EDITORIAL

CHALLENGING DEVELOPMENT THEORIES AND MINDSET

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Your journal *Health Policy and Development* has been out of circulation for almost a year. Our sincere apologies. This was due to technical and management problems, which we are now slowly but firmly addressing. We would like to assure our readers that the journal will not disappear again.

This issue, and indeed the current international literature, have together raised a number of issues about health and social development, and have challenged well known, almost sacred economic and development theories.

First, that the emigration of highly skilled health workers can in theory lower the social welfare in the country from which the migrants are coming (Clemens, 2007). Policies to impede emigration are thus thought to raise the welfare of the country of origin of potential emigrants and that of the world as a whole. But a new study suggests that Africa's low staffing levels and poor health conditions are the result of factors entirely unrelated to international movement of health professionals. On the contrary, it suggests that emigration has facilitated a greater production of health workers in Africa. The factors for poor staffing and health status in Africa include the skewed staff distribution, absenteeism from work, waste of staff time in gossip and social events, internal migration of health staff to other sectors, and important mid-cadre professional posts are unfilled.

The study in particular notes that most of health workers who migrate abroad are highly professional and not suited for primary health care, which is what most of Africa's ill health needs. Children in rural Mozambique do not die due to lack of cardiologists and specialized nurses but because they lack oral re-hydration, anti- malarial drugs and basic treatment for pneumonia. The implication of the study is clear: instead of wasting energy and time on impeding international health-worker movement, African countries should address the key factors which are well known, causing poor staffing and health status.

Second, public-private partnership (PPP) is fast becoming a panacea for health management and socio-economic development. But a series of international studies have found mixed results on the usefulness of PPPs (Sundawell and Forsberg, 2006; Nikolic and Maikisch, 2006). The concept is typically unclear. True partnership doesn't actually exist. Each partner pursues its own vision, not a common vision. Partnership is much talked about but not always applied or desired. PPPs have become *de facto*, privatization after the failure of the public sector, which has been wrecked by neo-liberal policies. But where PPPs have worked well, the regulatory system is functional, there are skills for management, enough time has been given to develop the partnership, there are inbuilt business and management functions, there are well-defined consultations, and there are channels of communication with all stakeholders. Most of these elements lack in African settings and need to be cultivated.

Third, is the infamous theory, which economists virtually cooked up, justifiably "to maintain macro-economic stability" in poor countries. That, substantial scaling up of aid inflows invariably leads to greater inflation, overvaluation of domestic currencies and the reduction of external competitiveness. Economists call this the Dutch disease. But a series of studies and papers by the UNDP's International Poverty Centre suggest that there is no evidence of aid flows leading to overvaluation of local currency (Chowdury and Mckinley2006; Vernengo M, 2006). That the notorious restrictive economic policies on public expenditure (especially for health, education and social welfare) are baseless. The studies suggest that in poor countries where social services have been destroyed by such economic policies, governments should use a 3-pronged approach: maintain low interest rate, increase overall liquidity in the economy and maintain a relatively depreciated currency. Such an approach will help support a fiscal space necessary for attaining the Millennium Development Goals (MDGs) targets.

Fourth, Nancy Birdsall's (the founding president of the Center for Global Development) piece in the *Boston Review* of March 2007 is instructive (Birdsall N, 2007). We will share the abstract of her article in this journal's next issue. The current theory is that for a country to develop, it needs high economic growth, which can only be

achieved through private-sector driven and export-led economy. An outcome of this approach is that increasing inequality is not only expected but a necessary cost to pay for "development". But Birdsall convincingly argues that this theory is mistaken and flawed. It applies well in established economic and political systems. She distinguishes between constructive and destructive inequality.

Constructive inequality occurs when institutions and democracy are functional and individuals have more or less equal opportunity to improve their welfare.
The difference (inequality) between individuals only exists with the level of their motivation to work hard, innovate and take productive risks. Constructive inequality exists in developed and rich countries and is a necessary element of progress. But in poor countries inequality is destructive (i.e. deters development) where the necessary institutions of the economy and governance are weak or dysfunctional or absent. Other forms of inequality coexist and do not enable people to get equal opportunities. These inequalities include injustice, indignity, and discrimination (typically on political, ethnic or religious grounds) and unequal access to opportunities. Destructive inequality reflects the privileges for the already rich and well-connected in the country and it blocks the potential for productive contributions of those not connected to the political and economic powers of the country. Birdsall advises that foreign aid should be reinvented to focus on public goods, agriculture, nutrition, health and education. She calls for the strengthening and reform of institutions, rules and customs to complement the global market. But she counsels that it is only through collective management (i.e. government and global institutions) that persistent and unjust inequality, which the markets are not able to resolve, will be addressed.

Finally, China's explosive economic growth has defied most neo-classical economic theories. This defiance cuts accross on the entire economy from lack of democracy to fixed value of the yuan (the local currency) to public/communal ownership of land (Sen A, 2001). Classical economic theory and mindset would suggest that China's economy should have collapsed. Not so. China's is on the verge of becoming the world's economic super power.

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In this issue .....

In this issue of *Health Policy and Development*, true to our name, the authors explore a wide variety of issues linked to health, health policy and development. The articles address two broad themes: Management of Health Services and Public-Private Partnerships in Health. A few articles address miscellaneous health or development issues.

Under Management of Health Services, Paschal Nsekuye exposes how many health workers simply collect health management information (HMIS data) for the sake of fulfilling an obligation from higher authorities rather than for the sake of having it used to improve their management and planning. In a study in one health sub-district in Kisoro District of S. W. Uganda, the author concludes that there was no local of use of HMIS data.

One resource of health services commonly mismanaged is health unit land. In a study conducted in hospitals in S. E. Uganda, Sarah Nabulime finds gross mismanagement and ignorance on land issues among hospital managers, encroachment by hospital neighbours and staff as well as weak and often conflicting government laws which seem to abet encroachment. The author concludes that if the laws are not rectified, a lot of hospital land will be lost to private interests and it will be difficult to expand health services in future.

In order to enhance community participation in health, the Uganda Government has started Village Health Teams, a strategy aimed at utilizing community resources in primary health care management. In one district, the start has been successful, to the point of winning a national award, and seen as a key enabling factor for the decentralization of health services. Innocent Komakech elaborates on how this was done.

As the developing world grapples with the problem of external brain drain of qualified health workers to the rich and developed world, an unnoticed and undocumented internal brain drain takes place. In Uganda, health workers move from the private-not-for-profit sector to the government health services due pay differentials as well as moving from rural to urban areas in search of better social conditions. Paul Onzubo explores the attrition of health workers from one rural enclave in N. W. Uganda, the West Nile region and identifies the main reasons for attrition to be salary-related, followed by interpersonal conflicts between health workers, their managers and local politicians.

Under Public-Private Partnerships for Health, John F Mugisha *et al*. address the question of funding of private-not-for-profit health training institutions. In a study of private-not-for-profit health training institutions in Uganda, they explore the channels through which the funds flow in order to reach the primary destination, the student. They find that funding has dwindled in quantity and recommend that the schools employ efficient measures of financial management to increase credibility and enhance government support.

Christine Kirunga Tashobya *et al*. analyse the history, justification and mandate of the public-private partnership for health in Uganda. They trace the inclusion of the partnership as a deliverable in Uganda's second Health Sector Strategic Plan (HSSP II). They also highlight the challenges faced in its implementation such as skepticism about autonomy, stagnation of funding, unilateral decisions by partners and the slow formalization of the partnership among others. They suggest how the partnership may be strengthened.

In the first of a new and unique serialization of African Health Systems to continue in our future issues, Maurizio Murru explores the Ethiopian health system and puts it in a political context giving detailed information rarely found in other documents. The author provides information that exposes aspects of the health system that one can use to compare the Ethiopian health system with that of any developing country. The narrative article is a rude awakening to the complacent observer of health systems in developing countries.

Under Miscellaneous Issues, Remigius Munyonyo elaborates on how cultural norms like not talking about sex with youngsters hinder the development of creative solutions to the problem of rapid spread of diseases like HIV/AIDS among the youth. Using a participatory-inquiry approach, the author breaks Ugandan cultural norms by mixing different sexes and age-groups, allowing them to talk about sex and observes innovative thinking coming out of the mixed group. The outcome of the creativity explosion is used to develop a useful facilitator's guide on teaching Gender and HIV/AIDS to different communities.

Benedict Mongula addresses the neglected issue of older people in Africa by looking at the access to health care in Tanzania. The author observes that despite poverty eradication being a major driving force in many current international development initiatives, their effect on the elderly in developing countries is not well documented. The author notes the negative effects of some health reforms like health cost-sharing on the health of the elderly in Tanzania and analyses the feasibility of free access in a poor country. The article raises the controversies surrounding the economic disparities among elderly people and suggests ways in which their health may be taken care of, even in a developing country.