EDITORIAL

POLITICISATION OF HEALTHCARE DECISIONS

In 1977, the world Health Assembly (WHA) decided that the main social target of Governments and International Organisations in the next few years would be the attainment, by all citizens of the world by the year 2000, of a level of health that will permit them to lead a socially and economically productive life (Resolution WHA 30.43). it was left to the health care practitioners and managers to fast-track programmes by which this resolution could be translated into practical expression. The Alma-Ata conference in 1978 attended by delegates from 134 governments and representatives of 67 organisations came up with a roadmap and sequential progress indicators but never questioned the time frame set out by WHA. The year 2000 has come and gone and for all practical purposes, Resolution WHA 30.43 has been consigned to the dustbins of history. Resolution WHA 30.43 may not have achieved the set goal but along the way it made great contributions in such areas as Maternal Child Health (MCH), and primary Health Care (PHC). Certainly the concept of Essential Drug List (EDL), an offshoot of PHC has contributed to rationalization and reduction of health budget. This is an example of a noble idea, which was politicised. Naturally health practitioners are being blamed for failure. They were expected to implement decisions in which they had minimal contribution. All political parties in democratic governments focus on health care policies in their party manifestos during elections. These are policies, which must achieve demonstratable results within a short term, usually 3-5 years. Often such policies, address the most popular immediate needs of the voters. Many other examples can be cited but two will suffice.

Between June 3rd and 7th 1985, I participated in a scientific meeting in Harare, Zimbabwe, organized by Commonwealth Scientific Council based in London. During one of the sessions, I witnessed an altercation between a representative of practitioners of alternative medicine and a Zimbabwe government representative. Apparently, a few years before the country gained independence, the ruling party, ZANU had promised the practitioners that once in power, it would allow them to practice in government hospitals alongside medically qualified doctors. After independence it dawned on the Government that such an arrangement was difficult to implement. The government was unwilling to admit the mistake and adopted delaying tactics, blaming the medical doctors instead. A similar predicament was experienced in Tanzania around that time but in this case, the government was willing to accept responsibility for the fiasco.

The second example is that regarding the introduction of Artemisinin-based Combination Therapy (ACT) in several Malaria Endemic Countries (MEC) of Africa. The cost of introducing ACT is prohibitively high in many African countries south of the Sahara. Yet some of these countries have made political commitment to introduce ACT even before the financial and logistical (procurement, distribution) implications have been critically evaluated. In some of these countries even cheap drugs like analgesics (e.g. paracetamol) are unavailable to the needy at the health centres in the rural areas most of the time. These countries are banking on donor support to sustain a long term health care programme! The Global Fund for AIDS, Tuberculosis and Malaria (GFATM) was established in 2001 to help fight the three diseases but the current level of funding falls far short of the requirement. Worse still, there is an apparent donor fatigue as is evident from USA government action which reduced its contribution to GFATM from previously $550 million to $220 million in 2005. Other donors are also apprehensive but discreet in their muted response. The realities of today's geopolitics are such that no responsible government should depend on donor support in critical areas of health care. Yet this is what is happening.

Politicisation of health care decisions is not bad *per se* but a reasonable balance between what is ideal and what is practical determines the outcome. In the case of HIV/AIDs, it has paid dividend in Uganda by promoting public awareness but led to confusion in South Africa. In some respect the medical

practitioners are to blame. While they are vocal in hospital corridors they often fail to give proper guidelines at critical moments preferring to argue endlessly on the merits or otherwise of important policy matters. Currently, few health care practitioners are involved in setting up Millennium Development Goals Programmes which aim at halving poverty in developing countries by the year 2015 and specifically promote better health care.

Editor–in–Chief