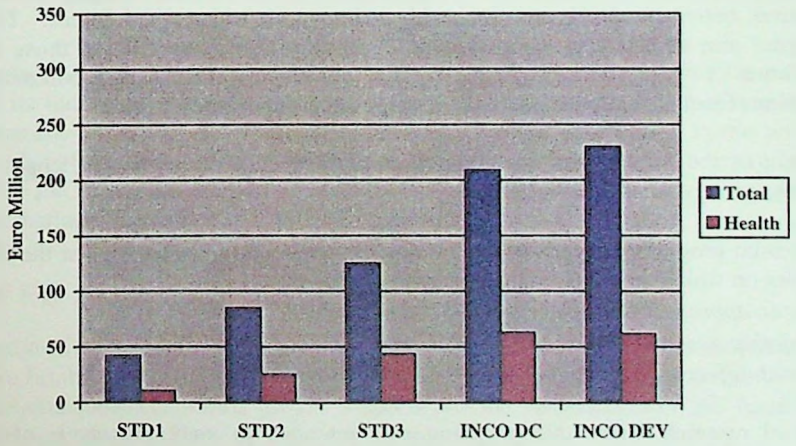
153M€ between 1983/86 to 2003/2006). The total health research budget within this framework increased from €10.5m in 1983/86 to €62m in 1998/2002 and remained at 25-30 % with a peak of 35% in 1991/1994. The budget for HSR, as far as data is available for FP4 and 5 is around 30% with 70% for Biomedical Research.

Table 1: Framework Programme 1 – 6 Budget and RTD Budget for Health and HSR 1983 – 2006

FRAMEWORK PROGRAMME			Research and technology for Development	Total budget € m	Health budget € m (% of total) RTD	No. Health con-tract	No HSR contra cts	HSR budget € m (% of health)
FP	period	€ m						
1	1984 – 87	3,270	STD 1	42	10.5 (25%)	n.a.	n.a.	n.a.
2	1987 – 91	5,400	STD 2	85	25.5 (30%)	154	n.a.	n.a.
3	1991 – 94	6,600	STD 3	125	43.7 (35%)	140	26	n.a.
4	1994 – 98	13,120	INCO-DC	209	62.9 (30%)	154	n.a.	19.6 (31.2%)
5	1998 – 02	14,900	INCO-DEV	230	62.0 (27%)	63	26	17.9 (28.9%)
6	2002 – 06	17,500	INCO-DEV[4]	153	50.0[5] (33%)	n.a.	n.a.	n.a.

Figure 3 shows the evolution of the international cooperation research budget and the health component over this period and the allocation for funding for health research between developing countries and the EU.

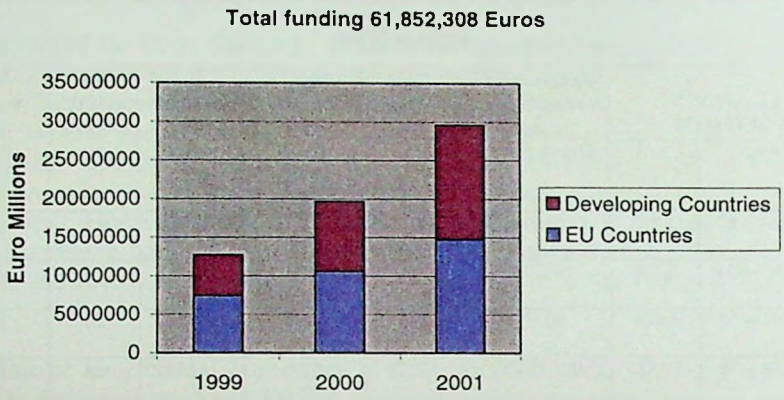
Figure 3: Evolution of International cooperation Research Budget, EC Research Directorate General



[4] In FP6 specific INCO activities involve all regions (DEV, Mediterranean Partner Countries, Western Balkans, Russia and the other NIS); the total budget for all regions is 325 M€.

[5] This figure is approximate and excludes funding for research into the three diseases (TB, Malaria, HIV/AIDS) which from 2002 is funded separately. In FP5 in INCO this was at a level of approximately a further 15M€.

Figure 4: Allocation of funding for health research (1999-2001) EC Research Directorate General



These programmes show an interesting shift in approach by the EC. Initially they focused on bilateral activities between the EU and recipient countries, then on specific programmes in the Framework Programme structure. Within FP5 a new strategic objective of policy issues was introduced. In December 2002 the EC launched the first calls for the 6th Framework Programme with a different structure and philosophy. The innovation is the creation of a European Research Area (ERA) for better co-ordination amongst European Institutes and open to the world. Developing countries are now able to access funding in all European Programmes such as studies of European health systems.

In FP6 it was decided through bi-regional dialogues to launch Platforms on health (and other areas) with the Specific Support Actions instrument with EU and partners from other continents to help consolidate regional education and research capacities, to innovate technologies and implement, wherever required, better standardisation in health technologies and methodologies. These EC-bi-regional dialogues aim to establish priority areas to solve problems specific to those regions. A Platform is a forum of equal partnerships in Research and Development, where common issues are identified, solutions formulated and new research proposals formulated.

The development of the EC research programme demonstrates some of the challenges facing any research funding agency and are outlined below.

Firstly, any research programme needs to have a clear purpose and objectives. For the EC there are the key principles on which their funding programme are based:

- *Thematic approach to all Developing Countries (DCs)*
- *Partnership based on Europe-DC dialogue; and*
- *Regional differentiation among DCs.*

At a broad level research under this programme is intended to meet the needs of Developing Countries with a clear link into the development of relevant policy. However there are other key objectives. These include increasing emphasis on the need for research projects to support the research infrastructure in developing countries through capacity-building activities with adequate participation and involvement of such countries in the programme. However there are some inbuilt tensions in the objectives. Firstly their key objective of supporting developing country health systems may sit uneasily with the overall Framework objectives to strengthen the scientific and technological basis of the EC to make it more competitive. Furthermore, the programme was initially (and to some degree still is) viewed by some European Tropical Medicine Institutions as having a key role in

providing support for them. Indeed given the increasing pressure on such institutions to generate funds this remains a tension in terms of objectives.

Secondly the programme has contributed to getting HSR on the map through the EC role as an institution that explicitly funded research into health systems and health policy. Linked to the above has been a role for the INCO-DEV research programme in supporting the development of the role, concept, definition and methodology for HSR both through project support and through, for example, support to meetings.

The EC research programme has also explored different mechanisms for funding research projects including both 'regular' research projects and mechanisms to develop networks of researchers already working in a particular field. Box 2 provides an overview of these.

Box 2: Some instruments used in support to HSR in developing countries

Source: www.cordis.lu (http://fp6.cordis.lu/fp6/calls_activity.cfm?ID_ACTIVITY=532)

Instrument	Characteristics
Coordination action	These are actions (concerted and thematic networks) where research is ongoing elsewhere and researchers get together for concertation or thematic networks where they are ready to involve all stakeholders to implement research results
Shared Cost/STREP	These are research projects in to new areas of investigation. STREP (Specific Targeted Research Projects) replaced Shared Costs projects in FP6.
SSA	Specific Support Actions for wide dissemination of results, for identification of new research areas and policy implementations

It is also important to recognise that the INCO-DEV programme has faced difficulties, most recently in 2002 when its individual nature was under threat, with proposals to absorb it into the wider EC research programmes[6]. Whilst, lobbying by research institutions contributed to the reversal of this decision, it is clear that complacency over the sustainability of the programme may be misplaced. However in FP6 INCO is a Directorate and in FP7 its specificity should be ensured together with the opening of International Cooperation to all EU programmes.

Analysis of EC sponsored HSR projects

The review analysed completed projects funded in FP4 and FP5 using reports as the primary source of data. There are limitations to the methodology used which are discussed in the report but the general conclusions are considered as valid. Boxes 3 and 4 provide case-studies of EC funded support to HSR in Thailand and Burkina Faso.

[6] Kroeger A, Falkenberg T, Tomson G et al 2002

Box 3: Success story of Thailand HSR and EU contributions

Source: Personal Communication Nitayarumphong S 2004

Thailand was supported to develop a model of integrated healthcare in one province through HSR from EU fund before and after INCO-DEV up till 1996.

The development of a provincial healthcare model attracted demand from other provinces to follow the same development, at the same time other ongoing health care development in the country also need innovative approach to be pushed to go further. This urged to develop a national project covered the development of integrated healthcare in five other provinces and later in nine provinces.

The support of EC fund was shifted to DGI development fund started from 1996 to 2000 with the intention to develop a package of policy and plan for overall healthcare reform in the country. The outcome of DGI- supported fund did not only end with the outcome of a package of health policy and plan for reform, but also a model of appropriate healthcare in various provinces and a draft legislation on universal coverage for healthcare for all Thai citizen.

These products were adopted by the newly elected government in January 2001 especially the implementation of universal coverage. Lessons drawn from out were that EU had contributed a certain level of technical assistance from the research project to national program in Thailand and process of learning through interaction between Thai and EU researchers including networking with other countries did bring the increase of capacity of human resources to implement the Thai healthcare reform more effectively. In addition, more integration among EU different departments from knowledge to actions could generate a real impact for changes to happen in healthcare development.

Box 3: Burkina Faso Case-study

Source: Personal Communication Diesfeld, HJ 2004

The development of the Programme for Science and Technology for Development by the EC in 1984 provided the opportunity for collaboration between Heidelberg University, the MoH and the Department of Public Health, Faculty of Health Sciences University of Ouagadougou. Research was designed to measure the quality, effectiveness and utilization of preventive and curative health services at the district and community level and accepted by the MoH and the EC.

The Ministry of Health seconded a national researcher, the Faculty of Health encouraged 3 medical students to act as junior researchers and Heidelberg seconded a Principal Investigator, responsible. DED and GTZ provided technical assistance and transport. Field research was completed by 1985 and data analysed in a participatory evaluation with the health services in 1986. In December 1986, the medical students defended their theses successfully - the first time that medical students did their thesis work "in the field" of basic health care up-country rather than the protected area of the University Hospital. In the course of this event a "Partnership" between the Faculty of Health Sciences Ouagadougou and the Medical Faculty of Heidelberg was officially inaugurated.

As a consequence of the evaluation the Ministry of Health planned a further project for action research which was again submitted to, and approved by, the European Commission in 1990 under the title "Action research on the utilization of health services in Burkina Faso" with the Ministry of Health providing the Principal Investigator. The study, based in Nouna, aimed to assess the output and outcome of newly organized rural health services. The major policy changes to be tested were:
participation of the target population in financing and management of health services
enhancement of service quality through standardization of medical tasks
increased attraction by better integration of services,
introduction of a delivery system of essential generic drug,
strengthening of mother's skills in treating key childhood illnesses.

The study population comprised all 6000 households in Nouna hospital catchment and 3 health centres - around 30,000 individuals. Health impact was monitored through changes in age and cause-specific mortality using censuses and vital events registration and verbal autopsy of all child deaths. A sub-sample of 600 households was studied by periodic household surveys which yielded information on changes in health service utilization, health care expenditure and time lost due to illness.

This Demographic Surveillance System (DSS) still exists and enabled the MoH to become part of the INDEPTH network (International Network of Demographic Evaluation of Populations and Their Health) in 1997. The new research programme studied different topics. Several new research assistants were engaged at the expanding research station in Nouna. The MoH provided a building complex within the Nouna District Hospital, a former epidemiological field station. Field investigators, interviewers and data entry clerks were recruited and trained. Research aiming at improving child health, equity and efficiency implications of prepayment schemes and health insurance were undertaken.

The iterative process between MoH and Nouna Research Station and the growing number of completed research projects led to increasing acceptance of this kind of scientific cooperation by the MoH. This and efforts to seek further funds alongside favourable developments in the acceptance of HSR, internationally, within the University of Heidelberg and within the German scientific and research sponsoring community as well as the Federal State of Baden Württemberg, paved the way towards establishment by the Burkina Faso Government of a 'Centre de Recherche en Santé de Nouna' in 1999 as a national reference centre, in line with EC policy to develop research partnerships and structures for strengthening European and African research capacity.

Focus of research projects

Each EC call specifies broad domains, such as '*rational organisation of health services*' or '*policies for improved practices*' resulting in a variety of project proposals being submitted and approved. These are reflected in the titles of the projects funded in FP4 and FP5 (examples are given in the report), and in the classification of the 43 projects reviewed, according to a typology in 9 categories (see Table 2).

Table 2: Typology of the 43 research projects reviewed

Determinants of health	1
Implications of specific health issues	2
Impacts of intervention	8
Health sector reforms	10
Quality of care and of services	8
Inputs in health systems (human resources, drugs, and others)	7
Research methods	1
Citizen perspective and user involvement	3
Health policy	3

There are currently 36 ongoing projects from FP5 and new ones from FP6 in a variety of HSR areas.

The opportunity to choose research topics within a broad arena is valued by researchers, who consider they can apply for funding for research they prioritised themselves. However, the requirement of working out detailed plans including deliverables at the stage of submission is also seen to limit the freedom of research. Some of those interviewed also think that this 'academic freedom' is one of the reasons for the lack of synergy between the EC 'research for development' programme and the EC's national and regional development co-operation programmes.

The EC is aware of this challenge, and has sought to improve the '*relevance for development*' of its health research, especially HSR. Various tracks are being pursued such as promoting the involvement of practitioners, policy-makers and other stakeholders, as research partners and the review by regional panels of research proposals which have passed through scientific review to judge on relevance and relative priorities. However the information on the criteria and processes used by these panels are not always clearly disseminated.

Concerns have been expressed about these mechanisms, and suggestions made that the EC should develop procedures, involving a mix of different stakeholders from the South and the North, for selection of domains of research, and of more specific topics for the calls on which to invite more focused research bids. Such a process might be part of an annual meeting of such stakeholders organised by the EC.

Partners and Partnerships

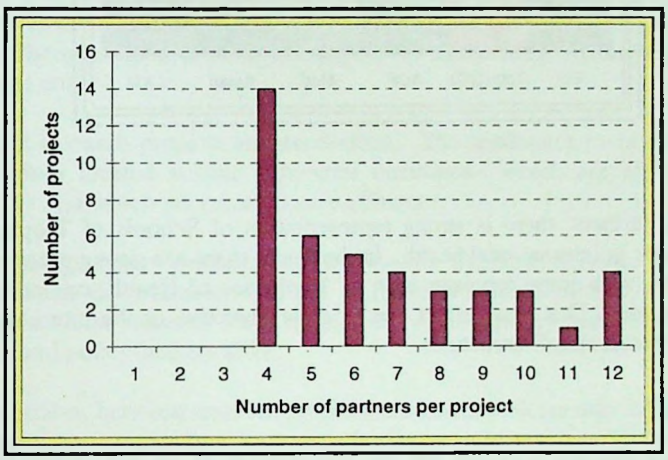
One of the prominent features of the EC research programme is its cooperative nature, both among European countries, and between European and Southern partners. The creation of a research partnership is seen as both an end in itself and a means to achieve the research end. As such it is an absolute pre-condition imposed by the EC for accessing project funding. Initially a minimum of one European and one Southern partner was required (1:1), but this evolved to a 2:2, and then 3:3 minimum, partly triggered by the requirements of the wider RTD programme.

The increased number of partners (see Figure 5 also led to increased budgets per project. In the 1990s a typical HSR project had a budget of €400 - 800,000 for 3 or 4 years. Many new projects however now have budgets of €1,500 -2,000,000 for a similar duration. The current trend is towards encouraging larger projects and partnerships. However it is considered that a variety of instruments is

desirable, some allowing for long-term funding of such larger endeavours, but others more appropriate for exploratory, innovative or more reactive research, which may thrive better in smaller projects, with shorter time-frames and with simplified approval mechanisms.

Among the 43 projects reviewed, there was a even split between those with between 4 research partners - the minimum required in FP4 and FP5, 5 - 7 and 8 - 12 partners (see Figure 5). Most partnerships have similar numbers of partners in the North and the South, resulting in roughly half of total partners from the North, and half from the South.

Figure 5: Number of partners per project in 43 HSR projects reviewed

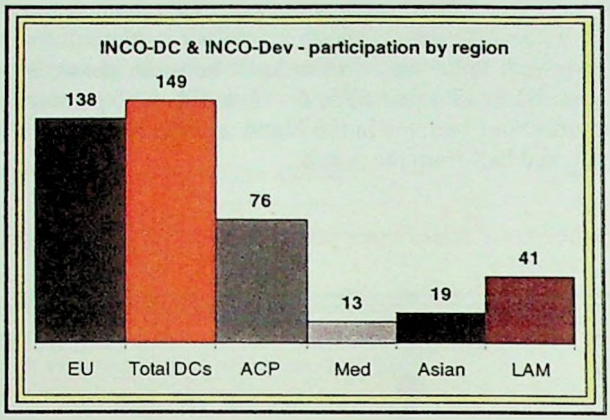


Geographical representation

Figure 6 provides information on the source of partners by region. Northern partners are always European, and Southern partners within one project are usually from the same region. Among Southern partners, slightly over half are ACP countries followed by, in decreasing order, Latin America, Asian and Mediterranean. It is understood that there has, in recent years, been an increase in Asian partners[7] (This geographical spread of partners in HSR projects is very similar to the entire INCO program. Projects still largely focus on research in Southern health systems though there is potential for greater learning in both directions, particularly given the new Accession countries.

[7] Anna Karaoglou personal communication

Figure 6: Participation of partners by region for 43 HSR projects reviewed



Types of partners

Among the Northern partners, there is strong representation of Schools of Tropical Medicine and other academic institutes in international health. In the South there is a strong presence of universities and research institutes, with some representation of Ministries of Health, co-operation agencies or civil society organisations. This may reflect one original objective of the international cooperation component to support research infrastructures.

Quality of partnerships

Many partnerships are brought together for the formulation of an INCO research project, and relatively few are long-standing stable partnerships. Although such 'dynamic networking' can be seen as a factor of the success of the programme, it is also perceived in some quarters as instable and jeopardising the research.

A positive feature of the INCO-DEV programme has been its concern for equitable partnerships to attain a balance between institutions in the North and the South at a number of levels including funding streams and research leadership. This balance has not yet been reached though there appears to be an increasing number of projects led by Southern institutions and a trend towards more equally shared budgets.

There are constraints to achieving a better balance including current capacity. Whilst this is partly being addressed by projects in which capacity-building is a key component, the North-South difference in project leadership is still perceived to be substantial. Factors contributing to the Northern dominance include the costs of project preparation and meetings, the difference in experience and tradition, and the capacity to disentangle and interpret the information on calls, priorities and procedures from the EC. Another difficulty reported is a lack of joint development of research methods arising from the proposal writing process and the complex methodological nature of HSR.

Production of knowledge, dissemination and impact on health systems development

HSR faces particular problems in terms of measurement and attribution. Knowledge produced through research is disseminated to a variety of audiences and through different channels. Publication in peer-reviewed journals remains the cornerstone of measurement of academic impact, and the main report gives examples of the many publications arising from EC funded research. However there is

little evidence on the relation between such academic impact and societal impact. Such considerations lead to a tension for INCO-DEV objectives in terms of attaining a balance between contributing to science or to development.

For the EC, HSR has a mandate to support health policy and planning. However, whilst the individual scientific and technical evaluation asks for "deliverables" of the proposed projects and most research proposals attempt this, there is no mention of the research outcome beyond "expected outcome" in the project overviews. Indeed the timeframe of INCO-DEV project funding/monitoring may be too short, with outcomes occurring beyond the funded period not automatically coming to the attention of the Commission.

Most projects state that *'research results will influence health policy'*. This goal is pursued in different ways, such as communicating research results to policy-makers, and involving them in the research to enhance the ownership of results, using results in teaching, writing reports, policy briefs, and scientific publications.

Few EC-funded HSR research projects are stand-alone. The academics involved in the EC-funded HSR projects are often located within influential institutions which are also involved in other development activities and which the research may influence.

One aim of the *'Accompanying Measures'* (now *'Specific Support Activities'*) in the INCO-DEV programme is to promote dissemination and use of research results. It is our impression that this needs further attention. *How* research feeds into policy, or how policy uses research, is still unclear for most researchers and policy-makers alike.

The different time horizons between research projects and health policies may also hamper such input. INCO research projects have typically a 3 - 4 years horizon, while health policies can have very short or very long timeframes.

However, most researchers interviewed confirmed that many HSR projects did not get beyond the formulation of recommendations to policy makers, and that they remained often in doubt whether they had actually been taken up. But most interviewees could point to an example where they thought research projects had been successful in influencing policy. This was often attributed to the early involvement of policy-makers in the project. One recognised success where research in Thailand (see Box 3) evolved through different phases spanning well over a decade, resulting in a major health care reform for the entire health sector. This resulted from a long-standing North-South collaboration, spanning various framework programmes, and EC development agreements, in which the researchers progressively became the policy-makers.

Strengths and weaknesses of the INCO set-up and procedures

Strengths perceived by researchers are that the programme allows considerable freedom for the researchers to define the research projects, that it works towards equitable research partnerships and that it supports capacity building, in both the North and South. As in any programme, however, there are areas where strengthening is required.

Transaction costs

One challenge faced by the EC is to develop administrative procedures which meet accountability requirements, are efficient, and not too onerous for researchers. There is, however, a perception that EC funding carries significant transactions costs, which may be a barrier, particularly for small institutions. In particular the co-ordination of a large partnership is very time-consuming, during both the preparation and management of the project. Investment in proposals is, of course, uncertain to lead to funding, and this, coupled with the perception of falling 'success rates', may be a considerable

disincentive for research groups and even an absolute barrier for most Southern research institutions, at least to act as co-ordinators.

The procedures for application are complex. The instruments are multiple and eligibility criteria not always easy to comprehend. Such procedures may contribute to difficulties in creating equitable partnerships, as Southern partners have additional difficulties in understanding them, including access to the website or phone. There are also concerns as to the level of allowable costs, and disbursement schedules, given the changing nature of national research support.

Administrative reporting requirements, and the advance payments procedures, cost statements and payments, which cause very long delays in money transfers are also criticised. Steps already taken, such as the running of training workshops for co-ordinators, are to be commended but there may be other areas in which dialogue between the INCO Directorate and researchers could be productive. A regular meeting of involved researchers may provide a useful opportunity for discussion with the EC over how such procedures can be improved.

Selection process

The selection process for projects involves two steps – scientific review and regional review. Some respondents judge that the nature of the peer review process by experts leads to conformity in themes and methods rather than innovation and relevance. Many people do not understand the role of the regional panels and the basis on which they judge. However, most people accept that any such selection processes have their inherent limitations, and judge the track record of STD and INCO-DEV as being fair.

There is a view amongst researchers that there should be a two-stage process, as practised by other research funders. This is seen as a way of reducing the heavy burden of the current application procedures. However the resource implications of this are seen as prohibitive by the EC. There is also a process of pre-proposal checking within the EC for obtaining feedback on outline proposals early within the application. There is however recognition within the EC that attention needs to be given to making the overall application procedures less complex for applicants.

Capacity-building and Getting Research into Policy and Practice

There is a need to build up and strengthen the existing limited capacity in HSR. In the last decade, health development in developing countries was retarded, not only due to financial and human resource limitations, but also by limited capacity to produce their own policy.

Very few studies have been carried out regarding HSR capacity. One such assessment of HSR in developing countries was conducted through a postal and web survey to 176 HSR institutions in developing countries[8]. It concluded that HSR producers need to increase their capacity and build up a critical mass to engage effectively in policy development as well as to absorb a larger volume of resources. The relationship between funding and critical mass needs further research to identify the best funding support, incentives and capacity-strengthening approaches.

There are differences in HSR experiences between regions which reflect their varying contexts. This is well reflected in an Alliance report which points out, for example, the significant history of HSR within the Latin American region and more recently its development in South East Asia.

In the above study of successes and failures of capacity-building of institutions different programmes such as TDR, IHPP, and COHRED were analysed. This suggested a number of different strategies

[8] Gonzalez-Block, M and Mills, A (2003)

including a general need for national mechanisms for institutionalisation of health systems research including enabling dialogue with policy-makers.

The EC INCO-DEV programme has emphasised the importance of capacity-building and GRIPP. This is, for example, reflected in its application process which includes explicit consideration of this. However there are various aspects to capacity-building which call for more detailed and delineated strategies. In particular capacity-building:

- ***has different implications for individuals and institutions***
- ***needs to relate both to researchers' ability to disseminate effectively and to the policy-makers' ability to use research***
- ***needs to recognise the different needs of Southern and Northern institutions.***

A major element of the EC INCO-DEV HSR programme has been mechanisms for collaboration between researchers from the North and the South. This is supported by a main conclusion of a study of the International Health Research Programme of the EC[9].

It is important however to recognise that alongside the overall objectives of any programme in this area, the specific project mechanisms deployed by any funder, including the EC, are key. Thus the specific mechanisms such as priority-setting, application and reporting will all have implications for capacity-building. There is, for example, within priority-setting criteria, a need to strike a balance between short term project goals and long term HSR capacity-strengthening - for "sailing while mending the boat".

The recent phenomenon of international and national mobility of human resources is a major emerging threat to the research community with both 'push' and 'pull' factors. A high turnover of national health authorities has also resulted in the frequent "loss" of institutional memory and policy-makers who have been sensitised on HSR. There is a need to develop human resources, institutions, and the research environment. A critical mass of researchers representing different disciplines such as physicians, epidemiologists, health economists, bio-statisticians and social scientists needs to be linked to visible institutions, since the HSR area needs good links between policy-makers, planners and the institutional set-up. Communication and dissemination of results from researchers should reach these people to foster a positive research climate enabling evidence-based policy-making. Collaborative research networks could also play a role in research capacity-building and promoting utilisation of research findings.

Tools to accomplish the above include allocation from national health expenditure as well as earmarking a proportion of project funding from development agencies for research capacity-strengthening. Training of young professionals could employ a staggered (sandwich) model with research carried out in their respective countries and course, with analysis outside to safeguard the relevance of the research. Networking or twinning of institutions (South-South or North-North) would assist in building institutions. Grants for supporting returnee graduates enabling them to maintain and further upgrade their competence will be of crucial importance. The maintenance of a long-term perspective in these relationships will be equally important.

Producing and using research results is one of the major operational components of a national health research system. However, the current weakness is that the research process and the policy process tend to exist in different domains, with research often having limited impact on policy. Researchers and decision-makers tend to interact only around the product of their processes which may be, for example, the results of a study for the researcher and a set of priorities for the decision makers. More attention needs to be given to establishing and maintaining ongoing links between these.

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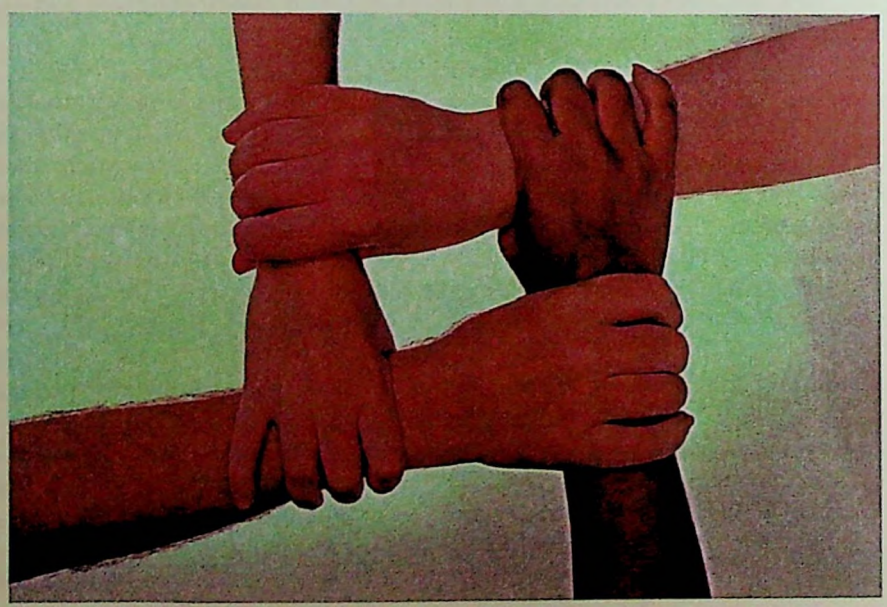
[9] Guha-Sapir D (2002)

Many scholars defend a linear relationship on GRIPP, in which research automatically leads to rational policies, but most argue that the relationship is more hazy. Even the best designed research with clear results does not necessarily get translated into practice. The relationship between research and health policy is rarely 'rational', but based on an interplay of personalities, context and political expediency. Researchers and policymakers belong to overlapping communities of interest, which sometimes work closely but at other times pursue separate paths. They have different concepts of time. For policy-makers, timing is urgent and short term and public opinion is important. Researchers often take a longer-term view and refer to a peer group who value political impartiality. Research findings will therefore only reach policy agendas when various factors come together, namely, when the solutions offered are considered feasible; when there is support for such solutions; and when policy makers feel it is legitimate to take action.

There has been an over-simplification of getting research into policy and practice through the strengthening of researchers' communication skills. This is based on an assumption that proper packaging would ensure the best use of research. There is a need to incorporate several other factors, for example, the active participation by key stakeholders in the research planning process and the involvement of researchers in the policy process, social marketing of research results to the general public through an informed media[10]. This requires a national mechanism with a dynamic, interactive, and inclusive process. Skill and understanding of the concepts and practices of knowledge management for change are essential for this national mechanism. Both governments and international research community have major roles to play to stimulate research into action.

Health Systems Research System

In conclusion, this review of the EC support to HSR has focused on a series of different elements of health systems research. It is important however that these are not viewed in isolation but as part of an overall health research system[11]. Changes to one part of the system are likely to result in effects elsewhere. Any system includes explicit and implicit 'carrots' and 'sticks' which influence the behaviour of the actors within the system. The EC has, through its recognition of the importance, not only of the production of knowledge, but also of capacity and the GRIPP process, have made important interventions in all parts of the research system. It is important that these interrelationships are also recognised and better understood. Mexico will provide an important opportunity for this process.



[10] Chunharas, S (2000)
[11] Pang, T, Sadana, R, Hanney. S et al (2003)

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Guidelines for Proposal

Case study global public private partnerships in health

NOTE:
Please take into account that this proposal concerns only the realization of the case study in your country / geographical area where the field research will take place.
At this moment Wemos does not have resources to support other activities like production of educational materials, promotional activities etc. In the next workshop, in March – April 2004, we will discuss and decide about the lobby and advocacy activities.

1. **Introduction**: (not longer than 1 ½ page)

- Short introduction of your organization:

- Description of main objectives
- Description of main activities
- Structure of your organization
- Geographic coverage of the activities of your organization

- How do GPPI's relate to the activities/objectives of your organization, and why is this issue important for the work your organization is doing.

2. **Objectives**:

What objectives is your organization aiming to achieve by carrying out this case study?

3. **Expected results and indicators**:

Results you expect to have obtained after completion of the case-study. For each result formulate indicators, when possible, to measure if you have obtained these results.

4. **Planned activities**:

Describe the activities that you have planned in order to prepare and carry out the case study and add a time frame according to the planning agreed in the workshop (end of May in The Netherlands)

GPPI study file
Sent by Dr Jose Ulrera
JN
27/6/03

e.g.

- Definition of geographic areas;
- Hiring a consultant / extra personnel; defining functions ;
- Interviews with health authorities
- Interviews with local groups and leaders, etc.

5. **Budget**

Please use the planned activities for the estimation of it, e.g.

- Travel expenses
- Consultancies
- Materials
- Extra office costs

NOTE:

The budget can not exceed Euro 5.000 for the period between July 2003 and July 2004, this amount does not include travel and accommodation costs related to the workshop that will take place in Kenya in March – April 2004.

THE PARTNERSHIP
For Maternal, Newborn & Child Health

World Health Organization

CoMH-67

EXECUTIVE SUMMARY

Newly-formed global health partnership aims to harmonize and intensify actions at country, regional and global levels in support of the Millennium Development Goals for maternal and child health.

Why a new global health partnership for maternal, newborn and child health?

Each year, more than half a million women die in pregnancy or childbirth, and more than 10 million children die before their fifth birthday, almost 40% in the first month of life. Recent research finds that at least two-thirds of these deaths could be prevented with proven, cost-effective interventions that could and should be available to every woman and child today. By expanding access to these interventions and integrating maternal, newborn and child health efforts, an estimated 7 million deaths of women and children could be prevented each year. Given the scope of this challenge, no individual country, organization, or agency can address it alone.

What is the Partnership for Maternal, Newborn & Child Health?

The Partnership for Maternal, Newborn & Child Health is a new global health partnership launched in September 2005 to accelerate efforts towards achieving Millennium Development Goals (MDGs) 4 and 5. This new partnership is the result of a merger of three existing partnerships: the Partnership for Safe Motherhood and Newborn Health, the Child Survival Partnership and the Healthy Newborn Partnership. The Partnership aim is to intensify and harmonize national, regional and global action to improve maternal, newborn and child health.

Who is in the Partnership for Maternal, Newborn & Child Health?

The Partnership joins together the maternal, newborn and child health communities, encouraging unified and effective approaches that promise greater progress than in the past. The Partnership is made up of a broad constituency of more than 80 members representing partner countries, UN and multilateral agencies, nongovernmental organizations, health professional associations, bilateral donors and foundations, and academic and research institutions.

What does the Partnership for Maternal, Newborn & Child Health offer?

The Partnership provides a forum through which members can combine their strengths and implement solutions that no one partner could achieve alone. The Partnership supports country-led efforts towards universal coverage of essential interventions for maternal, newborn and child health by focusing on the following:

- **Country Support** - actively promoting improved partner coordination in countries and supporting the creation, implementation and evaluation of a single national plan.
- **Advocacy** – raising the profile of maternal, newborn and child health on political agendas and advocating for increased resources - financial and other.
- **Effective interventions** – promoting the assessment, scaling up, and delivery of evidence-based, cost-effective interventions, with a focus on reducing inequities in access to care.
- **Monitoring and evaluation** – assessing progress by holding stakeholders at all levels accountable in meeting their financial and policy commitments.

How can we get involved?

The Partnership for Maternal, Newborn & Child Health welcomes new members. To learn more about the Partnership's activities and how you can become involved, please contact us.

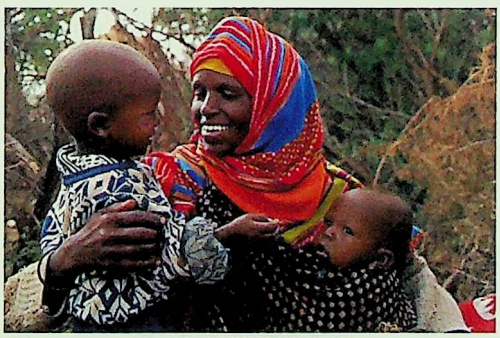

Photo Credit: WHO/Liba Taylor

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THE PARTNERSHIP
For Maternal, Newborn & Child Health

World Health Organization

RESUMEN PARA LA ACCIÓN

Una alianza para la salud, de reciente constitución, aspira a armonizar e intensificar las actividades en los planos nacional, regional y mundial de apoyo de los Objetivos de Desarrollo para el Milenio relativos a la salud de la madre y el niño.

¿Por qué fundar una nueva alianza mundial para la salud de la madre, el recién nacido y el niño?

Cada año más de medio millón de mujeres mueren durante el embarazo o el parto y más de 10 millones de niños mueren antes de cumplir los cinco años, casi el 40% durante el primer mes de vida. Investigaciones recientes han comprobado que por lo menos dos terceras partes de estos fallecimientos podrían evitarse con intervenciones probadas y eficaces en función de los costos que podrían y deberían estar a disposición hoy en día de cada mujer y cada niño. Cada año podría evitarse una cifra estimada de 7 millones de fallecimientos de mujeres y niños si se ampliara el acceso a estas intervenciones y se integraran los esfuerzos en favor de la salud de la madre, el recién nacido y el niño. Habida cuenta de la magnitud de este desafío, ningún país, organización u organismo puede por sí solo responder adecuadamente.

¿Qué es la Alianza para la Salud de la Madre, el Recién Nacido y el Niño?

La Alianza para la Salud de la Madre, el Recién Nacido y el Niño es una nueva alianza mundial de salud fundada en septiembre de 2005 para acelerar las iniciativas encaminadas a lograr los Objetivos de Desarrollo del Milenio números 4 y 5. La nueva alianza es consecuencia de la fusión de tres asociaciones existentes: Alianza en favor de la Maternidad sin Riesgos y de la Salud del Recién Nacido, la Alianza para la Supervivencia del Niño y la Alianza para la Salud del Recién Nacido: El objetivo de la Alianza es intensificar y armonizar las iniciativas nacionales, regionales y mundiales encaminadas a mejorar la salud de la madre, el recién nacido y el niño.

¿Quién participa en la Alianza para la Salud de la Madre, el Recién Nacido y el Niño?

La Alianza enlaza las comunidades que se ocupan de la salud de la madre, el recién nacido y el niño, promoviendo enfoques unificados y eficaces que prometen progresos superiores a los de antes. La Alianza está formada por un grupo amplio de más de 80 miembros que representan a países miembros, organismos de las Naciones Unidas y organismos multilaterales, organizaciones no gubernamentales, asociaciones profesionales de la salud, donantes bilaterales y fundaciones e instituciones académicas y científicas.

¿Qué ofrece la Alianza para la Salud de la Madre, el Recién Nacido y el Niño?

La Alianza ofrece un foro en el cual los miembros pueden combinar sus puntos fuertes y aplicar soluciones que ningún participante podría conseguir por sí mismo. La Alianza apoya las iniciativas de los paises para conseguir una cobertura universal de las intervenciones esenciales para la salud de la madre, el recién nacido y el niño, centrándose para ello en lo siguiente:

- **Apoyo de los países:** - promover activamente una mejor coordinación de los miembros en los países y apoyar la creación, ejecución y evaluación de un plan nacional amplio para la salud de la madre, el recién nacido y el niño.
- **Promoción** – elevar el perfil de la salud de la madre, el recién nacido y el niño en los programas políticos y defender la asignación de mayores recursos, financieros y de otro índole.
- **Intervenciones específicas:** – promover la evaluación, ampliación y realización de intervenciones basadas en los hechos y eficaces en función de los costos a favor de los servicios de salud de la madre, el recién nacido y el niño, centrando el interés en reducir las desigualdades del acceso a la atención.
- **Vigilancia y evaluación** – evaluar los progresos realizados estudiando periódicamente el acceso a los servicios de salud de la madre, el recién nacido y el niño y haciendo a los participantes en todos los niveles responsables de que han cumplido sus compromisos financieros y políticos.

¿Cómo puedo contribuir?

La Alianza para la Salud de la Madre, el Recién Nacido y el Niño da la bienvenida a nuevos miembros. Para conocer mejor las actividades de la Alianza y cómo participar en ella póngase por favor en contacto con:

1211 Geneva 27 - Switzerland - Tel.: +4122 791 49 14 - Fax: +4122 791 41 71 - email: info@pmnch.org
www.pmnch.org