Human Rights in Health

Ciba Foundation Symposium 23 (new series)

1974

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Human Rights in Health
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Contents

G. E. W. WOLSTENHOLME and K. M. ELLIOTT  Introduction  1

C. M. ELLIOTT  Financial resources: present and future  3
Discussion  10

B. H. DIETERICH  Water supply in developing countries  19
Discussion  28

G. F. WHITE  Domestic water: good or right?  35
Discussion  51

I. BURTON  Domestic water supplies for rural peoples in the developing countries: the hope of technology  61
Discussion  71

D. J. BRADLEY  Water supplies: the consequences of change  81
Discussion  91

N. W. PIRIE  The food potential  99
Discussion  113

W. H. PAWLEY  Whither the food and population equation?  119
 Discussion  127

D. B. JELLIFFE and E. F. P. JELLIFFE  Food supplies for physiologically vulnerable groups  133
Discussion  143

O. MELLANDER  Health services and medical education in China: a brief report  153
Discussion  160
G. EDSALL  The control of communicable disease: problems and prospects 169
Discussion 179

B. CVJETANOVIĆ  Cost-effectiveness and cost-benefit aspects of preventive measures against communicable diseases 187
Discussion 196

D. M. POTTS  The basic human right to the means of controlling fertility 205
Discussion 217

M. KING  Personal health care: the quest for a human right 227
Discussion 238

W. B. EIDE, M. JUL and O. MELLANDER  Bottlenecks in implementation: some aspects of the Scandinavian experience 245
Discussion 266

General Discussion: Integration of Western attitudes and the responses of recipient countries 275

G. E. W. WOLSTENHOLME  Conclusion 287

Biographies of contributors 291

Index of contributors 297

Subject index 299
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Introduction

G. E. W. WOLSTENHOLME and KATHERINE ELLIOTT

Most of the symposia organized by the Ciba Foundation in the 24 years of its existence have been concerned with medical and chemical research—with the experimental background to advances in clinical medicine. But from time to time we have broken away from this tradition, as we did ten years ago in a meeting published as Man and his Future, which explored the ethical and philosophical aspects of medical research. This step onto new territory, namely the social implications of progress in science and biomedicine, led gradually towards what is now perhaps a collateral tradition for the Foundation. In 1964 a symposium entitled Man and Africa tried to show what the situation in Africa might be if the continent could become a single entity, without the disadvantages of nationalism. Our 100th symposium in 1967 tackled an immense topic—The Health of Mankind. It attempted to survey the burden of ill-health in the world and trace some of its causes. It was only too clear then that the problem remained huge and that the numbers of trained health personnel were frighteningly inadequate and unfairly distributed. The symposium on Teamwork for World Health in 1970 therefore looked at unorthodox as well as orthodox ways in which this critical shortage might be remedied.

In 1971 we held a symposium on Civilization and Science: in conflict or collaboration? which examined the problem of whether modern attitudes to research and technology cause more of the present ills of mankind than they cure. Towards the end of the same year it was suggested that a meeting on the potential contribution of the most basic health measures, applied effectively and shared out more equitably, to a better quality of life for the poor and deprived, might be of use, especially to economic and health service planners. And it seemed fitting to hold such a meeting in the 25th anniversary year of the Declaration of Human Rights.

We make no excuses for calling this symposium Human Rights in Health.
Sir Harold Himsworth has recently defined a right as being 'an expectation in respect to matters affecting the interests of the individuals within a particular society which the consensus of opinion in that society accepts as justifiable'. (He added that he felt this applied just as much in Bangkok as in New York.) We believe, and we have based our planning of this meeting on this belief, that safe water and sufficient food are now among the minimum birthrights every human being should expect, and that a world in which technology has advanced so far and produced so much destruction and pollution should be capable of endowing every newborn child with these minimum benefits.

The year 1973 was not only the 25th anniversary of the Declaration of Human Rights but also the 25th birthday of the World Health Organization. Its Director-General, Dr Candau, speaks in his last report of 'good sanitation (which implies making drinking water safe) and adequate nutrition' as having become 'inalienable human rights'. This view strengthens our choice of four fundamental human rights in health as the minimum at which mankind should aim. These are: safe water to drink, sufficient food, protection against communicable disease, and access to the means of controlling fertility. All are interlinked, and they lead to a fifth—the right to have within reach at least some form of health care—which could, if interpreted in a wide sense, cover all the others.

We realize that other factors contributing to good health might also claim to be considered as rights: education and shelter, for example. But we want, in this symposium, to explore the practical implications—in terms of funding, human and material resources, and management needs — of adopting the above four determinants of health as universal human rights. The word 'adopting' is deliberately used here in preference to 'providing'. Our biggest task is to suggest ways in which people deprived of these necessities can obtain them for themselves or be helped with dignity to do so within the framework of their own cultures and traditions, and of the prevailing economic realities. Expertly informed commonsense must dominate humanitarian instincts if the symposium is to produce anything convincing or constructively helpful to the hard-headed pragmatists who accept responsibility and political authority: this is particularly the case where the resources are scarcest and disease is most rife.

Reference

In the face of the imbalance between the demand for health care—in the widest sense—and the supply of resources to meet those demands, it is easy to convince oneself that any talk of health care as a human right is vacuous. To declare something a right is to imply that the associated obligations can be met. But as Bryant and Gish have shown, resources are desperately short in the health sector in all poor countries. Indeed, national poverty implies extreme scarcity of all goods and particularly public goods.

The economists' job in this situation is threefold. First we can see whether there are reasons for believing that public resources—that is, government expenditure—will increase. Second, we can cast around for other types of resource. And, third, we can suggest strategies that will make the most of existing resources. This chapter tries, in a preliminary way, to tackle these three tasks.

Table 1 sets out data on selected countries that show the amount currently (or recently) spent by Ministries of Health per head of the population and the relationship this bears to income per head. As one would expect there is much variation, even at similar levels of income, but a regression equation, \( H = -0.0603 + 0.0176Y \), where \( H \) is expenditure on health, and \( Y \) income per head, was found to be significant at the 0.001 level \( (r = 0.753) \). This implies that as average income per head grows by £100, £1.76 per head is spent by the government on health care.

If we apply this relationship to future levels of income, we can see how much is going to become available to the health sector in the future. This is always a somewhat unscientific operation because we cannot be sure of the rate of growth of either national income or population. Further, there is no reason to assume that errors will cancel each other out: indeed it is more likely that they are multiplicative, since a higher rate of growth of income is likely,
TABLE 1

Income and public health expenditure of selected countries for 1967 or nearest date

<table>
<thead>
<tr>
<th>Country</th>
<th>Income per head (£)</th>
<th>Public expenditure on health per head (£)</th>
<th>Proportion of national income spent on health (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanzania</td>
<td>27</td>
<td>0.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Kenya</td>
<td>51</td>
<td>1.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Uganda</td>
<td>43</td>
<td>1.0</td>
<td>2.3</td>
</tr>
<tr>
<td>Ghana</td>
<td>87</td>
<td>1.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Ivory Coast</td>
<td>92</td>
<td>1.8</td>
<td>1.9</td>
</tr>
<tr>
<td>Tunisia</td>
<td>76</td>
<td>2.0</td>
<td>2.6</td>
</tr>
<tr>
<td>Zambia</td>
<td>110</td>
<td>2.8</td>
<td>2.5</td>
</tr>
<tr>
<td>United Arab Republic</td>
<td>67</td>
<td>1.2</td>
<td>1.7</td>
</tr>
<tr>
<td>Lebanon</td>
<td>176</td>
<td>1.2</td>
<td>0.7</td>
</tr>
<tr>
<td>Indonesia</td>
<td>37</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>Thailand</td>
<td>65</td>
<td>0.6</td>
<td>0.9</td>
</tr>
<tr>
<td>Ceylon</td>
<td>59</td>
<td>1.2</td>
<td>2.0</td>
</tr>
<tr>
<td>West Malaysia</td>
<td>114</td>
<td>1.4</td>
<td>1.2</td>
</tr>
<tr>
<td>South Korea</td>
<td>59</td>
<td>1.8</td>
<td>3.0</td>
</tr>
<tr>
<td>Honduras</td>
<td>84</td>
<td>1.0</td>
<td>1.1</td>
</tr>
<tr>
<td>Colombia</td>
<td>135</td>
<td>1.4</td>
<td>1.0</td>
</tr>
<tr>
<td>Chile</td>
<td>226</td>
<td>5.5</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Sources: WHO report8 and government accounts for individual countries.

other things being equal, to reduce the rate of growth of population. For these reasons, the figures in Table 2 should be treated as probable orders of magnitude, rather than as precise forecasts. It should be noted, too, that we are relating health expenditures to national income rather than total government expenditures. We are therefore ignoring current priorities given to health and are assuming that governments will approach an average expenditure on health in the future. Thus, although the third column of Table 1 shows that, at the moment, there are great variations in the proportion of income devoted to health, we have assumed that each government approaches the 'norm'. This seems a less risky assumption than the alternative—that political priorities will remain constant over twenty years.

One other methodological note is worth entering. We have considered only health budgets, although it is true that some preventive work, particularly in improving water supplies, is carried by other budgets, usually the Ministry of Public Works or its equivalent. Data are not available by which to separate these additional sums out but in most of the countries we are concerned with they are likely to be tiny, even negligible.

Treated as orders of magnitude, therefore, the figures in Table 2 show two
TABLE 2

Health expenditure per head in 1967 and 1987, for selected countries (in £ sterling)

<table>
<thead>
<tr>
<th>Country</th>
<th>1967</th>
<th>1987</th>
<th>Assumed rate of growth of income per head</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanzania</td>
<td>0.4</td>
<td>0.6</td>
<td>2.0</td>
</tr>
<tr>
<td>Kenya</td>
<td>1.0</td>
<td>1.6</td>
<td>3.0</td>
</tr>
<tr>
<td>Uganda</td>
<td>1.0</td>
<td>1.2</td>
<td>2.0</td>
</tr>
<tr>
<td>Ghana</td>
<td>1.1</td>
<td>2.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Ivory Coast</td>
<td>1.8</td>
<td>5.1</td>
<td>6.0</td>
</tr>
<tr>
<td>Tunisia</td>
<td>2.0</td>
<td>2.1</td>
<td>2.5</td>
</tr>
<tr>
<td>Zambia</td>
<td>2.8</td>
<td>4.6</td>
<td>4.5</td>
</tr>
<tr>
<td>United Arab Republic</td>
<td>1.2</td>
<td>2.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Lebanon</td>
<td>1.2</td>
<td>4.1</td>
<td>1.5</td>
</tr>
<tr>
<td>Indonesia</td>
<td>0.1</td>
<td>0.9</td>
<td>2.0</td>
</tr>
<tr>
<td>Thailand</td>
<td>0.6</td>
<td>3.6</td>
<td>6.0</td>
</tr>
<tr>
<td>Ceylon</td>
<td>1.2</td>
<td>1.5</td>
<td>2.0</td>
</tr>
<tr>
<td>West Malaysia</td>
<td>1.4</td>
<td>4.3</td>
<td>4.0</td>
</tr>
<tr>
<td>South Korea</td>
<td>1.8</td>
<td>3.3</td>
<td>6.0</td>
</tr>
<tr>
<td>Honduras</td>
<td>1.0</td>
<td>2.1</td>
<td>2.0</td>
</tr>
<tr>
<td>Colombia</td>
<td>1.4</td>
<td>3.5</td>
<td>2.0</td>
</tr>
<tr>
<td>Chile</td>
<td>5.5</td>
<td>7.9</td>
<td>3.5</td>
</tr>
</tbody>
</table>

Sources: as Table 1. Growth rates from World Tables (International Bank for Reconstruction and Development).

important features. First, there is already great variation in the amounts spent per head and this variation is likely to increase over time. This suggests that from the point of view of this symposium a pluralistic approach is essential. It is unlikely to be helpful to think about one strategy or one set of goals for all poor countries. I shall return to this theme in the last paragraphs of this chapter.

Second, even over the fairly long timespan presented in Table 2, some of the poorest countries will still be exceedingly poor. By 1987, Tanzania will be spending little more than Kenya is now spending on health. And Indonesia, with a prospective population of around 230 million by the end of the century, will be spending less per head than Kenya is now spending.

Is there any prospect that governments will switch resources from other uses—such as education or defence—to health? Inspection of the data in Table 1 reveals wide variations in this respect. Allocative decisions are based on political priorities and unless one expects the development of a much greater political demand for health services, at the expense of other forms of consumption, there is no compelling reason to foresee allocative shifts that will make much impression on the orders of magnitude revealed in Table 2. Cer-
tainty it would be a mistake to make any long-run plans on the assumption that there will be such shifts.

However, it would also be a mistake to assume that the figures presented in Table 2 account for all of the resources actually or potentially available. They do not, for the most part, include expenditures by local authorities (usually small) or by missions (in Africa, very significant: in Cameroon nearly half of all hospital beds are provided by missions). More important, they do not include private expenditures on health care, and it is on this element that I wish to focus attention.

There are two elements involved. The first is the sums spent by the élite to secure a superior service. Obviously, how significant these expenditures are depends upon the size and wealth of the élite. They are doubtless more significant in the Philippines than in Sri Lanka, in Malaysia than Tanzania. From our point of view they represent a financial resource—an ability to pay—that must be mobilized for the community as a whole.

The second element is more complex. We know that in most poor countries a traditional healing sector coexists with Western medicine and that this traditional sector is capable of mobilizing significant resources. How can those resources be made available for the purchase of a more scientific system of care? This is not the place to go into the sociology and anthropology of medicine, but work such as that of Marriott and Bennetti has emphasized that the cultural adaptation of Western medicine has far to go before it can command the same loyalty as traditional medicine. But, in many cultures, part of that process of cultural adaptation consists precisely in allowing the patient and his family to relate to the healer through a cash relationship. Where this is true and is an important element of the social psychology of healing, it is perverse to deprive the patient of a customary element of the healing environment by inflicting on him Western notions of philanthropy.

At this point two objections will be raised. The first is that this applies only to curative medicine. Peasants will pay to be cured—if they are convinced of the efficacy of the cure and if the social context of the cure is acceptable—but they will not pay to be protected from disease. This may well be true, though I suspect that there are already large areas of the poor countries in which acceptance of preventive medicine is growing faster than such an argument allows. Further, prevention and cure are not as separate or discrete as the objection suggests. But the point can be easily met by simple cross-subsidization—that is, curative medicine paid for at a price higher than its real cost can be used to subsidize preventive medicine. The man who pays handsomely for half a dozen sulpha tablets is providing smallpox vaccine for three or four children.

A second objection is that any fee-paying system is inevitably regressive in
its distribution—the rich can pay but the poor cannot: the rich are cured but the poor are left to die. Even if we leave aside the evidence to the contrary that is provided by the example of education (where the extended family helps to minimize the social selectivity of a fee-paying system), we find that a perverse distributional impact depends on an absolute level of charges. It can be minimized (though perhaps never removed entirely) by a relative scale of charges that fixes the absolute fee in accordance with the ability to pay. If it is said that this cannot be done in a simple rural community, the evidence of local taxation in Uganda suggests the opposite.

But what sums can be made available in this way? The World Health Organization’s *Fourth Report on the World Health Situation* gave some figures, gleaned it seems from macro-economic data and the reports of the Ministries. There are reasons for believing that these much under-represent the total flow of financial resources going to health, defined broadly.

Although they are extremely difficult to record systematically—since survey respondents are often loth to admit these expenditures—there is evidence that, in some countries at least, these private expenditures are several times greater than government expenditures. In Sri Lanka the government spends £1.2 per head per annum. Individuals spend on average £4.6, varying between £0.50 for the poorest groups and £5.4 for the richest. In Tunisia, one estimate puts private expenditures at over three times those of government, while relatively modestly paid workers in Dar es Salaam spent four times as much on medical care as did the government. There is statistical evidence of the same pattern from Zambia, Uganda and Ghana in Africa and reports of it from India and Thailand. We may assume, then, that it is common if not universal in Asia and Africa.

I must emphasize again that the mobilization of private funds for medical care depends upon the health system delivering care effectively and acceptably. There is little doubt that many hospitals and clinics in the developing countries would meet immense resistance to charges at the moment. This resistance is not evidence of reluctance to pay—since we know that many people do pay substantial sums—but of reluctance to pay for what they are getting (or think they are getting) from the existing health system.

Even more important than the mobilization of private financial resources, however, is the mobilization of what we can unbeautifully call ‘the resources of participation’. If we are right in believing that the old cosmology, in which death and disease were accepted as the inevitable lot of mankind, is increasingly rejected in favour of the hopeful belief that health is possible (and obviously the speed of that rejection varies greatly from social group to social group), then we can expect the development of an increasingly active desire for the sources
of health. To argue from analogy, the political demand for education has become intense in nearly all poor countries. In some that demand has been, as it were, energized by encouraging parents to provide their own schools. One of the best known examples of this has been the ‘Harambee’ school movement in Kenya, but ‘self-help’ schools of one kind and another have become a common feature of the educational landscape in many countries.

The proposition is that, if Western medicine were made more culturally adapted and thereby made to fulfil more of the social functions of the traditional healing system, equivalent resources of participation could be made available—with immense benefit to the total impact of medical care. Precisely what resources are likely to be so mobilized? Building and maintenance, simple furnishing, at least the subsistence income of health personnel and services such as cleaning, gardening and the production of food—these are all provided in at least some schools in which the participation of parents and the community at large has been encouraged.

It would be misleading to pretend that no problems surround their provision or that it is easily encouraged. The point is that the woefully slender resources of governments can be greatly extended if people really want the services in question. To that extent, it is probably true that it is easier to mobilize these services for curative rather than preventive installations—people will help to build a clinic more readily than a sewer. That may be distressing to those who wish to abandon curative work and put exclusive emphasis on prevention. But those who see the possibility of using a modest curative base as a point d'appui for a less modest preventive programme will be glad, at least, to have the possibility of a base from which to work.

I must now move to the third task: can the cost of a service be reduced? This innocent question bristles with problems, one of the most important of which is that, despite a growing volume of work under way, we still know very little about the level and structure of costs in the health sector. It is becoming fashionable to talk of ‘minimum health care’. That phrase, by itself, means nothing. Minima are not static: they are culturally defined and therefore vary from group to group within any one society. Minimum care for a rural peasant is not the same as the (subjectively defined) minimum care for a bank president in the metropolis. And if we try to define minimum care objectively, we have to be aware of the political resistance the imposition of such a definition is likely to engender.

A further difficulty stems from the effect of population density on delivery costs. As population density declines, the cost of delivery of a specific service rises. In the past this has skewed the distribution of health against the rural
dwellers and in an equitable system it implies sharply rising costs per head for delivery to the most impoverished section of the community.

Now let us pull together four facets of the discussion so far.
(1) To supplement the resources of government, private cash resources and the resources of participation must be mobilized.
(2) These are unevenly spread through the community.
(3) There is a political demand for super-minimal standards everywhere but that demand is roughly correlated to income.
(4) Costs rise (probably exponentially) as density of population falls.

If the object is to design as equitable a system as possible, these four facts plus some obvious but implicit assumptions suggest the following strategy.

\textit{Step 1.} Protect the entire population from major communicable diseases.

\textit{Step 2.} In the poorest countries, spend the remaining public resources on environmental and sanitary improvement in those areas where low density makes participation impossible. In the less poor, cover the same population with the simplest mother and child care.

\textit{Step 3.} Set up, under state patronage, simple maternity and curative units in the urban areas and run them as a commercial enterprise, designed to maximize profits.

\textit{Step 4.} Use the profits to trigger participation in lower-income urban and more advanced rural areas. Charge for the services of curative units built and run by local efforts on an ‘ability to pay’ criterion. Aim to cover costs.

I am aware that there are many pitfalls in this approach—and there may be many that I have not spotted. Some will object that an urban curative service will distort the distribution of skills and training. Some will point out that starting with preventive medicine will make the resources of participation more difficult to mobilize rather than less difficult. Some will say that this produces an inequitable distribution since the provision of services is still skewed towards the rich. All these objections may well be at least partially true. I put forward the strategy as one which, \textit{within known political constraints}, is more redistributive than any system I know (without being perfectly so) and one which guarantees to every member of the community protection against the major communicable diseases.

Are there countries where even the first step is impossible within existing public resources? There may well be: namely, those that are exceedingly poor and sparsely populated. These would probably include many countries in Central Africa (though not Zambia or Zaire), Bangladesh, perhaps Indonesia (especially outside Java) and perhaps Bolivia and Paraguay. This suggests that these countries will need sustained international assistance, but that
assistance will have to be carefully designed to prevent it diverting what resources there are from Steps 1 and 2 to Step 3.

The more immediate task is to make clear that the great majority of countries can already take Step 1, and Step 2, and that these will have a major effect on national morbidity. Indeed there are some historical reasons for thinking that Steps 1 and 2 will have more effect on national morbidity than a great extension of existing curative services. If that is so, the political fight implicit in Steps 3 and 4 will be well worth undertaking.

Discussion

Llewelyn-Davies: It is an extremely important question whether the proportion of the national investment cake—that is, of the income per head—which goes towards health in the broad sense is as fixed as the statistics indicate. I want to suggest that this will not necessarily be so in the future. Development in poorer countries has so far been a function of urbanization and of investment policies in urban areas. These policies have tended to be dictated by certain kinds of decision. When sophisticated decisions were made by international agencies they were often based on cost-benefit analysis applied to particular projects like electricity plants or highways. The investment appeared to be justified, in terms of the cost-benefit analysis of the particular project. What was omitted from the calculations was the total effect on the economy of the society of these heavy investments, very often made according to Western European standards. For instance, electricity plants have been installed with peak load safety factors equivalent to those required in developed countries, and highways built according to projections based on the Western car market. The mere fact that such expenditure was unjustified at the time, although true, is less important than the marked suction effect which this kind of investment inflicted on the national economy—a suction of resources away from social needs, such as health care. But there is a chance that this trend can be influenced into taking other directions in the future, because urbanization, which is the key process in development, is still at an early stage in many countries.

I have been involved in looking at cost and level-of-service comparisons between investments in health, education, transportation and housing in Colombia. These show that if the characteristic model of, for instance, road construction and electricity development is allowed to operate it will simply draw all the economic gain away from the other areas. But it is conceivable
that so long as the élite is taken care of (and Charles Elliott rightly stressed
this) one could divert this pattern into one which permitted an increasing share
of the cake to go to health. In addition, the trade-off between different kinds
of investment in health, over the whole spectrum of health, in terms of service
against cost, has not been very much looked at, and should be.

_Tewari:_ This uniform pattern in the allocation of resources to health makes
one wonder whether there is any point in struggling to obtain a larger bit of
the cake for health, partly for the reason that it is difficult to change established
practices, and partly because we may not be able to do so without damaging
other prerequisites for good health. Our experience in India has been that by
trying to do so, we deprive other critical sectors. Our Constitution has adopted
the right of universal primary education for every child, and over the last 25
years we have not been able to achieve this. The point is being made that if we
give more money to health we have to deprive some children of the right to be
educated, and if a considerable proportion of the younger generation remains
illiterate, are we getting the best from what we are prepared to invest, or from
the additional inputs that we might think necessary in the interests of better
standards of health? It has been claimed that the Education Act of the UK in
1870, and the steps towards universal primary education in Japan, contributed
more to the economic development of these countries than the inputs into in-
dustrial development itself. These questions are relevant to the allocation of
resources for health as well.

_Evang:_ Dr Elliott said that expenditures for the public sector in health gave
roughly £1.76 per £100 increase in income, as an _average_ figure, but even
among the well-developed countries the relationship between public money
spent on health services and the amount of private money spent on health
varies widely—compare Belgium and the UK, for example, or Italy and Sweden.
To what extent does the average figure give a true picture for the underdeveloped
countries, and has it been related to the percentages in the various countries?

_C. Elliott:_ This is an average figure based on a regression between public
expenditure on health, and income. The correlation coefficient is highly
significant, statistically, at the 0.001 level. It was not possible to correct for
variations in the degree to which the state accepts responsibility for health care,
but we were able to exclude countries like the Philippines which have basically a
private medical insurance system. So nearly all the countries in the sample
(see Table 1, p. 4) were those in which the government accepts a basic obliga-
tion to provide a health service from public revenue.

On the question of how realistic it is to try to get a bigger share of the cake
for health and para-health services, the sums are unfortunately so small, in
relation to the total demands upon them, that it makes very little difference if
the Health Ministry manages to increase its share of the cake by 5, 10 or even 20%. A 20% increase might increase expenditure from £2 per head to £2.40 a head, but this is still a very small sum. In other words, the magnitudes are not very sensitive to shifts in allocation and it is therefore not right to imagine that some political trick can divert resources from wasteful electricity schemes, or overgrown educational programmes, to health, and make a substantial difference to the total resources available. The situation is not very sensitive to the sort of marginal changes that are politically feasible. I think these countries are stuck with the order of magnitude that I mentioned.

_Evang:_ You raised the interesting question of whether alternative resources could be mobilized by making use of the willingness of the elite to buy the more expensive type of health service in developing countries. A solution along these lines has been applied in many economically developed countries already, by including the elite together with the rest of the population in a prepaid medical programme and basing the premium for health services on the taxation principle rather than on the insurance principle. The elite therefore pay more than the cost of their own services. If this were combined with a system by which the medical care programme provides not only curative medical care but also preventive medicine and rehabilitative services, one would in principle have solved the problem. However, this is clearly not applicable to poor countries, because the elite is so small that it cannot pay enough to finance the whole service. Secondly, if this principle is adopted, one accepts the obligation that the publicly organized health services will provide the quality of care which the elite asks for. If not, they will find some other way of getting it. Therefore, you have to establish a very expensive level of care, far beyond what a majority of countries in the world can afford at present.

_C. Elliott:_ But one would not expect to be able to finance the whole of the medical service from the surplus earned by the service designed for the rich. The trick is to transfer the consumer (and producer) surplus from the rich to the poor. It can then be increased by taxation revenues in the normal way.

_Wiener:_ Capital is not the only resource in short supply. There is acute scarcity of an equally decisive component, namely management talent. Many projects that are appropriately funded fail because they are not properly managed. To overcome this deficiency, we have to catalyse the growth of management capability in the local group in connection with its own health concerns. A further requirement that has been shown to be important, particularly in connection with housing projects, is the necessity of mobilizing local involvement in the conception and execution of schemes. A project in which the local group is involved has a better chance of success than one which is 'spoonfed' to that group. More concretely, when we are considering rural
areas, the common denominator is that such areas have too low an income, because their productivity is too low. We shall do little good if we expect the humanitarian philosophy of fighting poverty to provide the rationale for rural development programmes in the underdeveloped world. To be successful, programmes ought to be based on the economic motivation of the producer. This is perhaps the only motivation on which one can safely build, at least in the Western world. I believe that what has been said against economic motivation operating in the same way in underdeveloped as in developed countries has been proved wrong over the last 20 years. I refer you here to the work of Schultz.8

A further precondition of rural development is the setting up of cooperative or similar organizations at the village level. I think we should use this rural organizational infrastructure as a basis on which to build the additional superstructure necessary to provide health services. Here again, mobilization of participation by the rural population should be an integral part of the project design. My feeling is that the primary development campaign should be aimed at productivity and income increase, and that the organizational framework required for this campaign should be used as the foundation upon which the additional institutional features should be built for the provision of the four basic health needs. At the rural level we simply cannot afford two or three organizational systems.

Tewari: In principle, community participation is to be welcomed, but in practice the decentralization of planning presents immense problems, such as the availability of the required competence, and the capacity of the lower levels to project thinking and planning in the direction and to the extent necessary. I imagine that most developing countries, like India, have too little administrative, managerial competence to be able to delegate planning to the levels at which more decentralized development could be expected to take place. I agree that it is necessary to have community participation; but local people should be involved in planning too, and are enough competent people available at those levels?

The idea of community participation, and of drawing on private resources to finance health is, however, in conflict with the public declarations of a right to free health services which the newer democracies consider it an article of faith to promise their people. These pronouncements create difficulties for programmes which depend upon making use of private expenditure, which is of a substantial order, as Dr Elliott said. Surveys in India show that even a population containing more than 200 million people below the subsistence level is still spending 2–3% of its income on buying medical aid, mostly through the traditional methods. In the face of political pronouncements on the right
to free health services it becomes difficult to draw those resources into the public exchequer, where they could supplement public funds being spent on health services. It is difficult to tell political leaders that the public resources do not exist and that it is necessary to train people to contribute towards medical aid and not to expect it to be completely free.

This has to be viewed in the context of the type of medical care and the way it is obtained through traditional channels. In many countries not only are conflicts growing up between the so-called modern system of medicine and the traditional system, but there is the curious phenomenon of parallel systems of medical care being constructed as a result of people's demands to continue to use traditional systems of medical care. In the context of scarce resources this is a wasteful situation, and finding the means to reconcile or amalgamate existing systems is one of the major problems of developing countries. It is accentuated by the way in which health services have been structured, mostly by the transfer of patterns of Western medicine as practised in Western environments to communities which are socially and culturally differently organized. The adaptation of modern medical practice to these situations, particularly adaptation of the institutional set-up, has not taken place to the necessary extent. Research is required into the methods of delivery of health services, if the economic factors are to be adequately contended with.

One feature of this wholesale transfer has been the dependence on fully trained health professionals in situations where they are so scarce, and the unbalanced health teams which have grown up. Countries have been trying to use the fully trained nurse or doctor in situations where they see them used elsewhere but which are not economically feasible. The appropriate kind of teamwork, and the adjustments and balances that can be worked out, require much study. The delegation of health activities to technical personnel at lower levels, and the desirability of integrating traditional practitioners into health teams, are only two of the problems incidental to this question of planning.

Llewelyn-Davies: I am fascinated to learn that such large sums are being spent in the private sector, with the poorer people buying quasi-health services in the private market. One wonders how this money can be mobilized. Secondly, I am struck by the analogy that the private sector in transport has created in many developing countries a standard of transportation for the poor which is far ahead of what is available to them in developed countries, operating through a rather crude form of private market which no public transport system would ever offer. Can you see a way to do this for health care through the market, Dr Elliott, or is the intrinsic nature of health care delivery such that resources have to be mobilized by moving out of the market into a collective form of utilization?
C. Elliott: I am struck by your analogy with, for instance, the Mammy wagons of Ghana and Nigeria. I suppose the traditional healer is, in embryo, the health analogue of the Mammy wagon. But the need is to attach to the enterprise, energy and community links of the private operator some elements (not the whole package) of modern technology. They are, after all, Mammy wagons, not horses and carts. A number of experiments are going on, the most glamorous being the 'barefoot' doctor in China. A less special case is in Tanzania, with the registration, unionization and education of traditional healers. This is an immensely complex problem and rapidly becomes an emotional issue between practitioners of Western medicine and the champions of the traditional healers, but it is something worth looking at closely. Can one find a way of better integrating the traditional healing sector, which certainly in Africa is much bigger than we thought, into a total health delivery system? That is one possible way of short-circuiting the operation. Another way, which again is very complex and contentious, concerns the social function of the traditional healing sector—for instance, the relationship between the patient and the doctor, or the relationship between the doctor or the health worker and the patient's family. How rapidly can we de-culturalize Western medicine and re-culturalize it in another cultural setting in a way that would make possible the kind of cash relationship that exists between the traditional healer, and his patient and his family? I have no immediate answer on this, but these are issues that we have to take more seriously than we have done.

On the second question—the extent to which health is necessarily delivered collectively—one needs to be level-specific. Obviously at a simple level of curative health care, a 'market' relationship is possible and perhaps desirable. Problems arise, I suspect, when one comes to preventive medicine, and that, after all, should be the main emphasis of any programme. There collective organization is inevitable and, since group pressure is helpful in persuading recalcitrants to take the necessary measures, highly beneficial.

Evang: As far as this other resource goes, namely the money being spent by poor people for traditional medical services, the élite and the poor illiterate man or woman in the village have one basic feature in common: they are not willing to give up anything they have achieved. There is therefore no question of people in poor parts of the world changing from paying the traditional healer and transferring this money to other things. It would be almost impossible to change that practice.

It would be interesting to know the numbers of traditional healers. In India I was told in the 1950s that the combined Moslem and Hindu traditional services provided approximately one healer per 1000 individuals in the country, and in China in 1960 they thought they had about one traditional healer per
This is an interesting coincidence and perhaps says something about the quantity—the 'maturation point'—of such personnel.

_Tewari:_ There are three traditional healers for one doctor trained in modern medicine in India at present, or say an average of three or four per thousand people.

_King:_ I am delighted to see the emphasis laid by Dr Elliott on the traditional sector in medicine and on the need to study the equilibrium between orthodox and traditional providers of primary care. One of our most urgent priorities should be to experiment in seeing how we can improve the care that traditional healers provide. He also rightly said that we should look at why the traditional sector is often so popular, and try to see if we can incorporate some of the secrets of its popularity into orthodox medicine.

_Querido:_ We have discussed the re-allocation of resources to health and the alternatives of getting over to governments what one really wants to do. I have had some experience of this, and it appeared that talking in terms of Gross National Product is often ineffective. Recently I was able to get something across by talking about the training of personnel rather than about GNP. One can then say that the government is responsible for the educational cost of the personnel, and if they have defined the objectives of their education well, the next problem is how to acquire funds to make trained personnel productive. This can be done either by the community or by a local type of insurance system. The interesting point is that this seems to be the beauty of the approach in the Chinese situation: that in fact the 'barefoot' doctor does not cost anything, because he is not a civil servant who needs part of the GNP, but is simply a worker in the community.

_C. Elliott:_ The idea that one can greatly reduce costs by using personnel in a sense part-time—the other part of their time being used for their own support—is immensely attractive, but it depends on a fundamental political change which has been successful in China but which other countries have not managed to bring off. At the moment, the general position is that anyone who works in the public sector regards that as a claim to a lifetime's earnings. To suggest, in most of the countries with which I am familiar, that medical or para-medical personnel should support themselves and practise their particular technique would be politically difficult. If one could overcome that whole range of professional and personal convictions and aspirations, this could be an effective way of using manpower and saving costs. But it depends upon a fundamental political change that for most countries does not seem immediately possible.

_Evarg:_ This meeting is concerned with the problem of establishing and implementing certain basic human rights to health. The consensus referred to in the Introduction is, as we can see, not enough to establish a human right.
The consensus may result in a declaration in law, but even in a rich population the legal definition of a right does not produce the desired result.

It is interesting to make a comparison with other service sectors with which the health services have to compete economically. The two major areas are communications, including roads, television, airports and so on; and educational services, in the widest sense of the term. In many richer countries one of these sectors differs from the other two as far as the definition of rights is concerned, namely education. Not only is there a consensus that everyone should have the right to education, and not only is this defined legally, but it is frequently a punishable offence not to comply. In many countries a parent who does not send his child to an elementary school at the given age can be punished. Secondly—and this is more relevant to the situation in the health services—a person who has not received the education to which he is entitled under the law has a right to compensation. We must take this point into consideration as we discuss the question of human rights in health.

Victoria Garcia: When we speak about the rights of the individual we should also think about how to build up the responsibility needed to exercise these rights. Every right has a counterpart: the obligation to know, for example, how and when to use the medical facilities available; how to take care of them, avoiding wastage; how not to pollute our environment; how to have respect for others. I am aware how difficult it is to build up new values related to health in adults. That is why we have to consider our responsibility as professionals, and the responsibilities of the teaching staff in the school system or of the leaders within community organizations, to inform people about their rights but at the same time to teach them to be responsible.

References

1. BENNETT, F. J. (1963) Custom and child health in Baganda: Kiganda concepts of disease. Tropical and Geographical Medicine, 15, 148

This chapter reviews the ways in which people in the developing countries are supplied with water. It also tries to indicate the kind of change required before safe drinking water can be made available, gradually, to large numbers of people who are not only deprived of good and easy water services today but whose total environment reflects the conditions typical of underdevelopment: namely, the absence of environmental sanitation (of which water supply is but one essential element), poor housing, poverty and high levels of endemic diseases. The issue of water supply cannot be separated from the task of protecting the environment, a task which has become synonymous with the need to assure the human right to a higher quality of life.

Indeed, the word 'environment' has become a powerful expression for the concern people feel about conditions in their surroundings. Many people associate it with the pollution created by industries: with smog, noise, polluted beaches, radioactivity and pesticides. These are environmental problems in countries where large metropolitan and industrial complexes have been built for the enjoyment of a better life, and where high consumption levels have been accompanied by high levels of waste.

Industrial development certainly has much to answer for, but we should not forget that industrial pollution is only one part of a vast problem. To most of the world's population, the threat of the environment shows an entirely different aspect.

This has been vividly demonstrated recently by the resurgence of an old—and, in the developed countries, forgotten—disease, cholera, which is transmitted from man to man by a polluted environment—polluted not by industrial effluents but by human waste and unprotected water supplies. Hundreds of millions of people fall victim every year to a wide variety of communicable diseases in places where the biological pollution from community wastes is
allowed to reach drinking water sources. These diseases originate in a particular environment which also helps their spread, but they can be prevented by efficient environmental control and maintenance of community sanitation.

WHAT DO STATISTICS TELL US?

Reliable statistics from the developing countries are hard to come by. The only existing information on a global basis is from two surveys made by the World Health Organization, the first on urban water supply conditions and needs in 75 developing countries, which refers to the situation in 1962. This was published in 1963 as a WHO Public Health Paper. The second survey was on urban and rural water supply and on urban and rural excreta disposal in 92 and 61 developing countries respectively. This survey describes the situation in 1970 and was concluded in 1972.* In 1970 the plain fact was that 71% of the population of the developing countries included in the survey did not have what we would call a water supply, whether on the premises or within reasonable walking distance. In the cities and towns 50% had water supplied to their premises and 19% could walk and fetch the water. In the villages, however, a full 86% did not have access to safe water and this percentage represents more than a thousand million people.

DEFINITIONS

Before going any further with information from these surveys, I shall explain the meanings attached in these surveys to certain words.

First, 'urban' and 'rural': in the 1970 survey we simply let the countries' own definitions of urban and rural stand. The United Nations Population Division in New York found that no other arbitrary global criterion served the purpose any better.

Second, a 'piped supply' is a community public piped supply. 'Reasonable access' is (for rural areas) where a woman does not have to spend a disproportionate part of the day in fetching the water required for the family. 'Safe water' is water that is either naturally uncontaminated, such as ground water or spring water, or water that has been treated and chlorinated. Surface sources and open dug wells are not considered as safe water for this purpose, whereas well-protected tube-well water, even though it is not chlorinated, can usually be considered as safe water.

* Since this symposium was held, the results of the WHO 1971-1972 survey have been under further review. The data given in this paper represent the information available in mid-1973, subject to revision.