Have we learned anything from these exchanges? No doubt everyone will make her/his analysis of what was presented and discussed, depending on her/his experience, world view and conviction. As this colloquium has set out to clarify and possibly update concepts and terminology in the integration and disease control debate, it might be a useful exercise to reduce the complex discussions to a level of simplification that may help us reach some conclusion.

From the contributions, two contrasting types of generic (or macro-policy) reasoning appear in the narratives. There are those who imply that inputs and structures provided by disease-centred programmes will contribute to create and strengthen comprehensive health (care) services and systems. However, there are those who argue that if you succeed in developing a strong (and sufficiently resourced) multi-purpose health (care) system first, it will be capable of absorbing any variety of programmes.

As to the first assertion, experience provides positive examples in areas like surveillance capacity, diagnostic capacity, drug distribution systems, logistics, social mobilization pathways and capacity building in general. Evidence to the contrary, however, is equally provided, pointing to problems of competition for scarce resources (especially the health workforce), uncoordinated parallel drug supply and information systems, imposed inefficiency of additional resources through earmarking rules and the like. In other words, the first assertion is sometimes justified and sometimes not. As a general statement, it is therefore not very helpful, we must conclude that it depends on a series of conditions.

As to the second statement, its intrinsic plausibility is quite high but the problem remains how strong a strong health system needs to be before the assertion comes true. For both statements, the important thing to learn does not seem to be if it is true, but how and under what conditions it can work out well for which context.

Macro-level considerations also crop up in the difference between lethal communicable diseases and the more disabling, chronic ones, usually related to macro-parasites. To the extent that the lethal ones turn into killing diseases that spread more rapidly than the health systems can cope with, programmes to control them will require more resources and will frequently evolve in a planning and implementation environment that is beset with relatively high levels of uncertainty and low levels of agreement between stakeholders. These programmes then appear to crowd out successful, relatively simple, cheap and highly evidence-based programmes directed at chronic disabling diseases. This is exemplified by the present overshadowing power of HIV/AIDS, TB and malaria programmes that shifts attention and resources away from highly effective programmes for control of, say, helminthiases. It seems important to understand the mechanisms that are at work in this area of policy phenomenology.

Those who work at the implementation level, dealing with health systems in a local context, voice other concerns. Their question is how to cope with the multiple initiatives and programmes originating from outside their local context, all clamouring for their time and attention, often interfering with their planning, management and operational processes and in the worst case creaming off their workforce. The question here seems to be who is steering what, why and how, who decides and how policy and management decisions are reached, and how these processes can be optimized in a process of subsidiarity. For those who have responsibilities at the operational level, the present situation is a difficult balancing act and a delicate power game, the question being, bluntly put, who is ‘using’ whom: decision makers at the centre (and beyond) vs. peripheral, local decision makers and managers, health care system managers vs. disease control programme managers.

The observation proves that, efforts and good intentions notwithstanding, disease control policy designers and health care systems policy makers often appear to use parallel language systems: even when the same words are used, they can differ semantically and/or the syntax can be different. The question can be asked to what extent a ‘lively debate’ does not boil down to a conflict of poorly overlapping sets of values: under the surface are such incompatibilities as the tension between libertarian and utilitarian principles, between the individual and the collective interest, between the short-term and long term perspectives, between a measurable result and impact oriented attitude (prioritizing ‘cure’ and prevention), and a service and support-oriented culture (emphasizing ‘care’ for those in need and increased human autonomy). One of the intellectual challenges that remains will be to identify
and acknowledge these relevant variables and perspectives in such a way that a workable theory emerges, to guide decision formation in this field that is necessarily combining issues of policy, politics, management, economics, epidemiology, medicine, ethics and social sciences. One thing seems certain: in such a complex world optimised decision making will require a basic attitude of sensitivity to context and preparedness for dialogue.

It has been observed that health, not health care, is claimed to be a human right. While there is something to be said for this position, politically, an equally strong case can be made for the right of people, everywhere, to get care when they are or feel in need of it, for whatever reason – not just in the service of some specific cause, however legitimate and important. The multicausal nature of the deterioration of health status calls for a broad and comprehensive approach. Twenty-five years ago Halfdan Mahler, then director-general of the WHO, characterized Primary Health Care by the simple statement ‘Primary Health Care begins with people and their health problems’. In the year of the silver anniversary of the Alma Ata Declaration, restating that the starting point, the primary target and the basic perspective of all health improvement endeavours is people and their problems, may help to provide us with the common ground needed to join forces constructively across disciplines and continue to search for the best solutions.

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