EDITORIAL

Systemic failure

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When national healthcare systems fail, the effects can be global: epidemics spread across borders, causing new outbreaks of serious diseases. Accordingly, health is a global public good and providing good health care is an international responsibility.

In October 2013, an outbreak of polio occurred in Syria, a country where there had been no cases for many years. Because of the civil war more than half a million children had gone without vaccination. The World Health Organization and the UN children's agency UNICEF summoned resources and called for the largest vaccination campaign in their history. They plan to inoculate as many as 20 million children across the region to prevent the resurgence of a disease that was nearly eradicated.

In the summer of 2012, domestic cases of malaria were identified in Greece, a country where domestic transmission of malaria had not occurred in decades. Why? The Euro crisis had forced the government to slash its healthcare budget and suspend insect control programs. New HIV infections doubled because of massive reductions in syringe exchange programs for drug users.[1]

In Russia, India, and South Africa, tuberculosis (TB) is becoming increasingly difficult to treat. Doctors are encountering more and more multidrug-resistant and extensively drug-resistant forms of TB. These require extremely complex, lengthy, and costly courses of often toxic drugs. These findings have been documented in WHO's Global Tuberculosis Report.

While these three cases are quite different, they all share one thing in common: disease outbreaks occurred when healthcare became inadequate or unavailable. Typically, people blame the spread of diseases on viruses and bacteria, but it is important to highlight that healthcare systems are also at the root of the problem.

This is quite obvious in Syria's case. Syria's public healthcare system has collapsed in many parts of the country. Millions of people have fled from areas of conflict. Neither the Syrian Red Crescent, which is close to the government, nor the humanitarian aid given to the rebels can take care of all these displaced persons. So for the past three years, routine childhood vaccinations have simply not been given.

In Greece, the healthcare disaster was caused not by war, but rather by massive budget cuts. The Greek government has been tightening its budget as a consequence of bailout agreements with the country's main creditors. It is implementing the austerity policy forced on it by the European Central Bank, the IMF, and the European Commission. In the past few years most reports on the health crisis in Greece have focused on people who lost their insurance when they lost their jobs. When health emergencies occurred, they were faced with high costs for medications or hospitalizations. Because cuts in key pre-

[*] http://www.dandc.eu/de/article/gesundheit-ist-ein-globales-oeffentliches-gut-und-muss-den-post-2015-zielen-beachtet-werden

[†] http://www.dandc.eu/en/article/health-global-public-good-and-must-figure-among-post-2015-development-goals

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ventive programs, such as mosquito control or syringe-exchange programs, had scant immediate impact, they received little media attention at the time. Today, however, it is obvious that the prevalence of certain diseases is rising.

With respect to TB in India, Russia, and South Africa, the troubles stem from problems with the domestic healthcare system. Poor and marginalized patients are disproportionally impacted when they are faced with inflexible institutions and/or high costs. The problem is often not just the cost of medication, which most TB programs provide free of charge. The major challenges are the costs of travelling to a treatment center as well as loss of time or income. These are huge barriers for people who work in the informal sector. Although most people with TB no longer need to spend months in the hospital and can be managed as outpatients, the length of treatment remains a major challenge. Many fail to complete the months-long course of treatment required to truly cure TB.

Such failures put the affected patient at risk for a TB recurrence. There is yet another danger. Discontinued treatment promotes the development of bacteria that are resistant to standard TB drugs. This is a serious public health issue.

International responsibility

These examples illustrate why experts all over the world are beginning to reconsider the value of healthcare systems. For years, professionals at the WHO and elsewhere focused chiefly on the control of major diseases. They dealt with HIV/AIDS, TB, and malaria as well as global influenza epidemics. They focused on the "new epidemics" of chronic, non-infectious cardiovascular, respiratory, and metabolic diseases. But controlling specific diseases is simply not enough. Global protection from epidemics and serious illnesses requires functioning local healthcare systems. A failing healthcare system only encourages the spread of diseases. To repeat: Health is a global public good and providing health care is a global responsibility.

The latest buzzword is "universal health coverage" (UHC). Headlined by the WHO in its World Health Report 2010, UHC has become one of the most widely discussed terms among global health experts. It is a favorite topic in the debates on the post-2015 global development agenda. "Coverage", of course, is an insurance term. For years, poor people (and even members of the lower-middle classes) have faced "catastrophic healthcare costs" in the increasingly privatized healthcare systems of the developing world. This has been a central topic in every speech made by WHO Director-General Dr. Margaret Chan. According to estimates, 100 million people fall into poverty every year because of medical costs. Many of the very poor derive no benefit from healthcare services because they simply cannot afford the charges levied by health centers and hospitals. Bribes demanded by (often underpaid) health professionals are a related problem that is common in underfunded public healthcare systems.

The WHO has defined UHC as a system allowing people safe access to healthcare services, regardless of whether or not they can pay. Patients should be protected from exorbitant costs. The key characteristics of UHC are availability, accessibility, and affordability.

However this definition of UHC soon came under heavy criticism. Civil society representatives felt it focused too much on the economic accessibility of healthcare services. They warned that this concept would allow private healthcare providers to come up with new financing models that target affluent groups. The result would be a system in which public health care would degenerate into a grossly underfinanced system for the poor.

This is precisely what is going on in Brazil today. The country's Universal Health System formally offers comprehensive healthcare services for every citizen. However, private-sector providers are attracting the better-off with additional benefits and better service, leaving the public sector to shoulder the burden of huge – but unprofitable – health "risks." Most countries have a similar multi-tiered healthcare system.

It would be wrong for the post-2015 development goals to be limited exclusively to matters of healthcare funding. Civil society activists fear that a progressive-sounding concept will be whittled away because of limited resources. Ultimately, UHC in

many countries may end up meaning minimal coverage for the poor, unless they are willing to pay for additional care out of their own pockets.

Experts also criticize the WHO's narrow focus on the health sector. UHC is concerned only with questions of health information, awareness-raising, prevention, treatment, and rehabilitation in medical services. It neglects the social determinants of health. In the late 1970s, the WHO's vision of Primary Health Care addressed issues such as education, income, housing, food security, and social inclusion. By comparison, UHC's focus on the prevention and treatment of diseases offers a very impoverished understanding of health. Nonetheless, it is heartening that recent WHO documents acknowledge that a sufficient and adequately-paid professional staff is indispensable for appropriate healthcare. Social determinants are also being mentioned once more.

More health or more medicine?

The importance of healthcare quality – not just accessibility and availability – is evident in Indian and Bangladeshi programs to reduce maternal mortality, a Millennium Development Goal. Attempts were made to reduce the number of home deliveries by promoting deliveries in health centers and hospitals. But it turned out that the quality of institutional obstetrics was often inadequate and the risks for pregnant women were sometimes even greater in hospitals than under the supervision of traditional midwives. In these settings, focusing on midwives would have been the right approach.

Monitoring is essential to ensure that "more health" is not equated with "more medicine." It is a well-known fact that all healthcare systems – and especially those with private providers – tend to develop and market services of questionable value.

UHC must be embedded in a human rights framework. The International Covenant on Economic, Social, and Cultural Rights, adopted by the United Nations in 1966, provides the right principles. It spelled out a "right of non-discriminatory access to health-care services" and included the social determinants of health. Furthermore, we must not forget that people deserve a say in major health-related decisions at the national and international levels.

If the WHO's UHC concept included some of these principles, it might escape from the straitjacket imposed by the healthcare financing model. But unfortunately the international debate is narrowly focused on financing: affordable service packages, minimal insurance levels, and the appropriate use of private and public monies. A global debate about solidarity requires a much broader vision of "UHC." Many low-income nations can only afford a highly limited universal healthcare system, even when they manage to collect higher taxes and make optimal use of public resources. Adopting a much needed equity approach means that the financial burden of healthcare cannot be left to individual countries. This is a global responsibility. Mandatory health financing mechanisms are required at the international level and the global economy needs to be redesigned for greater social sustainability.[2] If these things happen, the post-2015 development goals will apply not just to the countries of the global South. They will become truly global issues that concern all peoples.

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