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Policy

Integrated care: a fresh perspective for international health policies in low and middle-income countries

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Abstract

Purpose: To propose a social-and-democrat health policy alternative to the current neoliberal one.

Context of case: The general failure of neoliberal health policies in low and middle-income countries justifies the design of an alternative to bring disease control and health care back in step with ethical principles and desired outcomes.

Data sources: National policies, international programmes and pilot experiments—including those led by the authors—are examined in both scientific and grey literature.

Case description: We call for the promotion of a publicly-oriented health sector as a cornerstone of such alternative policy. We define 'publicly-oriented' as opposed to 'private-for-profit' in terms of objectives and commitment, not of ownership. We classify development strategies for such a sector according to an organisation-based typology of health systems defined by Mintzberg. As such, strategies are adapted to three types of health systems: machine bureaucracies, professional bureaucracies and divisionalized forms.

We describe avenues for family and community health and for hospital care. We stress social control at the peripheral level to increase accountability and responsiveness. Community-based, national and international sources are required to provide viable financing.

Conclusions and discussion: Our proposed social-and-democrat health policy calls for networking, lobbying and training as a joint effort in which committed health professionals can lead the way.

Keywords

developing countries, health policy, disease control, health care services, integration

Introduction

Disease control programmes are performing poorly, whilst at the same time access to essential quality care in low and middle-income countries (LIC/MIC) is limited. In a previous paper [1] we reviewed the role that international aid and health policies have played in these disappointing results. Both are neoliberal in their promotion of commoditification and privatisation of health care. We argued that the combination of government-operated disease control programmes together with privatised health care services constrained both programme performance and people's access to care. Whilst recognising other factors which contribute to this failure including state crisis, debt, corruption and patronage we concluded that there was a need for an alternative aid policy.

In this complementary paper we call for the promotion of a publicly-oriented health sector as a cornerstone of such alternative health policy. We define 'publicly-oriented' as opposed to 'private-for-profit' in terms of objectives and commitment, not of ownership. The combination of public aims and co-management gives the name 'social-and-democrat' to the policy. We outline health system-specific strategies consistent with this policy, with the potential to improve both health care and disease control in LIC/MIC.

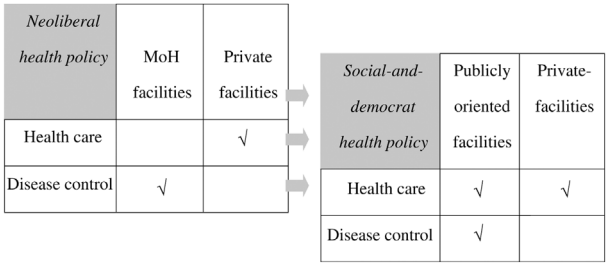

Figure 1. Neoliberal versus social-and-democrat health policy.

The social-and-democrat policy: promoting a publicly-oriented health sector

The backbone of the proposed policy would be a publicly-oriented health sector. We believe that the classical division of health facilities by ownership has lost its relevance. Not all government structures are 'publicly-oriented', nor do all private services always seek profits first. Not all NGOs are publicly-oriented with some NGOs, including faith-based organisations, following a for-profit or a proselytising rationale As such, a classification based on aims and commitment is proposed, using the framework of Giusti and colleagues [2]. Publicly-oriented, as opposed to private-for-profit, health care organisations are facilities and systems whose raison d'être is the response to the health demand and needs of the population. Publicly-oriented services aim to balance the concerns of the patient, the community, the state and professionals in care delivery and management. In contrast, private-for-profit services focus primarily on financial profitability and treat corporate and health professionals' income as an end in itself. This classification enables the formulation of quality standards for publicly-oriented health care delivery [3], which can inform teaching, research, partner identification, contracting, management, evaluation and health policy design. Providers from non-governmental, including denominational organisations as well as from community-owned or other social security facilities, could belong to this publicly-oriented health sector alongside government facilities belonging to the Ministry of Health (MoH) and city councils. Their social mission and management would be to balance the interests of individuals and society. Such a broadened publicly-oriented sector allows wide geographical coverage, integration of disease control in services in a manner that attracts patients together with equitable access to quality health care. Management contracts can be designed to secure a co-management structure which involves the participation of key stakeholders including the community in all publicly-oriented facilities and the delivery of health care responding to specific quality criteria to a defined population. Such contracts could help to distinguish those with a social mission from the others.

Figure 1 conceptualizes such a social-and-democrat health policy—and the allocation of services and programmes—as an alternative to the current neoliberal health policy.

We will classify development strategies for publicly-oriented health services according to an organisation based typology of health systems as defined by Mintzberg. This categorises organisations into five clusters depending on: their prime co-ordinating mechanism, key level and type of decentralisation [4]. As such, we start by examining strategies adapted to three types of health systems: machine bureaucracies, professional bureaucracies and divisionalised forms.

Machine bureaucracies

Machine bureaucracies are found in West and Central African countries, in the Andes, in Central America and in many Asian public services. They are based on norms and standardisation of work processes. Peripheral units are highly specialised, have limited autonomy and a reduced scope of output. This managerial configuration is inappropriate for the much diversified types of health care that dispensaries and hospitals need to deliver. However, disease control programmes can, to a large degree, successfully standardise work processes. This is why health ministries with powerful vertical programmes tend to display many of the features of machine bureaucracies. Each programme focuses on a narrow output (e.g. vaccination coverage rates), and develops its own information system and parallel management control systems. It focuses its research agenda on the burden of disease, rather than delivery of care. Each programme competes with the others for scarce funding. Such systems have a powerful techno structure but a weak apex, which tries to achieve coordination mainly through formal planning and control mechanisms.

Machine bureaucracies face four interlinked challenges (healthcare, financial, political and managerial) to achieve adequate publicly-oriented health systems.

The healthcare challenge: pursuing a health ideal compatible with Hippocratic principles

Confining public services to disease control units leads to underutilisation of professionals' skills as they are obliged to concentrate on a few, defined, conditions. This is dubious not only from an efficiency viewpoint, but also from a medical ethics' perspective. LIC/MIC patients are similar to service users elsewhere in the world in their concern to be considered as *persons* rather than as *cases* [5,6] and to access health care irrespective of the form of suffering. There is thus need for a broad application of the Hippocratic ideal, putting family and community healthcare at the core of services. To implement such an agenda, first line health professionals need both the will and the skills to interact with patients and communities to solve health problems, in an environment where poor communication was widespread [7] and where basic education of health professionals did not include psychosocial care. Until teaching programmes go beyond the biomedical paradigm, additional in-service training and coaching will be necessary to develop bio-psychosocial, patient-centred care [8] and to increase the problem-solving capacity of first line services. Rotations in district hospitals can teach primary care practitioners relevant know-how. Computerised self-teaching programmes based on complaints instead of diseases [9] can also improve clinical decision-making.

Strategies to improve primary care practitioner–patient interaction have proved effective in Europe [10] as well as in developing countries [11,12]. For instance, training in communication can be provided by a psychologist with expertise in practitioner–patient relationship, and *aide-mémoires* of special patients' problems can be designed to systematically explore psychosocial and psychosomatic disorders (e.g. sexual problems, drug addiction, and alcohol dependence).

Balint groups (case discussion groups for GPs that use psychodynamic theory and principles) permit the exchange of experiences and an analysis of how the professional's own feelings can interfere with case management. It remains to be seen whether these techniques are applicable to professionals in cultures that are not inclined to introspection, or whether other approaches, building upon traditional knowledge of social relationships, would be more relevant.

Peripheral hospitals delivering emergency, obstetrical, medical and surgical care are the indispensable complement of the primary care practitioners' frontline. The key feature distinguishing peripheral hospitals from first line facilities is their capacity to handle medical and surgical emergencies. Together, the first two health system's tiers are capable of solving 90–95% of health problems [13], under a management that integrates resources and structures and with a sustainable operating budget [14].

The economical challenge: viable finances

Free health care at the point of delivery is clearly desirable from an accessibility perspective, especially in LIC/MIC. As such, a number of Latin American countries (Costa Rica and Cuba, and more recently Chile, Brazil, Uruguay and Venezuela) have not blindly followed the neoliberal recommendations of international aid agencies to introduce cost-recovery. Instead they set up public systems delivering free health care and competing with a non-subsidised private-for-profit sector. Costa Rica, Chile and Cuba are now the best performers in the continent [15]. Zimbabwe, Lesotho and Kerala [16] also attained outstanding achievements under a government health care delivery system. Moreover, it took them only decades to achieve mortality reductions for which European countries needed more than a century [17]. None of these health systems were machine bureaucracies.

Based on a sample of 18 low-income countries, the IMF estimated in 1995 [10] that during 1983–1990, central government expenditures for health accounted for only 0.4% of GDP, compared to 2.8% for defence. The authors contrasted this with the need for health expenditure, which LIC face. Paradoxically, affordability could be within reach. There are reasons to doubt whether the cost of comprehensive care necessarily exceeds that of a few vertical programmes put together, known 27 years ago as selective primary health care [18]. In 2001 Vander Plaetse and Criel estimated the cost of comprehensive care in a Zimbabwean district at US$10 per person per year [11], slightly less than the US$10.75 referred to in the 1994 World Bank study based on selective care in the same country. Taking account of the additional resource needs arising from the AIDS pandemic [19], the WHO's Commission on Macroeconomics and Health estimate of US$34 per person per year [20] is currently more accurate. However, basic health services' requirements appear moderate enough to understand that political will—in both poor and donor countries—is at least as important as the country's GDP and that some LIC and all MIC have the economic potential to finance adequately their health sector.

The problem is to finance *publicly-oriented* services in a sustained manner beyond projects' deadlines in countries where the Government's social commitment

is weak. Theoretically the Bretton Woods institutions could lend a hand by imposing increased social health expenditure in debt and loan negotiations, as a backup to the 1995 20/20 Initiative [21]. But over the last decade this has not happened. As such, national pressure groups to increase LIC/MIC government health budgets are of paramount importance. Health professional groups (such as the Thai Association of Rural Doctors) and mutual aid associations representing users need to lobby governments and political parties to commit funds. In Egypt, Mali and other countries, communities involved in pilot projects managed to influence national health policies temporarily. These experiences give credit to externally funded pilot projects aimed at the development of community health centres.

Hospital care and drugs represent the main financial constraints for the sick, and communities are too poor to entirely take over health care expenditures. User fees *may* improve financial accessibility if and when they succeed in reducing the total cost of a sickness episode faced by the patient. To achieve such results, mechanisms to pool risk for items such as drugs, laboratory tests and medical images are needed. Prepaid schemes can increase solidarity between the sick and the non-sick, fee per sickness episode improves continuity of care and solidarity between slightly and severely ill, and health committees may define exemptions.

The Bamako Initiative, a large-scale experiment launched in l987 by UNICEF and WHO, proved capable of improving government health services. Revolving funds used to purchase essential generic drugs were negotiated against social control of government and NGO health facilities. Communities were drawn into the management of these funds in order to counter-balance the power of civil servants. In Mali, where health sector reform best known for its community-owned health centres was introduced since 1990, service utilization rates more than doubled [22]. In Benin and Guinea, where the Bamako Initiative was most successful, service utilisation rates increased even more significantly [23]. Admittedly, in many of the 35 other countries where it was implemented, the Initiative failed to improve utilisation rates. Specifically, it failed when cost recovery could not reduce the total sickness episode's costs for the user. We also now know that to increase the success rate of the Bamako Initiative, specific initiatives are needed to improve care acceptability and bio-psychosocial care.

At the global level, international aid can be urged to reorient disease control budget lines towards the financing of publicly-oriented health systems and services. To spend such funds, governments and aid agencies could deploy a contracting-in approach.

The political challenge: democratising the health sector

Confronted with his own statistics, former World Bank's president Wolfensohn stated that Cuba had done a great job on health [24]. Nevertheless, Cuba is well known for ignoring WB and IMF recommendations. It is said that Wolfensohn later questioned his advisors on the outstanding results obtained by this country. The answer could have been reassuring: Cuban policy was not replicable, at least not without its authoritarian regime. However, health systems such as those in Botswana, Zimbabwe, Costa Rica, and Kerala State in India also achieved decent access to good health care in spite of not being communist regimes as a result of their status as monopolistic publicly-oriented health care provider. They built on strong social commitment which also is not easily replicable. How then can publicly-oriented services be promoted in low and middle-income countries where governments badly lack it?

There is one LIC/MIC social feature which favours such plan. Communities organise themselves in order to survive. In shanty towns and rural areas, solidarity or communal self-help is extensively practiced. It takes care of elementary schools, waste dumping, water supplies, legal advice, access to telecommunications and even roads. To some extent, such community organisation substitutes for the limits of family solidarity and the ailing state health services. The social-and-democrat policy we propose builds on this potential. In a true political sense, our strategy thrives on community development leading to democratisation of health services. Community development could inject a degree of pluralism into their management under certain conditions. Firstly, the political nature of such participation is critical if it is not to be hijacked by dominant community groups. Secondly, basic quality of health care in publicly-oriented facilities is an important pre-condition for community interest in services co-management.

Because of the undemocratic nature of a number of LIC/MIC states, emerging social-and-democrat health policies will initially have to forego any influence on policy design and limit their ambitions to increasing the accountability and responsiveness of *operational* public services through community participation and social control. In hospitals and dispensaries, such strategies contribute to bringing together the professional, cultural and political identities of health professionals, as they root medical practice in a social project and open up avenues to traditional cultures in

modern societies, by involving communities in the management of a social sector.

Unfortunately community participation has often led to demagogic decisions based on unrealistic expectations and insufficient information on technical issues. Mutual control of opposed stakeholders can to a certain extent limit them. In practice, health facilities' management boards should consist of patients' and professionals' representatives, MOH district managers, and possibly representatives of any cooperation agencies involved in the region.

Such an approach aims at establishing a constructive dialogue between community associations, health professionals and government through co-management. It does not aim to replicate the history of the European mutual insurance, with the approach of purchasing care in the private sector and, in theory, improving its quality [25] which would be an illusory task [26]. Neoliberal policies follow this approach by promoting mutual health organisations independently from health care management (MHOs). All too often, in Africa, MHO coverage remained stuck at disappointing low levels [27]. One way of rescuing the concept of mutual health associations in LIC/MIC is to offer them the opportunity to co-manage publicly-oriented facilities. This is in line with our strategy.

The managerial challenge: successful and appropriate decentralisation

Decentralisation of power from central to district government levels can be an important opportunity for community participation, sustainable development and efficient use of resources through adaptation to local needs.

Decentralisation was implemented by colonial authorities in many LIC/MIC in the late 1950s and re-emerged in the 1970s for various reasons. These included objectives of overcoming constraints on development and improving community participation. By the end of the 1980s, the World Health Organisation (WHO) was promoting districts as baseline administrative units for decentralised health systems [28,29]. Since then, many developing countries have adopted a district policy, to improve management and to make top-down and bottom-up planning meet. Districts can be viewed as integrated local health systems requiring

- First line and hospital facilities as operational tiers interconnected under a single administrative umbrella.
- A capable executive team enjoying a degree of autonomy and authority over the health services, able and willing to coach health professionals [8,30]. International aid could recruit experienced staff for district management with a responsibility to improve health care and disease control (possibly in pilot projects designed to expand) instead of deploying them only in disease control programmes [31].

The managerial potential of district executive teams is linked to their responsibility, which encompasses a two tiered system, a large population (from 150,000 to 300,000 people) and many professionals. This potential can be enhanced with technical assistance. In the 1980s, several African national initiatives targeted district teams with ad hoc in-service training, coaching, and technical support (in Senegal, Burkina Faso, Mali, Congo for instance) [32,33].

Motivation of staff is a key issue for care delivery and system development. An appropriate practitioners' income, often an unfulfilled need in LIC/MIC, is necessary but not sufficient for these purposes. The UK approach to professionals' remuneration which mixes salaries, registration-based bonuses and fee-for-service, could be tested in LIC/MIC. Other factors such as living and working conditions and job satisfaction are critical (reference recent World Health Report on HR) Some health professionals find additional motivation in the Hippocratic ideal of subordinating personal interest to the benefit of the patient. Others may be inspired by faith, politics or quest for social recognition. They can gain strength by a health service organisation able to appeal to their complex professional, political, religious and philosophical identities. The enlargement of health service responsibilities from disease control to health care delivery provides the opportunity for the use of wider skills and thus, motivation from professional identity. It also provides better opportunities for long-term career progression.

Professional bureaucracies

West European Bismarckian health systems and private for-profit sectors in developing countries generally share the features of professional bureaucracies. They are characterised by standardisation of professional skills rather than output, a high degree of autonomy for working units, and weak vertical and horizontal integration. The key component of these organisations is the operating core. In professional bureaucracies, health professionals defend their autonomy against the influence of the central apex and techno structure is weak. Medical doctors work without technical supervision, on-the-spot training or evaluation. Their outputs remain almost totally unstandardised, and this contributes to increasing the cost of care. Self-employed professionals may invest in training to increase their technical skills, because increased prestige gives

them even more freedom in decision-making and revenues. The major drawback is that their mission, as they perceive it, is almost exclusively professional, i.e. medical, to the neglect of organisational aspects, resulting in poor integration and inefficient practices.

In such settings, there are various challenges. Firstly, there is a need to develop systemic links between first line services and hospitals (including referral systems, technical support by specialists and communication between primary care practitioners and specialists). Secondly teams are necessary bringing together doctors and other practitioners such as medical assistants, nurses, and physiotherapists. There is also a need to introduce reflexive methods to continuously improve quality of care (e.g. medical audit, technical supervision, coaching, self-learning methods). Lastly, the regulation capacity of LIC/MIC administrations needs to be strengthened.

Experiences in Belgium have helped address the first three challenges in developing countries, although it could not be exported. Firstly, the ''Study Group for a Medical Reform'' over a 15-year period demonstrated the potential of an independent research and training unit disseminating specific quality criteria for health care delivery [34]. It managed to promote integrated health centres which nowadays represent between 5 and 10% of the country's first line care. Secondly, the federation of these health centres acquired influence at national policy level. Finally, the ten years experience of the Local Health Systems project suggests that motivated professionals from first line services and referral hospitals can take over some district team tasks even in the absence of a formal management structure and with only modest ad hoc funding [35,36]. With the technical assistance of an academic unit, voluntary networks of health professionals from functional units used their influence to improve coordination between tiers, hospital management, clinical decision-making, service organisation and quality of care.

In terms of control and regulation, European features should be treated even more cautiously in LIC/MICs. So far, there is no single experience which suggests that the French, Belgian and German health systems can be exported. The creation of a welfare state in Western and Northern Europe arose from unique socio-political circumstances in a particular historical context [37,38]. European governments secured access to health care for the vast majority of their population when low-income groups succeeded in defending interests within the political system. In the aftermath of World War II, workers' parties and civic associations were able to incorporate their social agenda into government policy, planning and administration. Since 1945 they have acted as a counterweight to the vested interests of health care professionals and private providers. As a consequence, social and health care policies in Europe were largely defined *by* 'the poor' and their representatives. Social protection developed in tandem with democratic rights. Institutional welfare for the population as a whole, based on solidarity through taxes, became the norm [39]. A similar evolution took place outside Europe in countries such as Canada and New Zealand.

By contrast, in the USA social and health care policies were created *for* 'the poor'. Residual welfare, not solidarity, has been the norm. This narrow concept of welfare as a safety net, confined to those who are unable to manage otherwise can be traced back to the English Poor Law (1598–1948) [39]. In the second half of the 20th century it has been reinforced by neoliberal ideology and has subsequently received worldwide promotion by policy-makers and aid agencies.

In the USA this evolution triggered a series of consequences for health care. In 1970, total expenditure on health was below 7% of Gross Domestic Product (GDP) in all High Income Countries (HIC). By 2003 it was around 9% of GDP in countries as far apart as Canada, the United Kingdom, New Zealand and Sweden. However, in the USA, health expenditure reached over 15% and is still rising [40]. It would be hard to interpret these figures as the price to pay for higher quality. By the turn of the century, the USA continued to lag behind the health systems of equivalent countries in terms of solidarity, equity and financial access. A predominant share of private expenditure in total health expenditure illustrates low solidarity: private expenditure totalled 56% of total health expenditure in the USA in the year 2000, compared to 30% in Canada, 21% in New Zealand and 15% in Sweden. Low public insurance coverage affects access and efficiency [12], and reflects inequity: public health insurance coverage reached no more than 24.7% in the USA in the year 2000, against 100% in Canada, the United Kingdom, New Zealand and Sweden [41]. Maternal mortality is an indicator sensitive to care accessibility: while in 2000 US maternal mortality was still 17/100,000, Canada was 6, New Zealand, 7 and Sweden only 2/100,000 [42]. It is difficult to escape the conclusion that the US health policy is inefficient [43] and ineffective.

Such policy-induced inefficiency is likely to pose bigger problems in LIC/MIC, where access to health care is even more constrained by the prevailing poverty. Moreover, in LIC/MIC, the poor rarely take part in shaping policies or setting budgets. A common sight

in developing countries is a lack of social pluralism in government decision-making, which tends to increase inequality [44]. The elite that concentrate power in many LIC/MIC have little interest in redistributive policies. Indeed, more than a few LIC/MIC governments willingly adapted their policies to neo-liberal aid conditions [45]. As a result of this concentration of power and the influence of private doctors, improvements in the regulatory capacity of LIC/MIC governments remain a challenge.

Divisionalised forms

The United Kingdom, Costa Rica, Chile, Sweden, and Jordan have health services which tackle disease control and health care challenges simultaneously and allow a degree of autonomy and decision-making capacity at the periphery. Their divisionalised health systems provide interregional coordination whilst allowing regional difference based on geographically defined health districts and regions. This system favours both accessibility to health care and user participation. While these systems have proved to be amongst the best, they share two specific drawbacks. Firstly bureaucratisation resulting from managed care which is symptomised by a plethora of guidelines, mechanistic evaluations and paper work which may affect professionals' motivation, and problem-solving capacity. Secondly, some countries lack reflexive methods.

Both professional associations and political groups have proved essential to defend the public mission of divisionalised national health systems and improve their operations. We concentrate here on their technical challenges.

While some degree of clinical decision-making standardisation is needed, improvements in health care quality cannot rely solely on managed care techniques which, in many systems, have grown unduly. Alternative techniques are available. Coaching, also known as dynamic guidance to professionals, is available to support motivation and quality of care. It is broader than traditional continuous professional development (CPD) as it offers psychological support to professionals and teams as well as assessment of individual and group learning needs based on observation and discussion [46]. Coaching builds upon methodologies such as education-oriented supervision (as opposed to control supervision), inter-vision (peer review of critical cases' management), action- and operational research, medical audit, users' interviews, Balint groups and managerial interventions. One aspect of coaching can be visits of experimented midlevel professionals to health centres and hospital wards where they directly observe clinical activities. It permits detection and correction of professionals' deficiencies such as in utilisation of evidence-based medicine, professional-patient communication, use of reflexive methods, or team work. Experience with coaching in LIC/MIC pilot projects [32] suggests it helps to bridge the gap between health care delivery and management. It certainly is an innovative tool to identify learning needs, which traditional CPD is unable to fulfil [47]. Furthermore it can strengthen common culture and practice [48]. In addition to coaching, action and operational research, and specific forms of audit led by the professionals themselves instead of external evaluators can be valuable devices to improve reflexivity in divisionalised health systems.

Which organisational configuration is likely to support such managerial techniques? It needs to foster a high degree of professional staff initiative, community participation, action- and operational research, continuous evaluation and managerial autonomy [4]. An organisational form worth consideration at least is adhocracy, defined by Mintzberg as a configuration co-ordinated chiefly by mutual adjustment and characterised by horizontal job specialisation based on formal training [49, p. 253–282]. An adhocracy performs ideally in complex environments. Its managers become functioning members of the team. It is called operating adhocracy if its main purpose is to produce creative solutions to unique problems on behalf of its clients, as in health care. In an operating adhocracy the administrative and operating work tends to blend into one single effort. However, though appealing at the level of the service providers, a health organisation as a whole cannot be a pure adhocracy. As a system encompassing both health care and disease control, it also tends to give middle managers the authority to control their own units, resulting in a configuration that Mintzberg describes as the divisionalised form [49, p. 215–252]. When in balance, the resulting structural hybrid [49, p. 283–297] becomes a divisionalised operating adhocracy.

Conclusions

Solidarity through publicly-oriented services is needed to avoid a catch-22 with disease control for the poor and health care for the rich in LIC/MIC. A publicly-oriented health sector defined by mission, and able to balance individual and collective interest, allows the successful integration of disease control with healthcare and equitable access to healthcare.

We favour a pluralistic social representation within, and an increased accountability of, health institutions. If communities are to support public services, health

professionals and policy-makers must aim at improving care quality. Our proposed social-and-democrat strategy thus relies on consistent medical, managerial, socio-political and economic features: family and community health care delivered by decentralised units, local health systems, and community development of public services in machine bureaucracies. Under such an approach professional and political identities may echo each other and become an active motivational force. A political and technical terminology common to those who endorse the principles presented here would further strengthen this strategy.

Stakeholders outside the health sector may have an interest in supporting our proposal on different grounds. If Western politicians can ignore the avoidable suffering, mortality and anxiety in LIC/MIC, they cannot ignore the global political instability when 60% of the world population lives with less than US$ 2 per day and is lacking access to health. The US government seems to recognise this: it supports the development of public services in countries it considers geopolitically important. Throughout the industrialised world conservative politicians should understand that it is difficult to restrain economic migration without first improving conditions in emigrants' countries. They also ought to be aware that family-planning initiatives and AIDS control programmes fail when they are not integrated into health services offering acceptable health care. Social democrat politicians would find support amongst voters by exporting mechanisms that favour solidarity and that form the foundations of democracy. Green politicians could be inspired by the opportunity to put social control of the state apparatus into practice in contexts where communities still exist. Finally, investors could find an indirect opportunity in our strategy to stabilise their assets in LIC regions nowadays not attracting capital.

As committed and progressive health professionals we should tirelessly explain to all people, parties and policy makers the importance, choices and stakes of international health policy. Together we can bring disease control and health care back in step with ethical principles and desired outcomes, and contribute to a fairer and safer world.

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