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**38<sup>th</sup> Union World Conference on Lung Health  
Plenary Session 3: Health Systems that Serve:  
What's the Bottom Line?  
November 12, 2007**

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**RITVA KAUPPINEN:** Okay, Ladies and Gentlemen. Good morning. Still we can stay good morning for you. I hope you have had a very nice morning lectures, and now it's time for the third plenary session. I'm Ritva Kauppinen, coming from Finland. I am just physician, but here I am as a sub-chairperson of the Finnish Lung Health Association in the board that I chair.

On behalf of the board, I would like to thank the Union for organizing this plenary session in the honor of Professor Eero Tala. And also in the honor of Filha's, the Finnish Lung Health Association's centenary. Our organization has during the years long get always very important and practical help from the union. And we are very thankful and pleased for this honor.

Before introducing Professor Enarson, I would like to tell the audience shortly something about the Finnish Lung Health Association [inaudible] Eero Tala. Our Association was founded as an anti-tuberculosis association during the time when tuberculosis was a big health problem in Finland. Death rates was huge. We even don't know exactly the rates from that time. The health care services were very weak, sometimes not at all, and also the living standard was very poor. That was the time before Finland was an independent country.

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One of the basic activities from the beginning was education. It started from the education of the tuberculosis nurses. Our association pressed also the Parliament for establishing better health care services, to getting better facilities, to building TB hospitals and so on. The Association started the activity in case finding, using mass x-ray, and also later started vaccination.

Nowadays all these activities are past. The situation in Finland concerning tuberculosis is very good. The Association had one important thrill, of course, to getting this very good situation, but we all know that also the changing improving in the leading standard and of course these modern chemotherapy for tuberculosis had a very crucial point in changing the situation and changing also our work.

Filha has now during the last decade directed one part of the activity toward the chronic lung diseases. We have launched the national programs for asthma, COPD and sleep apnea. And we have not only launched these programs, but we have taken care of the implementation, from the upper health care level to the primary health care level, to the practice. And that's the key point in the work. And that has also made these programs very successful, as we can read from the results. Now most of our activity is cooperation, consultation, training, all the health care expertise in our country, but also abroad, mostly in our neighbor countries.

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We are working as a cooperating center of the Union and also WHO, also in the other fields of the respiratory diseases. This cooperation has been very fruitful. We have discussed a lot. We have made the basic work and learned from each other. Filha as a non-governmental organization, has plan for the future to be globally active, acting expert in the whole field of prevention and treatment of tuberculosis, other pulmonary diseases and infections related to them.

Today we will have the Eero Tala lecture. Eero Tala was professor in the pulmonary medicine in the University of Turku since 1968 until 1984 when he retired, but continued many scientific activities especially in the Union, and he was also board member in our Association. He was the head of the University in chest medicine and dean of the medical faculty.

His main activity concerned tuberculosis. And he was one of the opinion leader in the chest medicine in Finland. I will say some aspects of his work. He started in Finland the short course chemotherapy in tuberculosis, and it changed a lot our treatment, also use of resources, and helped the patient. He also started in his clinic the fully-supervised tuberculosis treatment, first among treatment who where under the risk to become defaulters. This kind of supervised treatment was like the later launched DOTS which the Union launched.

Professor Tala was the editor of the first National Tuberculosis Program, published 1986. And now our Association

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20 years later has been involved and then published the new National Tuberculosis Program. Professor Tala was active teacher and educator, fantastic person as a educator. He actively pried [misspelled?], and advised, and directed the students and other scientists who made the studies, for example, for the doctoral thesis. He has also many connections to abroad to the International Scientific and other organizations including the Union.

So I am happy and pleased that Professor Enarson will have this Eero Tala lecture, and I am thankful for my special privilege to introduce shortly Professor Enarson. I think that nearly everybody knows that he is born in Canada, but I don't know how many knows that he has also roots to Scandinavia, as a Finnish person, I should say that, or course.

He is graduated in psychology, in biology and in medicine, and after his post-graduate studies he was certified by the American Board of Internal Medicine and a Fellow of Royal College of Physicians of Canada. His practical and scientific activities as well as experiences are as promising, many-sided, including the practical work in the field in Africa and in many other places. His academic works relates primarily to epidemiology and to the control of tuberculosis and of occupational diseases.

After being professor in medicine in the University of Alberta, he since 1991 has been the director in the scientific

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activities in the Union in Paris. I think we all know his activity through the Union to develop the current global strategy for the fight against tuberculosis. He has traveled all the world helping people, encouraging people in the field and in the scientific work. Professor Enarson has helped also us in our association giving advice, cooperation and understanding us and our work.

So I have the pleasure to ask you, Professor Enarson, to have the lecture.

[Applause]

**DONALD ENARSON, M.D.:** Thank you very much, Ritva, for that kind invitation. And I would like to reiterate some of what Ritva has said to us concerning Professor Eero Tala. Eero Tala was a very close personal friend and a person for whom I have a deep respect. Unfortunately he died, but we present this lecture in his honor, and also in honor of the centenary of the Finnish Lung Health Association.

The cooperation between the Union and the Filha was very much promoted by Professor Tala, and at a time when the Union was struggling desperately financially and organizationally, the help of the Finnish Lung Health Association was key to our survival. So we owe a great debt of gratitude both to the Finnish Association and to Professor Tala himself. And it's a deep honor for me to give this lecture in his name.

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I'll speak to you today about health services that serve, what's the bottom line. And in this session I will talk about three things. First of all to outline the success of tuberculosis services which is our heritage and our history to compare this with other health services, particularly in low-income countries and to discuss what are some of the determinants of the quality of these services in relation to a comparison of them.

First of all, tuberculosis control. Now virtually all of you, or many of you, know this story very well, but I would like to underline certain aspects. First point, quoting from the official documents, is that the achievement of most health-related millennium development goals depends on overcoming health system constraints that hinder access, equity and quality of care. And the Stop TB Partnership it is quoted and stated is committed to be an active player in the health strengthening partnerships. So you can see already we have declared our position as partners in the struggle against tuberculosis, but trying to extend our knowledge and expertise beyond this to the general health system.

We need to understand where we have come from in tuberculosis, understand where we are in other health systems, and then create a report card for ourselves as to how well we are doing and where we need to go if we are really going to

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realize this commitment that's a written commitment of the Stop TB Partnership.

The hypothesis underlying this statement is that high-quality TB services will have an impact on improving health systems by sharing the lessons learned. So for those of you who understand epidemiology and clinical research well, we must always begin by a hypothesis. And we're going to, in the course of this presentation, address that hypothesis with what evidence that we have.

First when we talk about tuberculosis services, the current strategy for eliminating tuberculosis is dependent on the consistent delivery of high-quality service to individual patients. So prevention is based in care, and that care must be of high quality. And as we well know, this quality is regularly monitored.

And I would like to just review the experience we have in the Union from our partnerships within low-income countries. The focus of this strategy is on the new smear-positive cases of pulmonary tuberculosis because, first of all, there are certainly cases of tuberculosis. That's where it started. And it started there because it had to start somewhere, and this was the first step. It's not where it stopped, and it's not even where it stopped at the outset. All cases were encouraged to be treated, unlike what some people say, that at the outset of the DOTS strategy they were excluded. That was not the

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case. But the focus was on the new-smear positive cases because we were certain of the diagnosis. Secondly, they were the patients that are most vulnerable and at highest risk of dying. And thirdly, they are the most potent source of infecting other people in the community.

But from the very outset, the principle of success of treatment as an indicator of the quality of the services was brought in to bear on scaling up these services in developing countries. And the thing that was most new about the DOTS strategy was this focus on monitoring of the quality of care. Virtually all the other elements of the DOTS strategy had already been discussed and adopted in various fora at the international and national levels, but this indicator was the new addition to the DOTS strategy. And obviously progress in case finding, the other major indicator, is an indirect indicator of coverage of the population.

So if we summarize several examples, and these are just two examples from my own personal experience of cooperation with various partners. I had the wonderful good fortune to gather with the Norwegian Heart and Lung Patients Association to work together and learn from colleagues in Sudan and in Nepal over a ten-year period. And this is a summary of their reports of case finding in those two countries. And you can see, as has been shown many times, initially the cases of rises, then starts to plateau, and now we expect it will start

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to decline. And this is an indication to us, an indirect indication, that we are reaching the targeted patients and that we may be able to demonstrate an epidemiological impact.

Now when we look at this indicator of quality of service—treatment success—and we say that our priority, at least in the Union is to work together with partners in low-income countries, the question arises, can low-income countries achieve good success, or is this dependent on the level of their wealth. And if we just plot the gross national income per capita in U.S. dollars against TB treatment success as reported on the website of the World Bank, you can see there's no relationship whatsoever. Now that's illogical. There should be a relationship.

Clearly the resources available should—if there are more resources—contribute to improve quality of care, but that's not the case in the DOTS strategy. We have been able to uncouple the necessary relationship between resources and quality of care. So this is one of the key achievements of the DOTS strategy, and now the new Stop TB strategy. We can deliver quality services in any community and in any country.

And we can see again, summarizing the case finding in Sudan and Nepal as the cases rise, plateau and begin to decline. Previously we've shown you treatment success, high-quality success even from the outset, but then extension to

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increasing numbers of cases but able to sustain the quality of successful treatment.

Now the question arises, will this strategy prevent tuberculosis? And the strategy is focused on preventing tuberculous infection in children in order to gain a generation of children who are infection-free, and therefore to break the chain of transmission and to eliminate the disease. Well evidence to show that this can be achieved in a poor community is very sparse. One piece of evidence that I know of is evidence from the Beijing municipality of China.

Now many people are well-aware of the preparations for the Olympic Games, and you see on your television these beautiful buildings and the big avenues, and the traffic, et cetera. But Ritva and I both know, having visited China over many years and particularly Beijing, that prior to the year 2000 the area, particularly the rural area of Beijing, was a very poor area indeed, and there was little economic progress from the end of the cultural revolution until the later 1990s.

So it was a community affected by limited resources. And yet with the introduction of modern chemotherapy and modern treatment approaches which were equivalent to the DOTS strategy introduced in 1978 by my colleagues in Beijing under the leadership of Professor Kahn Wang Jing [misspelled?] extension to the entire community to all of the patients we could observe over the same period of time, a steady decline in tuberculosis

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prevalence, and in the incidence of tuberculous meningitis in small children under five years of age, which is an indicator of tuberculous infection. And tuberculin surveys subsequently performed have demonstrated that there's almost no infection in young children in this community.

So this is evidence that this might work. Now some evidence is coming from other countries that it doesn't seem to be working in the way we think, and we need to be cautious about our conclusions and rigorous in demanding the evidence that what we think we're doing we are actually doing.

So that's for tuberculosis. We think we know what we're doing. We have been able to demonstrate that we can deliver this in communities with very limited resources, and we can maintain high quality of services and monitor those services at a global level systematically over many years. This is a major achievement. There's almost no other disease in which this has been accomplished.

What about other conditions? We cannot just happily go into hospitals and clinics and outpatient areas and be proud of ourselves of what we have achieved in tuberculosis while beside our patients lie other patients with pneumonia, asthma and other conditions, and their care is of poor quality. It's ethically unacceptable for us just to be proud of our achievements and not care about the rest of the community and the other clients of the health services.

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And you can see that in the Stop TB Partnership we have all committed ourselves to improve this situation. But first we need to look at what is the situation. We look at the relation of these conditions to the wealth of the communities, the availability of routine indicators of quality and coverage of care, and evidence from special analyses. In this case we will refer specifically to our experience in a project called the Comprehensive Lung Health Services Project, which is funded by the World Bank.

First we look at certain measures of health, and disease and illness in relation to wealth. And here again we use the information available on the public website of the World Bank and plot gross national income per capita by the health index. For example, TB incidents, under-fives mortality, life expectancy in years and childhood malnutrition. It's quite clear from this plot that as income rises TB incidence declines. It's also clear that as income rises under five childhood mortality also declines. And it's also clear that as wealth increases life expectancy increases—not surprising—evidence that poverty and disease are part of the same picture.

But when we look at routinely-reported indicators of quality of service, we have very few of them. Looking again at the same website, the World Bank HNP statistics, we have listed four indicators. There are direct indicators and indirect

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indicators. A direct indicator is immunization coverage. It's more a process indicator than it is an outcome indicator. But the only real outcome indicator is tuberculous treatment success.

So we don't have very good information to know where we are at the present time and where we need to go. There are indirect indicators under-fives mortality rate and life expectancy that we showed you before. But we have little information on a systematic basis to know where we are and where we're going.

So we've been able to undertake a situation analysis in the project funded by the World Bank. We specifically selected sites for participation based on high-quality indicators of tuberculosis services, centers that have already reached the global targets and have sustained them over a period of time with a view to introducing other lung health services in the same institutions, but as part of this undertook a situation analysis prior to the intervention. And we did this systematic analysis—the situation analysis—prior to the intervention using clinical audit of consecutive cases in those institutions, and comparing that to internationally-recommended standard case management.

We selected three sites globally, one in China, one in Sudan and one in Benin, places where we have long-term cooperation and we know the situation particularly with regard

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to tuberculosis. And when we came to evaluate the quality of services for childhood pneumonia, for asthma and for smoking cessation, we used certain measures to identify the quality of care. First of all we asked ourselves, was there an adopted case management strategy for these conditions? Now all of these conditions have internationally-recommended strategies that health services are to be adopting, but in fact when we looked at it only childhood pneumonia had the internationally-recommended standard case management adopted in any of these institutions.

When we looked at indicators of quality of care, we found that in no single instance, in spite of the fact that tuberculosis services were of very high quality, in no instance were the diagnostic and classification criteria on the standard case management applied to the care of the other conditions. Essential drugs were never assured, and on many occasions there was rupture of stock with patients going without treatment.

There were inadequate practices that were routine. The diagnosis of treatment was not based on the evaluation of the patients, and there was no routine monitoring in evaluation in place for any of the conditions. These are simple things that we all know about in tuberculosis care, and yet none of them were there for the other conditions in the same institutions where tuberculosis care was good.

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And if we tried to look at an indicator related to the other conditions such as under-fives mortality in relation to TB treatment success, we don't see any relationship between the two. So there's no empirical evidence to suggest that where we have been able to successfully introduce tuberculosis services it's had any impact whatsoever on what indicators we do have available.

So we have a dilemma. We say that this is what we intend to do. Up to now we have no evidence that we're achieving it, and we need to analyze the situation to understand why that is the case. When we look at the health services we need to look at expenditure and it's relation to wealth; that is to say, do rich countries spend more on health than poor countries? And Anne Fanning showed us in the previous session on the symposium on ethical considerations that in fact where the need is the greatest the expenditure is the lowest.

Secondly, is there investment in the public services for health? Thirdly, what are the characteristics of the human resources in these health services? And finally, what mechanisms are there for quality assurance and quality improvement in the health services in general? Well if we look at health expenditure in the—look at expenditure of financial indicators, that is, growth national income per capita in relation to public expenditure on health per capita, there's

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not much of a relationship. This seems to be a political issue that's not necessarily related to the availability of resources, again referring to the World Bank statistics. If we look at human resources for health care and health services we can look at absolute levels, we can look at critical shortages, we can look at policies for creating and retaining personnel, and policies for supporting those personnel.

Here from the World Health Report of 2006 are the human resources, the health work force per thousand population in various regions. And obviously there are more health care workers per population in the Americas than in Africa. There's a huge differential by location. And in fact from that same report we can look at those countries identified as having critical shortages of health service providers. And you see the map looks almost like the map of distribution of the tuberculosis problem, the poor countries having the greater critical shortage of health services personnel, so one of the issues clearly is the issue of health personnel and their ability to deliver services.

Another map looking at a global distribution is this map that was published in the *Guardian Weekly* some time ago. And this map shows us what happens to people who are trained at a high technical and scientific level in terms of whether or not they stay in their own country. And you can see in exactly the same areas where the health work force crisis is the

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greatest, we have the greatest out-migration of those who are being trained. So obviously one thing that's needed is to create more—a stronger workforce through training, but it's no benefit if we train them and they simply move away.

And if we look at this issue of migration, here is one study from Uganda that shows the out-migration of health care personnel in the years 2001 and 2002. And you can see that a substantial proportion of the existing health workforce moved out of the country, and you can see where they went—to the United Kingdom, to the United States and to other countries of Africa. And why did they go? The survey asked the question to those that were interviewed, and they reported the following reasons. First of all, to gain experience—hopefully to gain the experience and come back again, but we don't know. Secondly, because they were recruited by other countries. Okay, who are these countries that are recruiting the health workforce in an environment where there's a critical shortage of health personnel? And we need to examine those policies. Obviously the United Kingdom is doing it, obviously the United States is doing it, and obviously other countries of Africa. We're not going to say which are those countries of Africa, but one can guess just thinking about it, and we need to think about these kinds of policies.

Thirdly, they pointed out that they have no future in their home country. How sad to think that you have to move

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away from your home because you think you have no future.

Fourth, they sited better conditions of work in the place they were going to. And finally, they indicated that they can make more money. These are all normal human reasons to move with the exception of being recruited by other groups.

Here's another study about migration of health personnel, in this case in Malawi, looking specifically in the years 2002 to 2007. Now Malawi—we'll remind you from the WHO assessment—has a staffing level of 0.5 nurse per thousand population, or 1 nurse per 2,000 population. They have a vacancy rate in their health system of 42%, that means to say that there are posts, but no one to fill them. And in our experience in collaborations with partners in Malawi, we meet conditions like a half or full-time equivalent nurse in a ward for ninety very ill small children. So it's a true and critical shortage. Now where did these Malawian nurses go? Well this pie diagram shows you—again, United Kingdom North America and then other countries. And again if we ask them why did they go, I'm sure they will cite the same reasons.

Now we have good news on this study because it was a study over a long period of time in which this was a major and critical issue in the quality of care in health services in Malawi, but the policy was change to improve the remuneration of the nurses in the latter two years of the study, and the out-migration drastically dropped.

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Clearly out-migration of nurses from Malawi has been high, at a high level historically. It's mainly to the United Kingdom because the nurses have reciprocity there. This was changed when remuneration was increased and is now drastically reduced, but internal migration continues. Nurses and other health professionals leave the public services to join NGOs and other internal groups and going into private practice. So what are the policies that we can use and we'll let Malawi use to some extent to support our health services personnel? If they're moving out because their conditions are not good, then we need to understand how to support them.

We need to pay attention to mobility within the health service. We often find that people are trained, understand the task, but then they're shifted to another post. We need to look at that carefully and how it affect people's point of view about their work and satisfaction with their work situation.

Secondly, we need to look at remuneration and incentives. If we keep on training people and they keep on leaving and then we have to retrain people or we have absent posts, we cannot gain for the health services and it costs a lot of money. We need to be much more imaginative in redirecting our resources to retaining the staff we have by improving their remuneration for their work and looking at incentives.

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And finally the issue of survival of the personnel—Tony Harris in the first plenary session of this meeting showed how the death of health services personnel is a major issue particularly related to HIV and AIDS. And we need to think of ways to prioritize HIV/AIDS services to insure that these individuals stay alive and stay productive.

Now what are the mechanisms that we know from our experience to improve and assure the quality of health services? First of all is standardization of practice. Second is monitoring and evaluation. Third is supervision and training, and fourth is setting priorities for the health services. Well how do we standardize practice? First of all, we need a definition of standard case management. And in the conditions we just talked about they are already there but not being used. Secondly, we need to identify the essential elements—drugs and tests. Thirdly we need to insure that these elements are continuously available. It's the DOTS strategy all over again for the general health service.

What about monitoring and evaluation? Clearly recording tools are required that meet the needs of the service providers. Not recording tools that are designed for epidemiological purposes or for somebody else offsite. These should be tools that improve the efficiency and quality of care of the individual patients. And we do this by insuring that they're simple and essential, and that they're required for

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care. All of us are tempted always to increase the complexity of this system, and we all know the processes we've been going through recently trying to collect more and more information. But there's a rate limit to that after which we gain nothing and, in fact, start to lose something.

We also need to pay attention to the collation and analysis of these results at a local level. As we move to more sophisticated methods of recording and reporting, particularly as we take advantage of the advances in electronic systems et cetera, we must never forget that the main purpose of collecting this information is to inform the local service providers. And by introducing the more modern methods, we need to insure that this function is not lost.

And finally what we've learned through our experience in tuberculosis is that peer review is essential to share lessons learned, to share how problems can be solved on a local level within the context of standard case management.

We need a supporting structure. Here we have the typical supportive structure for tuberculosis that we know works. We have the service providers, we have a basic unit of management that provides quality assurance of that care, we have the regional level that provides the training and supervision, and finally the central level that provides—among other things—policy, planning and coordination. This is

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present for tuberculosis, it's not present for many other diseases.

And if we look at the investment in these support services, again going back to the World Health Report of 2006, we look at the workforce per thousand and the percentage of investment in support staff among the various regions. We can see that where the need is the greatest and the health service personnel is most critically limited, the investment in management and support services is lowest, so once again, a key element in introducing, assuring and improving the quality of care.

What about priority setting? Here's a study from a Ugandan hospital looking at priority setting in that hospital. There's a case study of a 1,500-bed national referral hospital. The study conducted in-depth interviews analyzed by a modified humanic approach. And what they found was that the priority setting in that hospital in no way met conditions of fairness. Now those of us from wealthy countries know that this is certainly the case in wealthy countries, but it's also the case in poor countries where the inequities are greater. And as usual, special treating and status influence the priority setting even at that location where the need was the greatest and the disparities were high.

So what's the bottom line? We know that we can deliver high-quality tuberculosis services anywhere, no matter what the

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resources of the community. We know that this is possible. But we have no evidence whatsoever that this has contributed to strengthening of other priorities services in the same institutions. Now we have committed ourselves. We are the Stop TB Partnership. We have committed ourselves to change this. But if we wish to change it we must do it explicitly. It will not happen by chance. Thank you very much.

[Applause]

**RITVA KAUPPINEN:** Thank you. Thank you very much, Don, for your excellent presentation which I think started in every mind the critical thinking for that what we are doing, what we should do, what we should not do. So we have time for some questions from the audience. Please. Are you so astonished and critical now that you even can't stand up and do some questions?

It's just now we are in the situation that in many countries we have the plan starting from the TB services to taking part for the other—the public health services. And as you say, that is easy to calculate these TB measures and that what we have done. But now we are in the situation also I think the other results. Okay, Thanks.

**SALING WEI:** Hello, Saling Wei [misspelled?] from China. Probably I can share a little bit experience how our recent consortium, funded by DFID in several countries, one is that I'm not [inaudible] from Pakistan we did in the EQA, is

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translated into the malaria control. Nothing is that way from TB. We developed the guidelines in terms of district implementation planning strategies for overall of the health system, which has been utilized in several places in Pakistan. Only in China what we did is like a decentralizing the TB surveys from the TB dispensary to the township hospitals, which is a county integration of the TB vertical system with horizontal primary health care system. And in this way they improve the quality of care and improved the situation links between the disease control department in the country with the township hospitals. Thank you.

**RITVA KAUPPINEN:** Please go on.

**ASMASONI:** Asmasoni [misspelled?] from Sudan. Don, how do you envision is the complementarity [misspelled?] that rural healths can make in health services?

**DONALD ENARSON, M.D.:** Again, I didn't-

**ASMASONI:** I said rural health's involvement, of rural health. There are other players in rural health.

**DONALD ENARSON, M.D.:** Sure. Clearly as we move forward we have to document where the needs are, and you're talking about rural health, distribution of population and, in fact, what you didn't underscore was migration of population. Obviously what we need to do as we move forward is to get a general system of evaluation, that's systematic as we've done in TB, something quite simple that we then track and trace as

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services—in the services that are being provided to find out where the problems are the greatest. And that will immediately identify issues, for example, geographical distribution.

But it probably won't identify and is becoming an increasing challenge both for TB and for other services is the issue of migration of population. And certainly recent studies that we've been able to do together with colleagues in China show that in spite of big examples, for example, in Beijing municipality, the lack of attention to the migrating or what they floating populations is going to be a risk for them. But I think we need to establish simple methods for monitoring so we know where the problems are.

**RITVA KAUPPINEN:** Okay.

**DR. AMIR ARMAHAN:** As a professional of this health system strengthening, especially the model of establishing the strong TB services and then trying to move out across the diseases and across the systems, there is a need for better communication at group level, maybe, between the TB authorities and other disease-control set-ups. And this coordination and communication need to trickle down to lower levels including the national, and sub-national and district levels, because at our end we have limitations in terms we can focus on district and facility levels. But there is a more strong support needed from the international bodies for convincing the national level programs and others who put serious effort in these directions,

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because there are certain barriers which need be addressed if we really want to make some achievement in these directions.

**DONALD ENARSON, M.D.:** I fully agree with you, and when you speak about the international bodies in our environment, clearly the governmental bodies such as the UN system and the non-governmental bodies, for example, the Union. And I think we need to think about what our various roles are. Clearly establishing policy, and setting policy and promulgating policy is the role of the UN system and particularly the WHO. But then we need to think about what we can do in the Union. And my guess is if we did a survey of the people in this room, most of you do not exclusively look after TB patients. So we're already there with the lessons we've learned, and yet even in our own practice we haven't extended those lessons to the other services, so we need to think of ways that we can try to do that and model, and provide information for the policy makers to develop those policies. But I think we need to think very clearly what is the union's role? What is our role together in contributing to health system strengthening. Clearly there's a problem, clearly we're not yet addressing it. The question, is what's the way forward? And I invite you all to join our new working group on health system strengthening. And Amir [misspelled?], I'm sure you're going to take the lead, aren't you?

**DR. AMIR ARMAHAN:** Thank you.

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**RITVA KAUPPINEN:** Yes, please.

**KATIA:** Thanks. I'm Katia from the [inaudible]. I have a question about the PPM component of the Stop TB strategy and I would like to hear your opinion about the fact if the PPM strategy might divert attention from the health sector strengthening, because this is still for me quite controversial. In Asia we have a very large private sector, and it's definitely necessary to involve the private sector in the TB control to make the impact of a TB control. But from the other side I feel doubting about the fact this might somehow reduce the gravitation from the health sector. This is the first.

And then a second question, maybe I understood from the previous one might be not example, but if in other countries where policies have been already set up and tested to better address the problem of the in-country migration and policies to organize a bit better UN agencies and NGO in the use of skill stuff, if they account the examples in that. Thanks.

**DON ENARSON, M.D.:** Okay. I understand you to be posing two questions. One is about private/public mix, and the second is about internal migration of the health workforce. First of all about engaging the private sector in tuberculosis services, when Mukund Ufnicar [misspelled?] asked me to write something in the introduction to the publication of the World Health Organization on private/public mix, first of all I was

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honored and surprised that he asked me. But it gave me the opportunity to point out that it's not a question of involving the private sector in tuberculosis services, because they're already involved.

Every survey that I know of the private sector in relation to tuberculosis shows that private practitioners are caring for TB patients, so they're already there. So it's not a question of involving them, it's a question of supporting them to improve the quality of their care. Sadly most of the studies I know where specific actions are not taken to strengthen the quality of care show that the quality of care is very poor. Even though patients or clients prefer those services for various reasons, in fact the quality of the care is usually not very good. So I believe it's not a question of whether or not we need to do it, it's a question of how we are going to do it and it must be done.

But at the same time, as I said to my colleagues in Nepal when we discussed this question ten years ago, at a time when their TB services were just beginning to be strengthened, I said to them, if I was a private practitioner or if I was a patient I would never go to your public services. They're so awful. So at the same time that we need to engage in conversation with our colleagues in the private sector, we also need to strengthen the public services. And as the two go hand in hand, they don't have to be competition, they can certainly

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be complimentary. And as we observed in the Catland [misspelled?] New Valley in the fall, as the public sector services were strengthened, the private sector began to refer patients and the medications for treatment of tuberculosis disappeared from the private market. So I think we need to not look at it as an either/or. It must be done together. And wherever there are private practitioners they will be caring for TB patients and we must find a way to help them to improve the quality of their care.

The second question, oh yes, internal migration. I'm sorry, I'm getting old. I forget. The question of internal migration, I've seen a number of examples of this issue in various countries. And what I have seen as a means of successfully addressing this issue is when the public service, when the Ministry of Health establishes a policy and a guideline for this kind of remuneration. I've seen a number of examples. I just came back from Afghanistan a week ago, and in that setting the government has adopted a very imaginative strategy of creating what they call the basic package of health services and then outsourcing it to private providers who are largely NGOs. And this was an exciting and quite, I think, successful experiment as one way to strengthen the health service. Clearly the NGOs and others could provide a higher level of remuneration than the government could do, and of course that would contribute to an out-migration of the health

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workforce, but by restricting it's role to policy-setting coordination, supervision and quality assurance, the government had lesser need for the health services personnel and they could be liberated then to go to these private providers. And in fact the remuneration was related to the distance from the capital city and it was one of the rare occasions where I saw people electing to go into the rural area because they were remunerated better.

Other examples I've seen is where the government meets together with its partners in the private and NGO sectors and establishes guidelines of limits of things like per diems for attending training courses, a salary scale, et cetera. And I think that these are issues that need to be brought together. But the leadership needs to be with the Ministry of Health.

**RITVA KAUPPINEN:** Thanks. Okay, now we have too still time, I think, because we started a little bit late, for two questions. There in up first, then in down. Please.

**HAMADASSAN:** Yes. I'm Hamadassan from Afghanistan. Thanks for Dr. Professor Donald that visited our country. But I have a question that our country is still suffering from the lack of consultants. And we are receiving some consultants with very good intentions, but whenever they're leaving the reckon [misspelled?] is still existing. So I'm just asking for your suggestion to cover this issue in both in short term and long term, how to cover it. Thank you.

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**DONALD ENARSON, M.D.:** What I saw agrees very much with what you've just said that your country faces dramatic challenges in scaling up and delivering services throughout the country after 25 years of destruction of those services. But I'm incredibly impressed with what you've been able to achieve in a very short number of years in service provision. But I agree with you that you will still have those vacuums from time to time but it will require a medium and long-term strategy in order to overcome those.

But I think you must be encouraged by the fact of what you've been able to achieve in a very short period of time, and not just for TB but in general for the health services. So I congratulate you. I was very impressed with my visit. I don't have any easy answers for you, but I sympathize with the problem.

**RITVA KAUPPINEN:** And the last one.

**MARINA GAVAMIKUENA:** Marina Gavamikuena [misspelled?] from South Africa. I would just like to ask what the Union is doing to try to discourage or put a stop to the rich countries poaching from the poor countries, the personnel. Because it doesn't matter how much we try to—or our poor countries try to raise the salaries. For instance, even here in South Africa there have recently been quite a remarkable improvement on the salaries of the net in personnel. But the fact remains that we can never catch up with the skills of the UK and the U.S.A. So

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I feel that the Union ought to have a weight with the countries which are continually recruiting actively even from within our country here and also from abroad that they try and discourage this kind of poaching. Thank you.

[Applause]

**DONALD ENARSON, M.D.:** I fully support your observation, Professor Gavamikuena [misspelled?]. And one of the things that the Union can do is first of all to present the results, name and shame. Who are the countries doing it? The United Kingdom, the United States. But remember there was another African country that's doing it. And guess who that African country is? I'm not going to say because I want to be a polite person. But it's a universal problem, and it's a problem first of all that we need to talk explicitly about, and we need to expose in the media.

In the United Kingdom, for example, there was a lot of discussion and a lot of criticism, and the government came out and said no, no, we don't have a policy like that. Of course we don't have a policy like that because we outsource it to private headhunters who do it and then we can say we don't do it. So let's expose the hypocrisy first of all. So if we want to do these kinds of unethical practices we have to say we choose to do unethical practices and not say we want to help poor countries but we want to steal all their health workforce.

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But we also need to be honest with ourselves, because it's a cascade. It's not something that just happens in the United Kingdom and the United States, it's a cascade coming from Ardicongo [misspelled?] to the next country and then finally into South Africa and then out to the rest of the world. So we need to be explicit about it, we need to talk about it, we need to expose it, we need to insist that if people continue to do it that they have to admit that that's what they're doing. And then if they continue to do it, look at course of mechanisms to prevent them from doing it.

**RITVA KAUPPINEN:** So I think it's now time for closing this session. I thank you once again this Professor Enarson for this very nice and excellent presentation. Thank you.

[Applause]

[END RECORDING]