Health McDonald’s down the Desert

THE CORE

Sub-Saharan Africa is the epicentre of the TB/HIV eruption. More than 28 of the 650 million inhabitants are HIV infected, 35 % of these have TB also, and the numbers increase. As a direct result, in many countries life expectancy is falling, flagging rising health inequity in the world. Globalisation cannot proceed leaving a continent behind to die. Only unprecedented action can counter the scale and speed of this disaster.

Biomedical R&D has been activated over the last decade to generate vaccines, better drugs and new diagnostics. Although badly needed, and new products probably underway, major breakthroughs are not yet in sight. However, the impact of existing products on the dual epidemic can increase by an order of magnitude, if western aid could be directly used to treat people and serve populations. To make that happen, innovation of health service delivery is a prerequisite. The proposal is to invest one billion USD over 3 years to develop, build and run a TB/HIV health centre franchise all over sub-Saharan Africa. There is sufficient agreement amongst experts to package TB/HIV prevention, cure, and care into a franchise formula. The formula has two major terms: (1) effective health service delivery, (2) continuity.

The potential of this new tool is tremendous, it will stimulate global participation at all societal levels, increase resources and in-kind support, bypass bureaucracy and dysfunctional administrations, connect aid directly to health service delivery, allow rapid up-scaling, provide direct coupling with R&D and introduction of new products, create cost effective back-up systems, co-ordinate drug procurement, standardise training, mobilise people, etc..
The system can be built in three overlapping steps: (1) develop the franchise formula, (2) create the conditions for implementation and (3) implement the plan. If taken on professionally this innovation can counter in scale and speed the dual epidemic

THE CASE

Differences in health increase globally. Populations south of the Sahara dominate the lower end of the scale. Sub-Saharan Africa holds over 70% of all HIV/AIDS cases, and tuberculosis is at an all time high and rising.[i] Life expectancy, low already, is falling in many countries in that part of the world. TB will not diminish as long as prevention and care of HIV/AIDS fail[ii]; the two diseases are entwined in a deadly relationship.

In the developed world concern is growing about the devastating situation in sub-Saharan Africa, and there is an increasing willingness to help. Recently more money has become available and there is more underway. However, a huge, three dimensional hurdle renders the transformation of western aid into effective sub-

Saharan prevention, cure, and care, slow and inefficient. The dimensions are political-administrative, infrastructural-technical and socio-cultural.

Since 1989 globalisation is a major driving force in international politics. It holds the promise of a joint responsibility for health around the world. As yet we are far from it. The numerous structures, schemes, sticks and carrots of the developed world to make aid available to the sub-Saharan nations change continuously, and show limited coherence. The developing countries, with their weak and in places corrupt political and administrative machinery's, carry the responsibility to transform aid into effective prevention, cure, and care. Impact on health remains limited.

Increasing support for sub-Saharan Africa comes directly up against problems due to lack of infrastructure in the broadest sense. Health systems, facilities, available technology, and human resources are far below the level needed to implement the necessary health interventions. Medical professionals leave the area. Health sector reforms are ongoing in many countries but it is hard to see significant impact on the quality and quantity of health service delivery. TB and HIV are, as noted above, still increasing.

Socio-cultural conditions, poverty, illiteracy, crowding, and sexual behaviour in particular, all promote the spread of the TB/HIV epidemic. The diseased carry a stigma which often leads to social exclusion. Consequently there is little to be gained and much to loose to learn one's HIV status. Therefore the vast majority of patients go undiagnosed. Many deny the existence of HIV/AIDS as a separate lethal disease. Even in hospitals, tuberculosis without and with HIV/AIDS are sometimes indicated as TB1 and TB 2 respectively. Societal openness and change in behaviour are critical for effective public health interventions.

Globalisation cannot proceed leaving a continent behind to die. To move forward the world must face this human disaster with innovative interventions, and new tools, matching the scale and speed the TB/HIV epidemic. The question is how to bring as soon as possible effective and efficient prevention, cure, and care directly to sub-Saharan Africa. How to buy with one billion dollars over 3 years, many billions life-years in health ?

WHAT TO DO

This is not the place for technical details of TB and HIV/AIDS prevention, cure and care. A bird's eye view of available interventions and R&D efforts suffices to identify the key problem and subsequent choice.

There are no vaccines available to prevent HIV/AIDS or infectious TB in adults. Infectious TB can be cured with antibiotics for 6-8 months (DOTS). This reduces, in the absence of HIV/AIDS, the spread of the disease. HIV/AIDS transmission can be diminished by changes in sexual behaviour. HIV/AIDS cannot be cured but treatment with anti-retrovirals (ARVs) causes viral load to fall, health to improve and life expectancy to increase dramatically. Resistance against ARVs can develop over time forcing to change the combination of drugs used. Evidence is building up suggesting that treating HIV/AIDS patients with ARVs also causes TB to fall steeply[iii]. Reducing TB and HIV/AIDS is thus in principle possible. However, with pressure rising to fully implement the interventions, it has become clear that the systems in sub-Saharan Africa lack the capacity to deliver the goods.

Effective vaccines, better drugs and simpler diagnostics for TB and HIV would be a great help in disease control. It is therefore reassuring to note ongoing R&D efforts, expanding over the last 10 – 15 years through increased interest, earmarked funding, specific schemes and product oriented organisations. However, Nixon's war against cancer showed that even more funding for biomedical R&D does not necessarily lead to breakthrough products. Some biomedical nuts are just too hard to crack in a pre-set time. The signs of progress in TB/HIV R&D are promising. There is commitment, support is still growing, and clinical trials (last steps in the value chain before production and marketing) are underway, but new, major breakthroughs are not in sight yet.

In summary, there is no silver bullet to bring instantaneous cure to patients suffering from TB/HIV, there may never be one, but ordinary bullets are available and better ones are underway. The core question is: what good are bullets if there is no gun ?

INNOVATION IN DELIVERY

Any vaccine, drug or diagnostic, requires, irrespective of its potential, a functional, quality assured delivery system to have impact. In sub-Saharan Africa the lack of infrastructure, facilities and human resources in health are important determinants of the rising TB/HIV burden. This is the infrastructural-technical dimension of the huge, three dimensional hurdle mentioned above.

Delivery of products or service systems is the world of business. To assure the customer of quality, branding is effective. If the brand needs to be produced close to the customer[iv] and fast expansion is the way to go, franchising is an obvious choice. The *franchiser* and the *franchisee* share the same incentive: financial profit. This incentive makes franchise systems work. Elaborate contracts describe the rules, the rights and the obligations, dividing the profit between the two.

The incentive for a TB/HIV franchise network in sub-Saharan Africa is not money. It must be health for the people there. As profit, health differs essentially from money because it is not a transferable currency. This difference introduces another actor in the franchise system, one who values health sufficiently to pay for it. The people in the region served by the health facilities are the obvious party to play this role, individually as well as collectively. Unfortunately money in sub-Saharan Africa is too short to provide health for a vast majority of people. The unliveable consequences thereof constitute for the international community the growing incentive to invest in health in that part of our world.

From this logic, it follows that there must be an investment balance between the (people in the) region and the international community. Such a balance can depend for instance on the GDP; this is country specific and will change with time. It should be noted that health in sub-Saharan Africa has a different meaning for those who want to invest in it because they get healthier (*region/country*), than for those who want to help (*external investor*) . These considerations have consequences for the franchise system and the related contracts (see also table 1). Developing a TB/HIV franchise is therefore not just an innovation for health service delivery in sub-Saharan Africa it will widen also the concept of franchising itself.

Input from franchise experts, interested in the region, is needed to fully develop this tool. Nevertheless, at its conception the viability of a proposal deserves full attention. To address that point it makes sense to be more precise about the intended outcome and to provide some indication how the system could be developed.

OUTCOME

Overall the intended outcome of the TB/HIV franchise is to deliver effective health services in sub-Saharan Africa to bring the dual epidemic down. However, there is an inherently related, secondary outcome which needs to be build into the franchise formula: continuity. Whatever vaccine, better drug or new diagnostic will come from R&D, reducing TB/HIV to low levels will take more than two decades. A TB/HIV health centre franchise is not a 'wash and go', it is a sustained effort.

Continuity requires a healthy financial base. This consists, as indicated above, of the shifting investment balance between the (people of the) region/country on one hand and the international community on the other. The incentive for a region/country to take part as a reliable actor in the franchise is assured as long the added value of the centralised support, guaranteed per contract by the franchiser, outweighs the own input. The franchiser will not only control quality but also provide technical services, supply, education and training, R&D links, etc. (c.f. below).

Continuity as an outcome has yet another consequence, human resources. In the fast start up phase, contracting experts from the region may not meet the need. Experts from the North may be called upon to run for a limited period TB/HIV health centres. However, regional experts provide by far the best human resource base for continuity. This implies education and training as a central facility of the franchise system. It should be noted that a substantial brain drain of medical experts from the region is ongoing. Creating specific TB/HIV professionals might serve this initiative. No more is needed for TB/HIV franchised health centres, it shortens education and training time and limits emigration. Incentives for regional experts to take up this career are: free education and training, long term employment and respect from people.

HOW

The viability of the concept is rooted in clarifying what kind of actors have to be distinguished, their responsibilities and the functions to be taken care of. The ultimate goal being the continuous delivery of TB/HIV health services. Table 1 presents some initial suggestions

TABLE 1
Some suggestions for actors and functions within the TB/HIV health centre franchise system.

Actor *activities*	**Responsibilities**
Franchiser	▪ **concept development** ▪ **franchise formula and branding concept** ▪ **certification of franchisees** ▪ **contracts (ext. investor -, franchisee -, region/country -)** ▪ **fast system expansion** ▪ **central support**
central support	▪ *site selection and creation* ▪ *training and education* ▪ *procurement* ▪ *technical back up of TB/HIV health centres* ▪ *monitoring and quality control* ▪ *R&D links*
Franchisee	▪ **start up & running TB/HIV health centre** ▪ **quality services** ▪ **efficient management** ▪ **staff continuity** ▪ **operates under 'holder contract'**
centre operations	▪ *case finding and treatment; prevention* ▪ *recruitment for education and training* ▪ *ascertaining accessibility* ▪ *registration and reporting*
External Investor	**Donor, public or private, providing, under the 'external investor contract', specified financial or in kind support**
Region/country	**Community into which the system expands, obliged to provide financial /in kind support according to 'country contract'.**

A new international consortium composed of parties with a responsibility to invest in health in sub-Saharan Africa (NGO's, Industry, WB, G8, WHO, etc.), should be created to act as the franchiser. TB/HIV managers from the region, NGO's, existing health facilities, etc. could take as franchisee responsibility for one or a chain of TB/HIV health centres.

These suggestions should be regarded as options. Help from experts in development, health service delivery, business and franchising is needed to build the real thing. The options are presented to demonstrate the viability of the concept; the main proviso is that global participation must be developed to make it happen.

Time is lost every day. The scheme in figure 1 presents three phases which may be distinguished to develop and implement this plan. It provides a first feel; little more is functional at this early stage. In the first phase, developing the franchise formula, two components may be distinguished: (1) the content, i.e. the package needed for TB/HIV control at the health centre level and (2) the franchise structure, including roles, central and peripheral functions, incentives, contracts, etc. Obviously there has to be a close connection between these two components and an integrated reporting line to a central board where go/no go decisions can be taken.

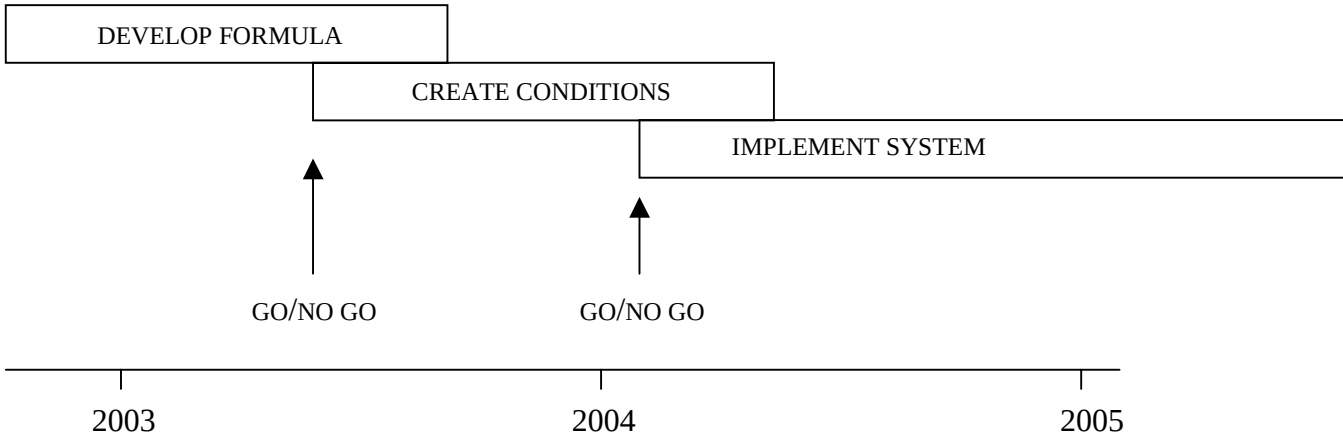

FIG. 1
A scheme of three overlapping phases of planning, and implementation for the TB/HIV health centre franchise.

POTENTIAL

A TB/HIV health centre franchise can provide a comprehensive, quality assured mechanism to use aid directly to treat people and service a population in distress. Shortcuts between people wanting to help and those who are in need are not new. They have been in existence in a large variety for centuries already, testimony to the responsibility man feels for his diseased neighbour. New are focus, scale and structure of the shortcut. Those are conceived to initiate, facilitate and accommodate global

participation; the world at large taking responsibility to treat this deadly epidemic. The time is right, the potential tremendous.

Distributing TB/HIV health centres over sub-Saharan Africa requires much more than one billion USD over three years, but this investment does allow to develop the TB/HIV health centre franchise system, to shape the necessary global process and to guarantee a successful start. Professional marketing of the concept can readily multiply this initial sum, the franchise system can effectively employ fast increases in financial and in-kind support from all levels of society. Critical selling points are: cost-effectiveness, quality assurance, rapid scaling up, adequate back-up system, coupling with R&D, regional participation, targeted training, continuity, etc.; a tool at last matching the problem. Marketing should be part of a comprehensive business strategy aiming at global participation, considering in particular high level involvement of the necessary partners in time.

Many components of this proposal require further thought, change, improvement and planning. The whole enterprise is in fact of such an ambition, and scale that it can succeed only with substantial professional muscle in all sorts of fields. Little less can face the scale and speed of the disaster at hand.

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[i] Williams, B.G., Nunn, P. & Dye C. Weathering the storm. 2nd Global TB/HIV Working Group Meeting Durban, South Africa, June 2002 (Publication in preparation)
[ii] Curry, C.S.M., Williams, B.G. & Dye C. Prevention versus cure for the management of tuberculosis in countries with a high prevalence of Human Immunodeficiency Virus. (Publication in press)
[iii] WHO is at the moment reviewing all the available evidence, scrutinising in particular the data from Brazil.
[iv] Delivery of standardised TB treatment (DOTS) is an example in case.