

Poverty and the health sector

Poverty can breed ill-health and ill-health can keep people poor, obviously, but not enough is known about how this works specifically. Adam Wagstaff, lead economist at the World Bank, shows how the existing literature brings to light three points in particular (pp. 97–105). First, publicly financed health care fails to reach the poor in almost all developing countries. Second, inequalities in health reflect inequalities in education, income, housing and other variables at the individual and household level; so efforts to combat health inequalities must deal at the same time with social and economic factors of this kind. Third, too little is known about the impact of policies aimed at mitigating health sector inequalities, and about how health services can reach the poor. The means of filling this gap exist, however: there is abundant information on the extent and causes of inequalities, and there are abundant measurement techniques for interpreting it.

Antimicrobial resistance and globalization

Resistance to the drugs used in antimicrobial therapy reduces the effectiveness of treatment. Meanwhile globalization means an infection which occurs in one country makes all other countries vulnerable to it. No country acting on its own can adequately protect the health of its population against antimicrobial resistance (AMR). Conversely, the preventive measures one country takes benefit others as well. Richard Smith & Joanna Coast review the options for action (pp. 126–133). AMR cannot be eradicated but it can be contained by strategies for avoiding the emergence of new resistant microorganisms and preventing the spread of existing ones. Education, rapid diagnosis, restriction of drug availability, and the distribution of guidelines are examples of possible national and regional interventions. A global approach is also indispensable. For this, the problem of AMR has first to be fully recognized and understood within countries. Countries then need to establish and

maintain global AMR surveillance data, using international standards in laboratory susceptibility testing techniques. Finally, research methods need to be standardized, research activities coordinated, and the resulting information disseminated.

Ethics in health research

If research is seen as the “brain” of a health system, ethics is its “conscience”, suggests Zulfiqar Ahmed Bhutta, of the Aga Khan University in Karachi (pp. 114–120). Though international guidelines exist, their adequacy and applicability in particular settings can be controversial. Specific issues include:

- public participation in research priority-setting;
- making the benefits of research available to the community which shares the risks of it;
- the use of placebos and standards of care.

In some cases the guidelines do not adequately take into account the realities involved, and in others both national and international standards have been unacceptably ignored to exploit the vulnerability of the populations concerned.

The main concern of health-related ethics, according to this account of it, is the reduction of inequities in health.

Trade in health services

Health services can be bought and sold internationally in four main ways: in the form of electronically or physically transmissible knowledge such as diagnoses and consultations; by patients going abroad for treatment; by health service providers going abroad to work; and by foreign investment in health infrastructure such as hospitals and equipment. In the OECD countries alone trade in health services is reckoned to be worth US\$ 3 trillion a year and rising rapidly.

Patients in Central America may obtain telediagnostic services from the USA; those with skin diseases incurable elsewhere may find effective treatment in Cuba; a coronary bypass operation can be obtained in India for a tenth or a

twentieth of what it would cost in Europe; a German company has 90% foreign equity ownership of a 200-bed hospital in Delhi; Chinese health professionals go on short-term contracts to work in Africa to foster trade and cooperation; 110 000 of the nurses in the USA were educated outside the USA.

Rupa Chanda cites many other examples in this overview of a buoyant and rapidly evolving situation (pp. 158–163). Is it good news or bad? In theory, the rising costs caused by inflows of foreign patients can be matched or exceeded by rising export revenue. In practice, however, income in the poorer parts of a population can remain static or decline while prices rise, unless public health policy measures redress the balance.

Self-help

Most health care systems are linked to formal employment and urban services. This leaves more than 1.3 billion people in the world without financial protection against the cost of illness, Alex Preker et al. explain (pp. 143–150). The rural poor and those who survive through informal sector activities are ill-placed to benefit from the usual resource-pooling arrangements which protect the rest of society. Many households thus become destitute when faced with severe illness involving hospital care. Public policies that in theory offer health care services to the whole population end up — often unintentionally — by channelling resources away from the poor towards those with more power and influence.

Efforts among the excluded to organize their own forms of safety net have produced various financing instruments over the past decade. These include microinsurance, community health funds, mutual health organizations, rural health insurance, revolving drug funds, and community involvement in user fee management. Governments can strengthen these efforts with well-targeted subsidies, reinsurance to enlarge the risk pool, technical support to strengthen management capacity, and in many other ways. ■