Sustaining Health Service Developments in the 'Third World'

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ABSTRACT

An increasing number of 'third world' health development projects are proving to be unsustainable once foreign aid has been withdrawn. It is argued that this is partly due to the fact that such projects usually deliver health care free of charge rather than allowing communities to incorporate the costs of health care into their local economies. There should be more emphasis on health development projects paying for themselves from the outset. Such projects might also incorporate the extant community based infra-structure of traditional medicine through direct collaboration with its practitioners.

INTRODUCTION

The costs of developing health services in the 'third world' are often met not by the indigenous population or government, but by foreign governments or NGOs (Non-Government Organisations). However, these days the attention of aid workers is turning away from 'development' and towards 'sustainability'. How can a service be sustained once foreign aid and foreign workers have been withdrawn? In many parts of Africa there is mounting evidence that it cannot (Lafond and Seaman, 1992). Since the colonial era those who have been responsible for developing health services in Africa have sought to deliver the service 'free of charge', on the basis that patients could not possibly afford to pay. The idea of a 'capitalist' enterprise amid social deprivation (and sometimes desperation) has been anathema to well intentioned and socially conscientious health service planners. It may now however be time to turn the tables.

PAYING FOR SUSTAINABILITY

Making health services in poor countries pay for themselves may be the key to establishing sustainable services: services which are not dependent on increasingly undependable foreign aid programmes. Paul Smith (1992) of 'Save The Children Fund' recently reported in The Health Exchange on the Khartoum Comprehensive Child Healthcare Programme. This project reasoned that unless effective medicines could be reliably provided by community health centres the uptake of their preventative and curative services would be limited.

To ensure a reliable supply they charged patients in socially deprived areas for the medications they received. Drugs were charged at roughly one third of their private sector price. Some essential medicines, such as paediatric syrups, were cross subsidised by charging relatively more for non-essential medicines. Smith reports that whilst no patients were exempt from payment the incidence of inability to pay was around only 1%. Furthermore, this system is reported to have increased the uptake of services rather than acting as a barrier to accessing them.

THE LOCAL MARKET ECONOMY

Within most 'developing world' cultures is a thriving social market where almost anything can be bought or sold, at a price. Everything has a value. Within this harsh world of social realities it is easy to think that if something is 'free' then it cannot be worth much. If people learn to get by on a free (foreign subsidised) health service then what must these same people sacrifice when the subsidies are withdrawn. I think that it is the difference between asking someone to pay you now for the present you gave them 5 birthdays ago, as opposed to asking them at the outset how much they are willing to spend on the item in question. The latter places the responsibility on the consumer. Bankrupt governments cannot support health service developments, but consumers may be able to. Good health may be priceless, but it does cost something. Opportunity costs reflect choice and choices reflect values. If I choose to have a cataract treated rather than to buy a pair of shoes and continue bare footed, then I could be said to value my eyes over my feet. To indignantly protest that nobody should have to make that choice is to hijack reality with idealism. It is also failing to acknowledge that in some cultures some people may prefer the social status that goes along with shoes over the benefits of good vision. The reality is that when a health service fails after the 'aidies' have withdrawn, the local population is left with no choice. Certainly one would hope that life saving medical services could be subsidised, so reducing the financial blow to the patient. However the sustained economic burden of providing 'free' health services to a population whose income is often untaxable, may result in the collapse not only of the health service but of the economy also.

CAPITALISING ON HEALTH

In 'Industrialisation in the Third World: The need for alternative strategies', van Dijk and Marcussen (1990) argue that developing countries cannot avoid a capitalistic phase if they are to progress from their present state. Emphasizing the vitality

of the informal sector they believe that small businesses rather than large scale industries are the key to progress. The informal sector offers an established commercial infra-structure already well patronised. This 'bottom up' economic argument also relates to the development and sustainability of health services in the third world. The last two decades in Africa have seen the influx of many ambitious large scale health projects with their accompanying costs of drugs, medical equipment, fuel and spares for vehicles, nurses, clinical assistants, doctors and allied professionals, dispensaries, health centres and hospitals. However perhaps what is needed is something altogether more modest.

TRADITIONAL HEALING

Not only do developing countries have informal business sectors which are an obvious means of expansion, they also have informal health sectors which offer a correspondingly obvious means of expansion. Like traditional traders, traditional healers are part of the social matrix of culture, enterprise, morals, religion and health. That western medicine has been 'getting it wrong' by vilifying traditional healers for the past century is only now beginning to be acknowledged (Good, 1987). In part this is due to some traditional healers being able to 'prove', by western standards, the validity of some of their therapies. However, there is a much stronger case for allying western and traditional medicines. Without such an alliance the majority of the population is beyond the reach of western style medicine.

In Swaziland, Green and Makhubu (1984) reported that there were more than 5000 traditional healers, representing a ratio of 1:120 of the population. Furthermore, over 85% of the population had attended a traditional healer at some point. Throughout Africa there remains a network of traditional healers, in both rural and urban areas, who perform similar functions to those of western general medical practitioners. Surely these are the people western health development projects should be collaborating with. They already have the authority and credibility of 'medicine men' and a historical epidemiology of local ills.

Certainly developing countries should strive towards establishing hospitals to manage the complexities of crippling tropical diseases, but they should not stride past their therapeutic heritage and infra-structure. Health services have a better chance of being sustainable if they incorporate indigenous health systems. The resurgence in traditional healing is not due to lower costs alone but also to its community basis: both contribute to sustainability. These aspects of traditional medicine present an opportunity for western medicine to reach out to more people and to do so in a more sustainable fashion, by collaborating with traditional healers rather than competing with them.

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