

The Failures of Privatization: A Comparative Investigation of Tuberculosis Rates and the Structure of Healthcare in Less-Developed Nations, 1995–2010

KELLY F. AUSTIN, CRISTINA DESCISCILO and LENE SAMUELSEN*

Lehigh University, USA

Summary. — Tuberculosis remains a persistent global health problem and key threat to development in poor countries. While many nations pursue privatization of healthcare, some accounts suggest that private health services are inadequate in addressing the TB burden. We utilize panel regression to empirically investigate data from 99 less-developed nations from 1995 to 2010. The results illustrate private health expenditures do not significantly impact TB rates, while public health expenditures reduce TB rates in developing nations over time. Thus, we caution against international development strategies which promote cuts in public spending and encourage privatization of healthcare as a means to stimulate growth or efficiency.

© 2015 Elsevier Ltd. All rights reserved.

Key words — tuberculosis, privatization, health, HIV, development

1. INTRODUCTION

Despite declining global rates of tuberculosis (TB) during the majority of the 20th century, efforts to eradicate the disease among poorer populations have been unsuccessful, where TB continues to represent a leading cause of death and underdevelopment (World Health Organization., 2012). The 2012 WHO Global Tuberculosis report notes that in 2011, 8.7 million people were infected with TB, resulting in nearly two million TB deaths (World Health Organization., 2012). Often considered to be an “old” or “forgotten” disease, the resurgence of TB, including into new drug-resistant forms and co-infection with HIV, makes this infection one of the most pressing current global health issues (Farmer, 1997, 2001; Gandy & Zumla, 2002; Lönnroth, Jaramillo, Williams, Dye, & Raviglione, 2009; WHO, 2012).

Patterns in international development and TB prevalence are deeply intertwined as over 95% of TB cases and 98% of TB deaths occur in less-developed nations (World Health Organization., 2012). Sub-Saharan Africa, the most impoverished region of the world-system, faces the highest TB burden and even hosts areas where rates of TB are increasing over time. For example, in Swaziland, TB incidence rates during 1990–2010 increased from 267 cases to 1,147 cases per 100,000 people (World Bank, 2013). Although poor and vulnerable populations tend to be most susceptible to the virus (Huffman, Veen, Hennink, & McFarland, 2012), other analyses depict within less-developed nations, TB has also been known to afflict more affluent and educated populations. Furthermore, TB often infects both males and females, as well as youth, adults, and the elderly (Basu-Khan, 2012; Kim *et al.*, 2005; WHO, 2012). This suggests the current patterns in TB stem from larger structural, socio-economic conditions, rather than individual behaviors or characteristics.

TB is very easily transmitted from person to person, and represents one of the most difficult infectious diseases to treat. For example, minimum therapy for uncomplicated cases involves six months of therapy using at least four different types of antibiotics (e.g., WHO, 2012). Given the continued and emerging complexities with this disease, and especially

the challenges to treatment under conditions of increased antibiotic resistance, the structure of healthcare provisions potentially represents a key factor explaining cross-national variation in this pandemic.

Healthcare systems have greatly transformed since the 1980s, especially in less-developed nations, as neoliberal development strategies call for a reduction in public provisions and increased privatization, along with a host of other reforms seeking to generate economic growth and efficiency through deregulation, commodification, and financialization (e.g., Arrieta, Garcia-Prado, & Guillen, 2011; Bunday, 2014; Collyer & White, 2011; McMichael, 2012; Obeng-Odoom, 2012; Wilder & Lankao, 2006). Indeed, the privatization of healthcare and social services represents a polarized debate in the broader global and public health fields (e.g., Basu, Andrews, Kishire, Panjabi, & Stuckler, 2012; Collyer & White, 2011), as well as in international development literatures (e.g., Arrieta *et al.*, 2011; Herrera, 2014; Maclean, 2011; Wilder & Lankao, 2006). Perspectives and ideologies rooted in economic modernization and liberalization argue that economic growth and privatization represent the best ways to improve health in poor nations (e.g., Firebaugh & Beck, 1994; Pritchett & Summers, 1996), and some studies indeed demonstrate private clinics may have shorter wait times and are more attentive to patient needs than public providers in less-developed nations (e.g., Basu *et al.*, 2012).

However, the upswing in healthcare privatization and claims of enhanced efficiency do not appear to be trickling down to reductions in health inequalities (e.g., Collyer & White, 2011; Lambert *et al.*, 2005; Obeng-Odoom, 2012; Wilder & Lankao, 2006). In fact a growing body of evidence questions the quality of private healthcare services, especially in developing nations, including issues with lack of regulation, the prescribing of unnecessary antibiotics or treatments, and poor knowledge and diagnosis of common infectious diseases among health workers (e.g., Basu *et al.*, 2012; Gbotosho *et al.*, 2009). The limitations to private healthcare may be

* Final revision accepted: October 3, 2015

particularly relevant to the increasingly complex nature of TB, especially antibiotic resistance (e.g., [Arrieta et al., 2011](#); [Lu et al., 2010](#); [Maclean, 2011](#); [Naterop & Wolfers, 1999](#)).

While current literature begins to scrutinize the characteristics and effectiveness of public and private healthcare systems, the bulk of this research represents case-studies or individual-level analyses of a particular country or locale (e.g., [Arrieta et al., 2011](#); [Gbotosho et al., 2009](#); [Lambert et al., 2005](#); [Maclean, 2011](#); [Naterop & Wolfers, 1999](#)). There is lack of comparative analysis examining the role of both public and private healthcare across developing nations, as well as for specific health measures, such as TB rates. Researchers have not yet considered that the effects of privatization likely vary depending on the health outcome under investigation; TB may represent an important and relevant starting point for careful empirical comparison of the efficacy of public and private healthcare systems across nations. As over 3 billion people represent latent carriers of TB, and addressing active cases requires careful and intensive intervention from the health sector, TB signifies a persistent and pervasive global health concern keenly tied to international trends in health service provision.

While social-scientific research on TB increasingly recognizes the importance of large-scale social and economic factors in explaining trends in this infection ([Bates et al., 2004](#); [Farmer, 1997](#); [Gandy & Zumla, 2002](#); [Lönnroth et al., 2009](#)), very few comparative studies of TB exist (see for exception: [Austin, 2015](#); [Maynard, Shircliff, & Restivo, 2012](#)). To properly make sense of the global dynamics of the TB pandemic, including the broader influence of increased privatization and the retrenchment of the state as a provider of healthcare, we utilize an analytical framework that explores the comparative structural determinants of TB rates across less-developed nations over time. Cross-national assessment allows us to more appropriately understand the wider context in which the persistence and resurgence of TB occurs, and how this may be linked to commercialization of the health sector in developing nations.

2. THE CHARACTERISTICS OF A PERSISTENT PANDEMIC: TUBERCULOSIS

Tuberculosis is a communicable disease that has plagued human societies for thousands of years. Since its first documentation in 8,000 BC, TB has severely impacted populations in all corners of the world, and it even represented the leading cause of death among people of Europe and North America in the 1800 and early 1900s ([Farmer, 1997](#)). Early explanations of TB link transmission to increased population growth and the concentration of populations in crowded cities ([Lönnroth et al., 2009](#)). Indeed, epidemiological characteristics reveal that TB is easily transmitted between people, and in fact can be acquired without sustained or intimate contact, as the tubercle bacillus remains active and infective in the air for hours after coughing ([WHO, 2012](#)).

Rates of TB fell rapidly in more affluent nations over the course of the 20th century. Often attributed to the development of antibiotics and other interventions in the 1940–50s, much of the decline in TB rates actually occurred before these advanced medical interventions became widely available, and the reduction was more likely due to improvements in basic health conditions and provisions ([Riley, 2005](#); [Soares, 2007](#)). Once global TB rates began to fall, it became a “forgotten plague” in the United States and other developed nations, where individuals currently very rarely encounter the disease ([Farmer, 1997, 2001](#)). However, medical efforts to combat TB in poorer societies have not been successful, and TB

represents a continued and growing threat to health and well-being, especially in regions of Sub-Saharan Africa, Asia, and Latin America ([Bates et al., 2004](#); [Lönnroth et al., 2009](#); [WHO, 2012](#)).

The TB virus, or tubercle bacillus, is a contagious respiratory infection transmitted through the air, which initially attacks the lungs and also can compromise the kidneys, spine, and brain ([Center for Disease Control \(CDC\), 2012](#)). Sputum smear microscopy is the most common tool to detect TB worldwide, and early diagnosis is a key factor improving the success of treatment ([WHO, 2012](#)). There are two different strains of TB: latent and active. Carriers of latent (or dormant) tuberculosis cannot infect others and do not suffer from any symptoms. The latent form of TB does not cause active disease in all who are infected, and as previously mentioned, estimates indicate around 3 billion people represent carriers of this form of the virus ([Bates et al., 2004](#); [Huffman et al., 2012](#); [Kim et al., 2005](#)). In contrast, active tuberculosis produces debilitating symptoms of cough, weight loss, and fatigue, is highly contagious, and if untreated often results in death ([Center for Disease Control \(CDC\), 2012](#)). Unlike many other infectious diseases, TB can also re-emerge in the same individual several times later in life even after they have been effectively treated.

TB has harmful impacts on economic growth and successful development, as major segments of the population can suffer from debilitating symptoms that cause them to be less productive, miss work, or become unemployed ([Bates et al., 2004](#)). TB also represents a major strain for household poverty, as the treatment for TB can be expensive and needs to be closely monitored. In fact, the propensity of the TB virus to acquire drug-resistance to a single agent requires the use of multiple drugs administered over a significant amount of time to be completely effective. As previously mentioned, standard “short-course” treatment for TB consists of 6 months of therapy using four different first-line anti-TB drugs ([Bates et al., 2004](#); [Center for Disease Control \(CDC\), 2012](#); [Kim et al., 2005](#)). However, medical professionals diagnose a growing proportion of cases as multidrug-resistant tuberculosis (MDR-TB), which is highly resistant to the gamut of first-strain antibiotics and many secondary interventions, including the two most potent TB drugs, isoniazid and rifampin ([Center for Disease Control \(CDC\), 2012](#); [Kim et al., 2005](#)). Since a little more than a dozen effective anti-TB agents are presently in use, the emergence of superstrains resistant to all known drugs is a serious global health threat for populations worldwide ([WHO, 2012](#)).

MDR-TB can be directly transmitted from person to person. It can also develop in a new case if people receive intermittent or poorly executed therapy ([Bates et al., 2004](#); [Harper, 2010](#); [Kim et al., 2005](#)). As poor nations have inadequate health provisions or poorly integrated health systems that promote unsatisfactory interventions, it is likely the emergence of MDR-TB is not solely a medical phenomenon or the “patient’s fault” for not adhering to prescribed treatment, but linked to structural inequalities in access to adequate healthcare. In fact, some studies report only around 15% of patients worldwide receive adequately supervised TB treatments ([Gandy & Zumla, 2002](#)). However, development of MDR-TB in patients is often portrayed as their failure to respond to therapy, or essentially issues of patient compliance. The patient’s agency – their ability to comply with costly and difficult regimens – is exaggerated in many medical reports ([Farmer, 1997, 2001](#); [Gandy & Zumla, 2002](#); [Harper, 2010](#)). As Paul Farmer notes (1997:353), “Throughout the world, those least likely to comply are those least able to comply.”

In addition to lack of accessible medical resources in less-developed nations, limited education and knowledge of disease

Download English Version:

<https://daneshyari.com/en/article/7393294>

Download Persian Version:

<https://daneshyari.com/article/7393294>

[Daneshyari.com](https://daneshyari.com)