

EDITORIAL

TROPICAL DISEASES AND ECONOMIC CHANGE

"Tropical medicine" would appear to have been a creation of colonial paternalism, to describe pestilences of conquered lands to which the western conquerors were especially vulnerable. The words imply a clear cut categorization of some kind, though of course the reality is that diseases of tropical and temperate climatic zones do not occupy entirely separate niches.

The perceived exotica led to the establishment of Schools of Tropical Medicine in port cities of Europe where travellers brought "tropical" diseases with them from other parts of the world, although there are important exceptions such as the Swiss Tropical Institute, located in Basel in a landlocked, non-colonizing country. It is interesting in this year, when Mahidol University Faculty of Tropical Medicine in Thailand is celebrating its traditionally significant Third Cycle - 36 years - to reflect on the changing world of tropical medicine. That center was itself modelled upon the Liverpool School of Tropical Medicine, one of the classic colonial creations which is at the threshold of its centenary.

It is already some years since the London School of Hygiene and Tropical Medicine, also on the verge of its centenary, moved to place more overt emphasis on issues in the mainstream of public health of industrialized nations in recognition of *realpolitik*, although much of its research retains a tropical orientation, reflecting long term historical interests. There has been a broadening of the disease horizons addressed by the Institute of Medical Research in Malaysia, created in like vein, which comes of similar venerable age at the turn of the century. So the changes are ringing widely. AIDS, a global scourge evidently of tropical origins, has played a part in accelerating the transition.

So, too, have other factors. It is perhaps rare that textbooks break new ground but arguably when first published in 1983 the Oxford Textbook of Medicine did just this, departing from the western norm. It did so simply by taking a truly global approach to systematics, giving diseases generic classification without treating those which preponderate in tropical countries as exotica and devoting about a quarter of the book to communicable diseases as a whole

regardless of demography. That may have been a quiet milestone but, in context, it was an important one in providing a more equitable view than had generally been done previously. It was moving with the times of great population mobility and rapid international travel, where disease enclaves of the past have become dispersals of the present and will broaden their impact in the future, a trickle with the potential to become a flood. This effort placed tropical diseases firmly in an integrated format where they surely belong as part and parcel of mainstream world medicine.

At the same time economic change has become increasingly global in character. Life expectancy is lengthening even in the poorest of countries, the age pyramid is broadening towards the top, chronic diseases, traffic accidents and environmentally-related disabilities are assuming greater relative importance as causes of morbidity and mortality and hence of focus in health care financing, with consequent concern in finance ministries. In this dynamic milieu we may well ask what is the future of tropical disease centers *per se* as entities distinct from institutions which bear the general disease burden. The UNDP/World Bank/WHO Special Program for Research and Training in Tropical Diseases (TDR) itself addressed this issue some years ago when it launched the Sick Child program, to encompass a wide spectrum of infectious disease against nutritionally and socially marginal backgrounds. Maternal and child health (MCH) programs worldwide have long addressed a cluster of items which have global relevance. The positive intrusion of UNICEF into primary health care over a long period has helped to promulgate a similar perspective.

An intriguing and disturbing carry-over from colonial times in a sense is the *expert syndrome*. That devoted individuals acquire special in depth expertise is a *sine qua non* of our existence, in the health sector as in every other sphere of human endeavor. That the world benefits from such expertise appropriately applied is beyond doubt, but that superspecialization has become dangerously narrow in technical focus is also beyond reasonable doubt. The *expert syndrome* has taken on a some-

what sinister tone: the *outsider* is seen as the *expert*, the insider as the recipient of the advice. *Experts* is a term widely applied to foreigners, mostly of western origin, certainly of western training, who dash in and out to leave their trail of wisdom from other cultures, other economies, other ecologies, other epidemiologic environments. The *expert syndrome* is often harmful, sometimes fatal to local initiative, as it casts aside intrinsic experience which, with enough resources, may better cope with the challenge. All health systems of the world can benefit from refreshing outside views, but rarely from authority extrinsically imposed.

Tropical disease control also suffers from the *expert syndrome*. The western schools specializing in this field put forward their distant "expertise" in the context of bilateral aid agency programs or are hired by international agencies to do so. The advice often comes with a minimum of cultural relevance and a maximum of technology, coupled with externally conceived and supervised "training" programs long on theory and short on local experience. These inputs are not necessarily bad, but the conceptualization is too often in the hands of the donor, with consequent ineffective sustainability, particularly in terms of economic or political reality. While some institutions in endemic countries run high quality educational programs of direct relevance, agencies and governments continue to push their candidates towards western academia, preferring historically endorsed diplomas to firmly grounded, real world expertise. In such pursuit, of course, the western bastions are kept in business by the aid industry, so they continue to take candidates away from more appropriate institutions in tropical countries, making money in the process.

The *expert syndrome* is caused in part by the *assumption* of international agencies dominated by the rich nations that, because they have wealth, their knowledge in most fields is superior, so this superiority renders them expert in comparison with their poor nation counterparts. It is also caused in part by the acquiescence of the leadership in poorer nations to the caveats placed on aid funds, which include being cast as people having less appropriate knowledge in all fields, regardless of history and present realities. It is perhaps time for rich countries with exploding health care costs to invite comment from experts in poorer nations that have more effective health systems despite much fewer resources, so to make for greater equity in the flow

of ideas and in the *expert* stakes and to contribute towards a partial cure for the syndrome itself. Such an eventuality would seem to be a long way off given the arrogance and pride of rich nation educators and administrators. Meanwhile much money is poorly utilized on unsustainable impositions.

One very influential player relatively new in policy contributions to the health field is the World Bank. Following the health-focused World Development Report of 1993, the Bank has expanded considerably its in-house capability in health care policy development and has brought the health sector to the fore in relation to economic planning, in recognition of the role of health, along with education, in fostering the advance of human resource capacity of poorer countries. This event is very positive in the sense that the health sector generally is not well equipped to handle macro-economic policy initiatives and the Bank is in a position to assist in this critical function. However, true to its traditional power structure, the Bank rides roughshod over local health care priorities in planning to impose its western concepts of what is appropriate, often missing the imprints that history has so obviously left as useful guides. More "jobs for the boys" from the western institutions, to reinforce their outside "expertise", but this time with more clout.

It is, of course, very easy to become cynically negative, whereas the challenge is to dream of positive options that are achievable. Integration of tropical disease case management into the general run of medical care in the public sector has been an aim since Alma Ata and there are some good examples. But one of the realities that tends to receive too little attention from the public health sector is the existing and expanding role of the private health sector in this very game. The sick patient interested in getting well is not concerned with disease classification, but simply with the likely severity and the chance of cure. The opportunity costs of travelling to a district hospital often are far greater than the medical costs of treatment at a nearby private clinic, so that utilization of the private health sector can be based on economic advantage, in addition to the possible issue of perceived quality of care. Integrating private and public sectors in health care planning is thus a high priority to ensure effectiveness and equity overall.

In some countries particular communicable diseases remain the subjects of vertical control pro-

grams, a matter that has to be reconciled with integration. Vertical programs for malaria, AIDS, and others still serve the purpose of focused control strategies. They often suffer from incomplete case reporting, which has negative impacts on resource allocation. Part of the reporting deficiency rests with the private sector and represents another reason for more effective integration of public and private sectors. Vertical programs can also develop appropriate drug policies, an issue of prime importance where drug resistance is an epidemiologic problem, but to implement drug policies requires channels created in the course of public-private integration, including workable incentives. To omit the private sector is to ignore critical human resources. The vertical and the horizontal are complementary, if there is enough management wisdom to reconcile the points of difference.

Returning to the macroeconomic picture in which the development banks play such powerful roles, behind so much of the tropical disease patterns is the major causative factor of poverty. Poverty may be considered in a sense as economic inequity. In the rush to embrace market economics as the engine of prosperity, the fundamental issue of equity rides uneasily on the coat-tails illusion: the tomorrow that never arrives. The reality is that on a global scale we have not even begun to approach an economic system that can effectively place equity in its rightful place alongside the goals of efficiency and effectiveness. The poor within nations suffer more from some infectious diseases than do the rich, and the poor nations likewise compared with the rich. Most of the world's poor inhabit the tropical regions of the earth and poverty underscores many of the diseases which traditionally are labeled "tropical".

Technology, organization, education can solve some of the problems, but not the fundamental ones. The issues in the arena of political economy are generally outside theegis or capability of the health sector. At the global level the portents for the World Trade Organization meeting in Singapore this December 1996 are not particularly hopeful, for the planning will be dominated by the rich

nations, who will pontificate on whether they will condescend to admit China to the club - a quarter of mankind held to ransom - and will set the rules to favor their already dominant economic position in world commerce. This is where the ultimate rules of wealth and poverty are written, this is where the newly rich nations jump across the table to join the established wealthy, to disadvantage the desperately poor, this is where the real power of disease control lies, outside the influence of the health sector. There is no choice but for this sector to take up the game of macroeconomic policy determination if any sustained impact can be felt in those domains where poverty perpetuates tropical disease.

Where does this stream of thought leave tropical medicine and the institutions dedicated to its eventual demise? They will continue to play important roles, particularly in collaborative research, if this is truly equitable in nature. But there is a cadre of highly trained personnel in many endemic countries who have the capacity to lead, to plan and to implement relevant policies without direct inputs by western "experts". They themselves are expert and in addition have a competitive advantage in the context of cultural judgment as to what will be achievable and sustainable. There is an increasing number of training courses established in endemic country institutions which can provide more appropriate, high quality education in the field of tropical medicine and health economics: that is where the international fellowship support should be focused rather than in the remnants of colonial empires. Great advantage can accrue from much greater attention to practical knowledge of economics by health sector leaders: microeconomics for more effective management, macroeconomics for policy determination in the real, competitive world of market forces. Unless the health sectors of poorer nations enter the arena of national planning armed with this expertise they will forever be subject to dominance from afar. The task for the western bastions should be to facilitate this change.

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