Commentary

More Myths in International Health Planning*

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There is a tendency for many articles dealing with policies and plans for health care in developing countries to cover a great deal of the same ground. Useful as they may once have been, these attempts to summarize so much that is patent-ly wrong with the health services in the poorer countries have evolved into a familiar format which now serves little purpose.

A problem caused by articles of this type is that they allow us to slip into dangerous oversimplifications. By glossing over the depth and complexity of the real issues involved and by relentless repetition, certain statements and concepts have acquired a quite unjustified credibility. They have become myths.

This paper looks at some of these myths and oversimplifications and tries to point out some of the issues they obscure.

1. The Myth of "Put the Rural Areas First"

This myth states that because in developing countries more people live in rural areas and more of them are poor, health care efforts should be concentrated there.

According to United Nations' estimates, in the next 25 years the urban population of the developing world will increase by some 1.3 billion to become 42 percent of the total. In Latin America it is more likely to exceed 75 percent. There will then be about 2.2 billion people living in Third World cities. Almost 300 of these cities will have populations greater than 1 million.

It is often thought that accelerated rural development holds the potential to stem much of this urban growth by reducing levels of rural-to-urban migration. Successful rural development may well reduce migration but this will not have as great an effect on urban growth as is usually supposed. The debate about to what extent rural development will reduce migration is in fact concerned with a good deal less than half of projected urban growth.² The actual size of cities now and their natural rates of population increase will ensure that the greater part of this growth occurs. Even if no further migration took place after today, Third World cities with populations of 10–20 million will be commonplace, with a few even bigger.

Short of a mass exodus from the cities—an event which without Khmer Rouge degree of control and determination is difficult to conceive³—the urban growth situation is irreversible. Indeed it would appear that the scale of urban growth will only be contained to that indicated above if a high growth in rural income is sustained. If it is not, then urban population increase could be much higher and, indeed, in countries with really large poor rural sectors with high population-to-land ratios where scope for rural development is not so great, this seems likely to be the case.

Furthermore, urban growth is not occurring in proportion to existing income groupings. Many big cities are now experiencing shanty town population growths in excess of 20 per cent a year and urban slums can already account for more than one-third of total city population.⁴

Although income differentials favor the urban population over the rural, the urban unskilled will remain very poor. In most rapidly urbanizing countries income inequalities within the urban areas will increase (indeed are increasing) as enormous labor surpluses depress the wages of the unskilled to levels in some cases only marginally above those of farm workers. Average income levels in urban squatter settlements can be lower than those in some rural areas.⁵ Furthermore, data on urban incomes can be misleading since figures for per capita income often cut across social groupings and therefore grossly overestimate the levels of the poorest. More importantly, however, income by itself is an unsuitable comparative measure of urban and rural standards. While incomes may be greater in urban areas, opportu-

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nities for self-help are generally fewer, particularly in food production. Studies quoted by the World Bank indicate that in some cities infant mortality among the poorest significantly exceeds that of their rural counterparts. Studies from Senegal could detect no difference in prevalence rates of schistosomiasis between rural and Dakar residents. Malnutrition rates in urban squatter settlements can be higher than in rural populations even though the urban areas as a whole contain relatively fewer families within the lowest income ranges.

Urban and rural problems are inextricably related. Almost any significant policy bearing on the one will have implications for the other. Pricing policies introduced “to benefit the farmer” invariably bring a further burden for the urban poor through price rises. Advocates of the put the rural areas first myth recommend a switch of resources to the rural areas and in particular to increased investment in agriculture—and for many countries this must be right. But it is quite possible to substantially increase agricultural investment without making noticeable impact on the poor. Not only is it possible but, as Lipton points out, it is actively practiced in many countries where this investment is of such a kind (emphasizing the production of raw materials for industry) and of such a scale (emphasizing accessibility for the big farmer) as to bring little benefit to the poor.

To overemphasize the rural-urban distinction is to disguise the much more fundamental distinction between rich and poor—of structural issues of income distribution, access to opportunity, and ownership of land and other means of production. The poor, whether urban or rural, are part of the same unskilled labor market which offers few prospects in either place. Wherever the unskilled laborer goes there are too many others like him to bid down his earnings. In the urban areas he must bear increases in the price of food staples which as a rural agricultural worker he does not benefit from. Increases in the price of staples, while burdening the urban poor, generally bring few benefits to his rural counterparts. These are subsistence and tenant farmers. Price increases are of no use to the former since he has nothing to sell, and the harvests of the latter are as often as not mortgaged in advance at fixed prices to landowners or merchants. It is common in Asia for farmers to have rents or debts expressed in terms of crop volume rather than money terms.

In the health field, the put the rural areas first myth is a reaction to the patterns of health care invariably seen in developing countries, i.e., with resources largely concentrated in the urban areas.

But again, this reaction does little more than create confusion and obscure the real issues of rich and poor with that of geographical location. The urban services that tend to absorb the vast proportion of resources and return few benefits are largely those hospital-based treatments at the disposal of higher incomes which offer advantageous remunerative opportunities for providers. They are inappropriate because they are the wrong kinds of services, not because they are in the wrong place. There is no reason why urban health services cannot be extremely cost-effective and reach large numbers of urban populations with needed maternal and child health and family planning programs and there is every reason why they should be doing so. Within the city itself, health services very often are not located in the high density slums where they are most needed because these settlements tend to occupy land illegally.

The myth about rural health priorities appears also to some extent to rest on unrealistic and somewhat romantic assumptions about stemming urban migration. Up to now, however, development efforts in rural areas have not achieved this effect. In fact, “Greater social amenities in rural areas may even promote migration, at least initially. So far as can be judged from limited studies, extension of education, improved transport facilities, the spread of national information media, and increased contact with urban-type amenities tend to increase rather then decrease the impetus to migrate to urban centres and from the smaller centres to the larger.”

Perhaps the truth is that real rural development will demand such fundamental changes in social control and ownership patterns that, in their absence, health care and other support services can only exert a counter-productive or indifferent influence. Of course there is evidence from selected integrated rural development projects to show that incomes have been raised and that health, education and other support services may have played an important role. These projects are invaluable but they are only projects and only constitute islands of development in a massive sea in which conditions are actively opposed to development because it would inevitably mean a redistribution of power and wealth.

In summary, under almost any conceivable set of circumstances enormous agglomerations of urban poor will be a characteristic of the world future. To many of the world’s poor, the cities offer the only real hope of a better existence and so—whether they are right or not, whether they stay or whether they return to be replaced by others, whether they come in desperation or whether they come as “pioneers” they will come to urban areas. They will leave it to academics and development experts to make the moral judgments about the relative merits of urban and rural life. These people will need health care programs. That the kinds of program they will need will be very different from those presently in evidence is not at issue here. Indeed whether “programs”—with all that implies about services provided by governments—is the appropriate orientation at all or whether people will have to do more about their own health through community organization and action is a matter for genuine inquiry and experiment in the health studies field. Such studies will not be assisted by the perpetuation of myths and in particular by being diverted down the sidetrack of rural as opposed to urban needs.

2. The Myths of Simple Prevention and Easy Treatment

The doctor knows that malnutrition and infectious and parasitic disease are, in a technical sense, easy to prevent. But the absurdity of pointing out to undernourished populations that they should be eating more or different food or
telling fishing villagers they must stay out of the water if they want to avoid schistosomiasis points up the limitations of this technical knowledge when faced with the real world.

The vast majority of illness in poor countries is so deeply rooted in poverty and culture as to be virtually unpreventable without revolutionary changes in the life-styles of millions. Solution to the kind of disease pattern faced is hardly within the province of the medical profession at all unless we are prepared to significantly widen the range of our knowledge, skills, and commitments. Our present understanding of the complex and interrelated systems conditioning levels of health is inadequate; our technical competence encompasses such a small band of the spectrum of possible intervention. In the poverty cycle linking ill health with inadequate food production or income and with environmental conditions and access to education and employment opportunities, where and what kind of interventions are effective and what are the appropriate organizational and institutional forms by which even present technologies can be made accessible?

Acute diarrheal disease and infections of the upper respiratory tract, whether presented or not, undoubtedly represent the most widespread causes of mortality and morbidity in poorer countries. Both are invariably clinical syndromes "... that include a minority of known disease entities, a predominating bulk of undifferentiated, presumably infectious processes, and an indefinite number of non-infectious illnesses." But regardless of the fact that acute diarrheal disease is not well understood, how well can it be "simply prevented and easily treated?" Treatment outcome can be good in theory for the individual in appropriately managed conditions. But control can only be effective at the level of the community, and this would require:

- comprehensive treatment, including the presence of a high-coverage medical care system of personnel and drugs for a sustained period and the use of this system by the population;
- behavioral and environmental changes to reduce risks of infection, including changes in traditional methods of food storage and preparation, reversal of the decline in breast feeding, and more attention to infant feeding practices;
- raising standards of personal hygiene;
- increasing resistance to infection by dietary changes and control of helminths, malaria, viral infection, etc., and other adverse influences on nutritional status.

In what sense then can it be said that diarrheal disease is "simply prevented and easily treated?"

The myth that the diseases of the developing world are easy to prevent and treat implies that they and the effects of interventions are well understood. Such is not the case. It implies that research is an unnecessary luxury in the face of the overwhelming need for action and, indeed, this is often explicitly said. But even within the medical field itself it is false to imply that the required knowledge is available and that extensive epidemiological work and controlled trials should take a back seat to implementation. Measles, for example—a leading cause of infant death in some countries—is comparatively well understood at least as far as it affects well-nourished populations. Whilst vaccination campaigns have been very successful in some places, there is still much that is unknown about their usefulness elsewhere. In African countries especially, where mortality and case-fatality rates are high, there are still many uncertainties. Since mortality peaks in the first years of life, vaccination should be undertaken at age nine to ten months, or six to twelve months, or earlier. But how many cases will maternal antibody still suppress immune response? Cost and organizational factors are likely to rule out revaccination for such cases. How well can the "cold chain" problems be overcome in any planned program? What effect does nutritional status have on response impairment to measles and indeed to other vaccines and how does this differ between primary protein and primary calorie deficiency? Studies from West Bengal indicate that this may be a key factor in the success of BCG vaccination for example. What are the effects of hyperendemic disease? Onchocerciasis has been implicated in the failure of vaccination in Mali and elsewhere—again for BCG. Certainly as far as measles is concerned it can by no means be safely assumed that vaccination programs are justified in many of the conditions that prevail in just those places where the disease is most serious. Most important of all, and something medical planners are often ill-equipped to assess, what are the opportunity costs of such programs? Under what conditions is it more cost-effective to focus resources on risk factors common to almost all illness outcomes—on poverty, ignorance, and malnutrition?

Health problems in the developing world are not simple and to constantly pass them off as being well-understood will do little to attract the kind of attention they deserve and the kinds of skills and dedication needed to solve them. They are immensely complex and require to be accorded high prestige and priority if they are to command the appropriate attention of sociomedical sciences.

This is not to imply that the knowledge required is so extensive that years of research are necessary before any decisions can be taken or actions implemented. The problem at this point in time is to strike a balance. On the one hand we know that our medical interventions are not very cost-effective in the social and environmental conditions common in the poorer countries. On the other hand, the complex interrelated nature of the factors causing these conditions and constraining efforts to alleviate them is insufficiently understood and, moreover, may not be amenable to the kinds of research method with which we are familiar. What we urgently need are some conceptual, systemic models which relate the major factors even if at this stage the strength of their linkages and interactions can be but cruelly calibrated. Such models would serve as the frameworks within which more meaningful policies and planning might be discussed.

3. The Myth of the Referral System of Health Care Delivery

Some so-called "national or regional health plans" consist of little more than an idealistic description of the hier-
archy of care ranging from the village dispensary through health posts, health centers, hospitals, and up to regional or national teaching hospitals, with staffing and equipment details added. Such plans are invariably of little use. While the referral system model may have some relevance in affluent industrial societies, it is doubtful if it has any in poor rural areas or indeed if it holds much promise as a model for the future. Observation of health services in the field reveal the almost complete non-functioning of referrals from one level to another. Studies are identifying some of the strong disincentives operating.36, 38

In the first place, where primary health services are inadequate, referral is a non-starter. In many rural areas only a small proportion of the sick are seen by the formal government health services. Far more seek assistance from traditional healers38, 39 (whom they understand and trust) and increasingly seek the advice and buy the products of the nearest (and invariably unqualified) village pharmacist.37, 40 Clearly where official coverage is inadequate this is inevitable but in many areas the quality of care dispensed by official staff, the cultural and social gaps between staff and patients, attitudes to illness rooted in magic and divine justice, irresponsible marketing by drug companies and the incentive of financial gain for their local peddlers act in some combination to ensure that even those government health services available are underutilized.

Secondly, official health workers themselves frequently supplement their earnings by “private practice.” This often applies to all grades of workers. There are consequently few incentives for them to refer a patient anywhere unless his condition is sufficiently grave that he is likely to die—a situation that clearly does not enhance their local reputation or business. The strongest disincentives of all are probably those affecting the decision-making of the potential patient himself: the high costs, loss of income or absence from essential farm work, the long waits and indifferent treatment that are often entailed by visits to distant health services. Such visits will often only be undertaken when illness becomes very serious and when all locally available possibilities are exhausted and, sometimes, not even then.

In practice, the hospital in the town receives very few referrals from rural areas. Instead it tends to dispense primary and some secondary care for those living within convenient access. Nor can the hospital itself refer downscars when local level primary services are inadequate. As a result hospital facilities and staff time are employed “unnecessarily” for simple but essential follow-up treatments. Moreover, this situation is unlikely to change unless the factors mentioned above change first. It is precisely in countries where these factors have been changed (e.g., in China) that a form of referral system can be made to work. While demographic and income similarities might suggest that such a system could be made to work in, say, some Southeast Asian countries, it is doubtful whether it could ever be workable in some of the very poor and low density regions of Africa. But more fundamentally, it would seem that the success of the system in China depends on a level of political will and social mobilization that is not present in most other countries. Whether we argue for such change or not, it is entirely unrealistically to plan health care delivery systems on the basis of a social order that does not exist—such plans will fail.

Alternatives to the referral model must seek to provide the widest possible range of assistance at the point of first—and invariably only—contact and, of course, to hugely increase the number of those contacts. What cannot be done here is unlikely to be done anywhere else. It is at this point that some of the results of high-resource and sometimes high-technology research can legitimately be applied if they can be provided in package forms usable in low-resource and low-technology situations.41 Convenient-to-measure risk factors42, 43 (to identify groups at higher risk), for example, usually demand sophisticated research, manpower, and facilities to determine and test. But if they can then be made available in simple-to-use and inexpensive forms utilizing few-point scales, scoring systems, simple measuring methods, and so on, then this knowledge can be put to widespread use.44, 45 The same principle applies to the development and use of simple diagnostic charts which can put something of the achievements of modern medicine in the hands of many health workers with only basic training.46 The development of comparable short-cuts in treatment must be an equally high priority.

It should be emphasized, however, that where equipment is concerned making high-technology results available in low-technology forms does not mean that reliance should be placed on foreign manufacturers to provide such equipment. This creates an unnecessary extra drain on scarce foreign exchange and contributes to establishing a dependency relationship for poorer countries. Part of the appropriate technology brief is that possibilities for local manufacture are maximized.

4. The Myth of One Doctor or Thirty Medical Aids

This appeal is usually based on comparing the costs (wages) involved to show that the price of the one will pay for about thirty of the others—the latter achieving more coverage. The “medical auxiliary” is wheeled out as the answer. As a generalization this is now hardly at issue or deserving of the degree of emphasis it has received in the past. For simply as a concept, the “medical auxiliary” takes us nowhere without his having been designed as part of the health-improving, problem-solving exercise. It is what kind of auxiliary that is of relevance. In fact in many situations the attraction of the auxiliary’s low cost obscures what appears to be a quite unacceptable performance at any price.44 This is not of course the same thing as saying that the doctor’s performance is acceptable because his costs are high. The issue is not doctors or auxiliaries but manpower planning and how it is best done. It is the process of problem definition, program design, and studies of effectiveness that is vital—not the attachment to a predetermined stereotype. It might also be noted in passing that the low cost of many auxiliaries as reflected in their low rates of pay, far from being a factor in their favor, is often one of the basic reasons
for their poor performance when the temptations of corruption and private practice are so great.

5. The Myth of Compulsory Rural Service

Periods of compulsory rural service and restrictions on foreign study and travel represent attempts to stem the emigration and urban migration of health services manpower. It is easy to see the logic of this view—the more so by those who do have the opportunity to travel and who in fact do choose to live in affluent industrial countries in or within access to cities. The argument that skilled manpower in the poorer countries should be limited in their activities and blinkered into devotion to duty is somewhat hypocritical and misses what may be a more fundamental point. Is it reasonable to expect individuals to fulfill socially useful roles when there exists no context of social responsibility and community service within to which to do so but rather one of ever-increasing potential material reward for the upwardly mobile? In such prevailing social contexts, those who might wish to serve their communities are severely disadvantaged. To accept this social context on the one hand, while on the other devising ways to pressure or bribe individuals into behavior counter to it, is to exploit a position of privilege. It is often said that systems of financial incentives can be employed to overcome these problems, but there is no evidence that this is the case except in affluent countries where the standards of the poorest are relatively high and where income inequalities are not so great. The extent to which financial incentives work even in richer countries need not concern us here but in poorer countries it is hardly a real option. Poor countries must compete to keep their skilled manpower in what is effectively a world market in which their buying power is small. Two or three years of compulsory rural service for newly qualified personnel does not change this situation. Even for lesser qualified staff, with no possibilities for emigration, financial incentive cannot be a solution to meeting social needs in poor countries. Where income inequalities are so great, the incentives to get more are irresistible and no health authority can pay sufficiently to overcome the rural-urban differential for skilled workers or to compete with the effectively open-ended price system of the private sector. Under these conditions, planning for social improvement which should be a constraint-removing, option-creating activity in which the ambition is to redistribute access to education and to increase opportunities for people to serve their communities becomes instead an activity of constraint. There is no clever answer to these problems as those working in developing countries know well. Schemes designed to overcome them are working against the tide of events. Solutions are soon seen to be partial and invariably create new problems elsewhere. Perhaps efforts focused more on creating community awareness which attempt to develop social rather than financial rewards may offer the best hope in countries where basic redistribution is on no political agenda. Similarly, in looking toward that small group of often-referred-to countries where health care efforts are having demonstrable success, perhaps it is the system of social relations we should be studying and not the mechanics of the barefoot doctors training. There may well be large numbers of people—particularly in village communities with cooperative traditions—who would have genuine desires to assist their communities with the new skills which education could bring. The extent to which this might be so is largely unknown but in the health field, at least, it can be said with some certainty that the selection of students and trainees does not generally seek out such groups.

It is difficult to extract useful generalizations from the above list of myths and, as always, much more difficult to offer constructive alternatives. It does seem, however, that one of the current dangers in talking about health care is that of becoming too preoccupied with the “medical system” that already exists and using this as a kind of straw man to knock down. By so doing we strengthen the notion that it is some kind of a system or organizational entity rather than a patchy-pot product of market forces and professional self-interest. In fact, the “medical system” was never designed for anything at all, and this applies as much to medical services in richer industrialized countries as it does to those in poorer ones. The planners of medical manpower who, aiming to solve actual health problems, came up with a job specification resembling that for the existing doctor would be sent back to the drawing board. The argument which emphasizes the inappropriateness of transferring the medical care solutions of the richer countries to the poorer ones is only of secondary importance. In short, there is a danger of giving credibility and purpose to what amounts to a fairly arbitrary set of technologies.

Indirectly then, this article is little more than a plea for planning in our efforts to improve health. Planning should not be constrained by arbitrary technologies and solutions—technologies must be variables in a problem-solving process. The fundamental problems underlying an approach to and a knowledge base for planning have been well summarized by Mahler. Before planning can be effective we need answers to four groups of questions:

1. Is it possible to assign health resources within a country on a problem-solving basis (using different mixes of preventive, curative, promotive and rehabilitative action)?
2. What medical interventions are truly effective and specific for prevention, treatment, or rehabilitation, as measured in objective terms?
3. Can such medical interventions and the risk groups to which they should be applied be described objectively and in such a manner that the amount of skill and knowledge required for their application can be assessed?
4. Is it possible to design a health care Establishment to carry out the above tasks which will result in the most meaningful interventions reaching the greatest proportion of persons at risk, as early as possible, at the least cost and in an acceptable manner?"
that form of medical pseudoscience which seeks biomedical remedies to social injustices or to otherwise “increase mystification as to the structural relationships which dominate social life.” Undoubtedly, health planning requires the development of models of some kind describing the social and environmental processes within which such planning takes place and the likely consequences of induced change and intervention. At this point in time, models which attempt a broad multi-sector overview are to be preferred to detailed but piecemeal approaches solely within the medical field. But it must be remembered that the world of social interaction that is observed and measured is in no way an objective and value-free world. The social and economic systems studied are as they are because of historical and continuing “induced change and intervention.”

All this takes the health planner into largely unfamiliar and, indeed, largely unmapped territory. He may be reluctant to take the necessary steps and may argue that it is not his business to do so but it is becoming increasingly clear that a commitment to “health for all” demands that they be taken. Moreover, it is necessary that the health planner take these steps in whatever political circumstances prevail. A final myth to note here might be that governments are universally committed to improving the health of their populations and that the health planner operates simply as a technical expert within such a context of commitment. In many countries, few things could be farther from the truth. Technical knowledge is one thing—and an essential one—but without political will it is of little use. Where there is presently no such political will because governments represent the more powerful and more healthy rather than the less powerful and less healthy, then development will occur only through demands by the latter upon the former. In such contexts, the role of health planning is to widen horizons and experiences so that appropriate demand will be expressed and obstacles to health removed. If those obstacles are primarily prevailing social structures rather than biomedical knowledge, then the health planner is in the business of social reform.

REFERENCES


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Radiation Protection Course to be Held in May

The seventh annual course on Radiation Protection will be presented at The University of Michigan May 1 to 12, 1978. The course is open to anyone with an interest in methods of measurement for control of radiation in the work place and in the environment. Particular attention is given to the critical interpretation and evaluation of such measurements with respect to human health.

The fee for the course is $550.00, which includes text material and a banquet, but does not include meals and lodging.

For further information, write G. Hoyt Whipple, School of Public Health, University of Michigan, Ann Arbor, MI 48109, or call (313) 764-0523.