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HEALTH OF THE UNDERPRIVILEGED

(Working Paper for the Technical Discussions)

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1. INTRODUCTION

The Constitution of the World Health Organization declares, inter alia, that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being and that unequal development in the promotion of health and control of diseases is a common danger. The adoption, in 1977, of the resolution on the social goal of Health for All by the Year 2000, by the Thirtieth World Health Assembly (WHA30.43) marked a watershed in the history of health development, and was firmly based on the concept of equity and social justice. The Alma-Ata declaration, in 1978, gave substance to this concept. The global strategy and the different national strategies have attempted to reduce the inequities in health.

Since 1978, Member Countries have also participated in two cycles of monitoring and one cycle of evaluation of the strategies for the attainment of Health for All by the Year 2000. While substantial progress in overall terms had been made in all the Member Countries of the South-East Asia Region, it was clear that inequities continued to persist and that benefits of health development had not percolated uniformly to all sections of the population. The second round of evaluation of the strategies, to be conducted in 1990, will depict the latest picture. As Dr Hiroshi Nakajima, Director-General of WHO, has said "Whatever the progress achieved, inequities in health remain unacceptable. As we approach the end of the twentieth century, we must reappraise the discrepancy between our intentions and reality".

Unless accelerated action is taken to identify the specific needs of the least privileged segments of the population and to fulfil them, the goal of HFA/2000 may not be reached. The remaining ten years of this century are crucial for understanding and identifying the problems of vulnerable and underprivileged sections of the population from a holistic angle. Adherence to social equity and justice demand that new avenues be explored and new initiatives undertaken to resolve this problem.

2. THE NATURE AND EXTENT OF THE PROBLEM - USE OF INDICATORS AND MEASURES

The dictionary defines "underprivileged" as meaning those less privileged than the others; not enjoying the normal standard of living or rights in a society. The working definition of underprivileged could be as follows:

> "Underprivileged are those who are deprived through some form - social, cultural or economic discrimination - of some of the fundamental human rights theoretically belonging to all members of a civilized society".

Such underprivileged people have less opportunity to improve the quality of life and are prone to exploitation by higher social or economic groups. Their main characteristics are low income, lack of adequate education, lack of knowledge, malnutrition, high morbidity, high mortality, and poor housing. In certain situations, people who are otherwise educationally or economically well-off, may have less opportunities to strive for better life due to social and cultural barriers and, consequently, are underprivileged.

Various terms have been used at different times to refer to such sections of the population in a society. These include terms such as vulnerable sections of the society, people below poverty line, less fortunate people, etc. The "less fortunate" is not a recent phenomenon. The 'less fortunate people' have existed since time immemorial and will continue to exist in the future unless societies wake up to the economic, social and psychological cost of allowing such inequitous structures to continue. The question, 'Why are they causing serious concern only now'? arises. The primary reason is one of conscience. The important contributor to the growth of such conscience is comparison. Improved communications have brought about an awareness among people that a better standard of living, totally different from what they are accustomed to, is possible. The stress is on the word "standard", and it refers to a condition which the whole population strives for.

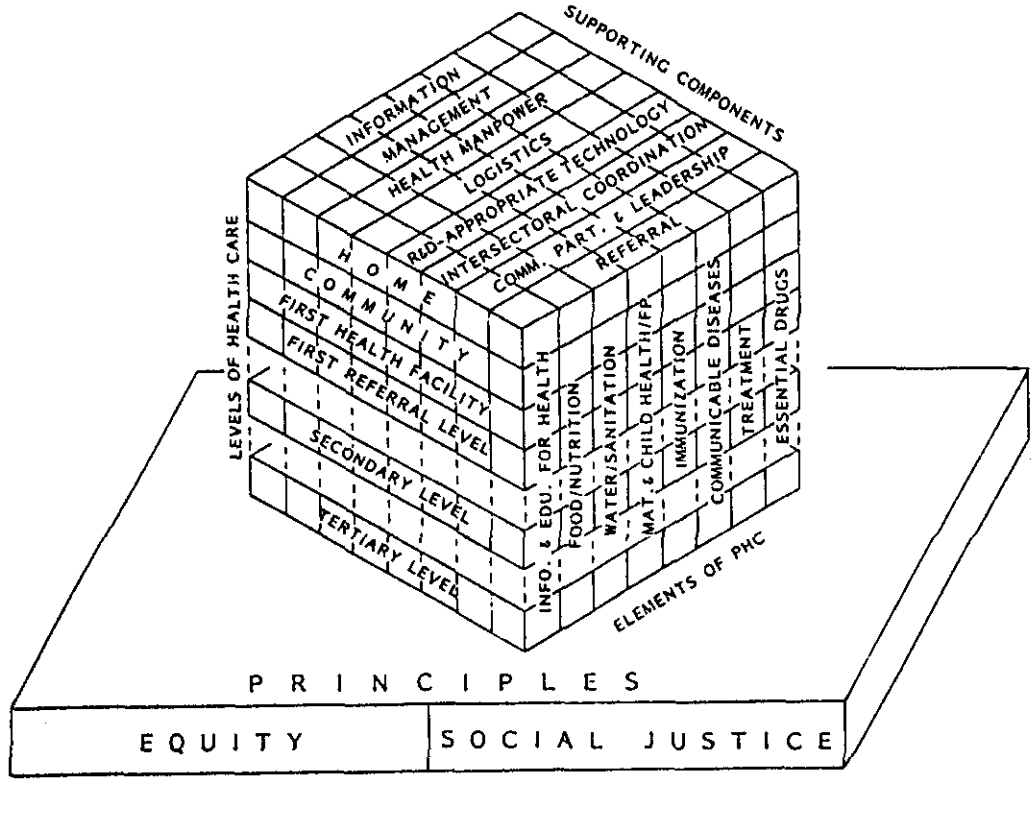
The persistence of inequity in health has to be recognized as a crisis. The presence, if not the prevalence of crises of different types, is normal in most societies. The extension of knowledge about problems of human health and ill-health depends also on sources outside the health profession. The pursuit of health has now come to be acknowledged as social and not merely a technical enterprise. However, the shift in emphasis from medical to a social model still has some way to go. The distribution of health or ill-health among and between populations has, for many years, been expressed most forcefully in terms of ideas on "inequality". These ideas are not just "differences". The focus of interest is not so much on natural physiological constitution or processes as outcomes which have been socially and economically determined. Interest needs to be concentrated on those conditions or experiences among populations which have been brought about by social or industrial organizations and which tend to be regarded as undesirable or of doubtful validity. Technological changes have generated more wealth and affluence, more consumption, more education, more communication and travel in this century than in all the preceding centuries. Technology is changing society in fundamental ways and creating such crises which the society does not know how to respond to rapidly and effectively. The increasing rate of technological change generates more and more of social and environmental crises. They come to a head more rapidly than in the previous centuries. They need societal responses that are quick. The lack of responsiveness to crises generates discontent. If the discontent spreads to large sections of a society, it will manifest itself into disruption and produce a negative impact resulting in alienation from society. In the current decade, man, society and governments have yet to learn to recognize a crisis before it develops rather than deal with disruption caused by discontent. Very often, states tend to deal with disruption and protests in a repressive manner.

In the field of health, the crisis, in terms of inequity, does exist. There are, however, very few examples of this crisis and the discontent

associated with it leading to disruption and protests. If at all, they have been more in the form of demands for improved and extended curative services rather than for the elimination of the underlying crisis. Societal problems are looming large today in the field of education, health, urbanization, transportation, crime, generation gap, environment, and the underdeveloped. The effect of rapid increase in population in some countries is another dimension. *This needs comprehensive crisis-recognition and problem-solving* approaches. In so far as health is concerned, the WHO definition of health "as a state of complete mental and social well-being and not merely the absence of disease or infirmity" shows concern to the person as a member of the human group. The emphasis is on the word "well-being". If disease is seen as a departure from a well-meshed geological and social performance, health by contrast becomes an ideal. Health, in fact, has two aspects - the *aspirational one associated with person's desires, and the instrumental one* associated with how well he can satisfy both his needs and desires.

The Alma-Ata Conference had urged that high priority be given to the special needs of those (a) who are most vulnerable or at the greatest risk, (b) those who are, for geographical, political, social or financial reasons, least able to take the initiative in seeking health care, (c) women, children and working population *at high risk, and (d) underprivileged* segments of the society. This concern for the underprivileged and vulnerable segments of the society is reflected in the national strategies. The evolution of primary health care as a tool to achieve the goal of Health for All is based on the principles of equity and social justice. The eight elements of primary health care, together with its components, are illustrated in the following figure:

Figure. GRAPHIC REPRESENTATION OF PHC IN THE NATIONAL HEALTH SYSTEM



The introduction of the district health systems approach was a step in the right direction to identify in particular segments of population who, for geographical or financial reasons, cannot have adequate access to health care. Other methods of identifying the underprivileged population have also been attempted. In particular, the risk approach to the improvement of health of mothers and children has paid handsome dividends. Thus, while the health sector generally recognizes the importance of improving the health of the underprivileged and the segments of the vulnerable population at the greatest risk, it has not yet approached this problem with a systematic identification of the underprivileged segments of the society and the vulnerable population.

The global strategy envisages a set of 12 global indicators (see Annex). Of these, it would perhaps be useful to consider the available information in relation to at least the percentage of national health expenditure devoted to local health, equitable distribution of health resources, the percentage of population served by primary health care and the percentage of population in identifiable special groups which have infant mortality of higher than 50 per 1 000 live births.

Health of the Underprivileged in South-East Asia

The importance of disaggregated information collection and presentation can be highlighted by the following two examples in respect of infant mortality rates (IMR) in India and Sri Lanka. In the case of India, IMR is broken down by state and by urban/rural area, and for Sri Lanka, by district. These two examples are shown in Tables 1 and 2.

TABLE 1. Estimated infant mortality rate in India, 1986
(Per 1 000 live births)

State	Rural	Urban	Combined
Andhra Pradesh	87	59	82
Assam	111	69	109
Bihar	104	68	101
Gujarat	124	66	107
Haryana	91	58	85
Himachal Pradesh	90	41	88
Jammu and Kashmir	86	58	81
Karnataka	82	47	74
Kerala	28	20	27
Madhya Pradesh	124	82	118
Maharashtra	73	44	63
Orissa	127	75	123
Punjab	72	55	68
Rajasthan	113	71	107
Tamil Nadu	93	54	80
Uttar Pradesh	140	88	132
West Bengal	75	55	71
Whole country	105	62	96

TABLE 2. Infant mortality rate in Sri Lanka, 1983
(Per 1000 live births)

District	Rate	District	Rate
Colombo	40.8	Batticaloa	23.9
Gampaha	17.9	Amparai	17.2
Kalutara	21.3	Trincomalee	13.7
Kandy	46.9	Kurunegala	27.1
Matale	24.0	Puttalam	26.3
Nuwara Eliya	51.5	Anuradhapura	22.8
Galle	27.8	Polonnaruwa	10.2
Matara	27.9	Badulla	29.8
Hambantota	14.3	Moneragala	13.0
Jaffna	22.2	Batnapura	36.3
Mannar	16.0	Kegalle	26.7
Vavuniya	17.4		
Mullaitivu	13.5	Whole country	28.4

It is clear that the national figure for India of 96 infant deaths per 1 000 live births hides figures as low as 27 per 1 000 in Kerala and as high as 132 per 1 000 for Uttar Pradesh. Similarly, this figure hides such a wide variation in rates as 62 per 1 000 in urban and 105 per 1 000 in rural areas for all India. Similar wide variations can be observed between the different states. In the case of Sri Lanka, the national average IMR is 28.4 per 1 000 while it varies from a low of 10.2 in Polonnaruwa to a high of 51.5 in Nuwara Eliya.

The disaggregation of information can be further extended, i.e., states can compile figures by district under them, and the districts by primary health care unit. From the point of view of achieving the stipulated norms of various indicators, this method provides a basis for identifying population segments and areas that need more attention.

Infant mortality is an important coefficient which may be interpreted as a comprehensive indicator of the standard of living, the level of health education and the effectiveness of the health care system. In the underprivileged population, this coefficient may be high.

The wide variation that is implicit in the information available on these indicators is illustrative of the fact that while there are islands of health prosperity in all the countries of the Region, there is also a hard core of ill-health affecting a large segment of the population of the Member Countries.

Traditionally, inequalities have been portrayed through the characterization of class differences. Inequality is difficult to measure and trends in inequalities, distribution of income and wealth, for example, cannot be directly related to indicators of health. In the absence of disaggregated data, one can make only subjective inferences. Consequently, methods, if any, adopted for the solution of problems, will also suffer

from inadequacies inasmuch as they are not specifically tailored to solve the problem. It is, therefore, of primary importance to obtain correct information using the most appropriate indicators.

Health indicators are part of social indicators. Social indicators cover a wide spectrum of activities. These include (a) collection of social measures such as infant mortality rates, numbers enrolled in primary schools, (b) development of macro- and micro-level measures to assist and guide in decision-making, (c) development of systemic indicators, such as assessment of quality of life, index of physical quality of life, socioeconomic accounting etc., to obtain a comprehensive perspective of social development, (d) research into new ways to measure important but hard-to-quantify information such as health status of the society.

3. DEVELOPMENT OF METHODOLOGY TO IDENTIFY UNDERPRIVILEGED GROUPS AND ASSESSMENT OF THEIR HEALTH STATUS

There are various approaches for identifying specified population groups or for assessing the health status of identified groups. In recent years, the refinement of rapid epidemiological assessment methodologies and their increasing application in diverse programme areas have proven useful, although research in these techniques is by no means complete. In general, rapid assessment methods include small area surveys and sampling, surveillance, screening of individuals or communities, and case-control studies.

Such methodologies have been widely and successfully used in assessing immunization coverage, but have also been applied in the fields of nutrition, maternal health, and diarrhoeal diseases. Rapid assessment may be directed at individuals, e.g. for the identification of those at risk for a specific condition, or at communities, e.g. for directing public health efforts and health services toward identified populations or to target specialized care to those most in need or most likely to benefit from such services.

The specific methodology and set of indicators to be used in any given situation, of course, depend on the objectives to be met and the outcomes expected. If, for example, the "health underprivileged" groups in a particular population need to be defined (screening), one would need to choose indicators that would clearly differentiate these groups from other more "privileged" groups in the population.

Appropriate screening indicators could include such data as access to safe drinking water, cleanliness of household, births attended by trained personnel, etc. These types of data are generally well recognized as being valid social indicators. They may also be useful for monitoring purposes, for example, to evaluate a project's progress, since they will change relatively quickly with the success of appropriate interventions.

Other indicators which could be used for screening but which are not amenable to monitoring situations include annual household income, female literacy, housing construction, etc. These indicators are not likely to change significantly in short periods of time, and therefore are not reflective of short-term programme impact. However, they would be useful in identifying groups or individuals in "underprivileged" or high-risk categories.

For assessing the health status of underprivileged groups, more specific indicators would need to be used. Examples include birth-weight less than 2 500 g, weight-for-age below a certain cut-off point for children under five years of age, infants fully immunized, prevalence of diarrhoeal diseases, and prevalence of night blindness in children. Again, the indicators chosen would depend on the purpose of the assessment, e.g. whether screening or monitoring, whether targets are individuals or populations, whether particular interventions are planned, etc.

After suitable criteria (indicators) to identify the underprivileged groups have been selected and tested, depending on the particular situation to which these criteria will be applied, an appropriate methodology could be developed. Sample survey methodologies, such as those used in EPI and diarrhoeal disease programmes, could be suitably modified to assess the nature and extent of the "health underprivileged" groups.

4. OBJECTIVES AND TARGETS

4.1 Objectives

The objective of development is to improve the standard of living. It is a value-laden concept with historical, philosophical and ideological dimensions. There is a need to reflect on what it is that the society wishes to develop, how it proposes to do so and what process it wishes to adopt. The choice of goals is not only fundamental to the question of development but also reflects a vision of values. Goals are not something unique. They undergo change over a period of time. They should not be confused with indicators of the degree of development such as gross national product, infant mortality rate, etc. Indicators can at best convey where we are and where we might be heading. The concept of development represents a broad set of ideas, and the desire to promote development cannot be pursued without due regard being paid to the goals and objectives of development. Thus, development constitutes more than progress and has to be rooted clearly and firmly in a socio-philosophical foundation.

In any society, there are broadly two sets of persons or groups. The first is committed to existing values and the second seeks the reallocation of values. The constituents of the two groups or categories are broadly similar, the single striking difference being that the opponents of change have, in varying degrees, a stake in the maintenance of prevailing policies. An attempt for change must lie within the perceived scope of legitimacy. The war on poverty is, at least superficially, recognized as legitimate in all countries. Even if it is backed by sufficient power and authority, it has still to cross multitudinous barriers to reach fruition.

In all Member Countries today, there is a recognition of the ill-effects of poverty. The definition of what constitutes poverty is, however, a relative one. Generally, this is linked to income levels. Most governments have also implemented programmes aimed at alleviating the conditions of the poor. Since all forms of political organizations have a bias for the exploitation of some kind of conflict and the suppression of others, issues of poverty are generally recognized as a threat to power. The exercise of such power takes place in the form of both decision-making and non-decision-

making. Non-decision-making can take several forms such as use of force, threat of sanctions, invoking of precedents, etc. There is a need to mobilize bias for the poor both by active decision-making and by non-decision-making. Thus, we, who are in a preferred position, have to recognize that the existence of wide variations in society is a crisis that can lead to dissension and widespread disruption. We have also to recognize that the full human potential of members of a society can be enhanced for the attainment of the well-being of all sections of the society only if even the poorest are assured of a minimum standard of living.

The attempt to bring about change has to be supported by successful exercise of power and authority so as to awaken public awareness and improve its scope of acceptance and radically alter community values. This imbalance between community values and issues becomes a two-way process. First, issues which survive ideological and political barriers of the political system must be resolved through a process of decision-making. Secondly, reshaping of this policy has to continue throughout the stages of implementation.

The incremental approaches to development which have been followed so far are unlikely to lead to a total reorientation of the health system. There is a need to analyse and reorient health policies recognizing the elements of conflict and political bias that exist in each society. The value conflictive element in policy-making involves the promotion of values related to a multiplicity of goals and objectives. This value promotion is a natural human result of diversity of value judgements in a society - a "means" to, and the "ends" of, a better life. The tools of this measure include activities such as negotiation, bargaining, mutual adjustment, etc., which are tangible aspects of policies as perceived by many people. This societal process enshrined in such actions as cabinet decisions, public hearings, parliamentary debates, has, as its goal, the allocation of resources according to some form of realization of conflicts. Topics of conflict are thus more concerned with matters of distribution of equality rather than allocative efficiency. An important element of policy-making is administrative or bureaucratic in nature. This includes routine activities of those employed for the purpose to simplify the procedure of decision environment and developing ways to standardize procedures and criteria for dealing with policy questions. The development and utilization of social indicators by this bureaucracy may either get suppressed at one extreme end or manipulated or prevented at the other extreme. That is to say, the substantive content and significance of information available to the bureaucratic system may get subverted by procedural wrangles or by incremental processes. A further element of policy-making deals with the application of analytical rationality to decisions on the allocation of resources. This is reflected in policy analysis but suffers from greater emphasis on allocative efficiency rather than distribution equity. There is, therefore, a need for all the three elements to co-exist with analytical rationality and for raising the conscience of the system.

4.2 Targets

The setting of targets is an important gateway between a policy initiative and the attainment of objectives. Within the framework of the national policy, once the underprivileged population groups have been identified,

the next important step would be to develop a specific national strategy and an associated programme/programmes within the framework of the national health policy and goals for improving the health of the identified sections of the underprivileged population. Programme objectives and targets, which are feasible and realistic in the overall socioeconomic and political environment, can be formulated at this stage. Targets within the objectives of the programme will focus on reducing the intensity of the most crucial factors affecting the health of the underprivileged.

The targets, in the first two years of a national programme, should be relevant to the national situation, be feasible and address specifically the identified underprivileged sections of the population. The following are some suggestions:

(1) Reduction in the percentage of newborns with a birth-weight of less than 2 500 g.

(2) Pre-school and primary education to be available to at least 25 per cent of the identified sections of the underprivileged.

(3) Income generation programmes based on self-reliance with collaboration to be introduced to cover the adults, including women, in the identified population.

(4) Primary health care service elements to be available to at least 50 per cent of the identified population.

(5) Adult literacy education programmes to reach at least 10 per cent of the identified groups.

5. APPROACHES AND ACTIONS WITHIN THE HEALTH SECTOR

5.1 Approaches

The absence of a sound theoretical base for health development as compared to other fields of science has resulted in the medical science focusing more attention on the individual rather than on the population as a whole. The increasing emphasis on technology in post-war years has also led to the attenuation of efforts and inherent strings of the health sector in the field of promotive and preventive health. There is undoubtedly a greater need to bring back adequate concern for promotive and preventive health. The technical discussions at the forty-second session of the Regional Committee recognized that the health sector in Member Countries had not made adequate use of epidemiology. There is a great inherent potential in the health sector to reduce inequalities in the health of the population in the Member Countries. It is to be recognized that in all developing countries great advances can take place in the health of the people as a whole if, in the light of the primary health care concept, adequate attention is paid to preventive and promotive health, including the availability of adequate water and sanitation. Living conditions and factors related to lifestyle contribute substantially to ill-health. If one were to consider the control of physical environment in its widest sense, it can be argued that the social, economic as well as psychosocial factors

have a large bearing on the health of the underprivileged. Thus, health promotion to improve the lifestyle - even of the poorest or the weakest sections of the society - can contribute a lot to improving the health of the whole population. Likewise, improvement in the living conditions can also lead to potentially great benefits.

Member Countries have adopted successful strategies to reduce or eliminate certain diseases. They have also adopted a risk approach to the improvement of health of mothers and children. It is possible to consider the issue of equity in the context of disease reduction approach for communicable or noncommunicable diseases. The issue could be related to social epidemiology and etiology of specific diseases. If one were to consider many infectious and parasitic diseases and relate them to the income, social status or living conditions, it would be found that people who are poor or socially disadvantaged or live in poor conditions, suffer the most. This applies to some varieties of directly transmitted diseases, such as TB, leprosy etc., to water- and food-borne diseases and also to vector-borne diseases. Thus the approach towards the reduction of morbidity and mortality in respect of communicable diseases in its gross form can be considered to improve the health status of the underprivileged. However, it is important to recognize the conundrum. The resources available for the reduction of morbidity and mortality associated with communicable diseases have been rather meagre. Secondly, these have not been sectionalized or seriated sufficiently to reduce or eliminate the risk to the underprivileged segments of the population exposed to these diseases. Thirdly, in relation to water supply and sanitation, in spite of the decade of development, statistics very clearly show that countries have not recognized the common danger as espoused in the constitution of WHO.

A somewhat similar methodology to the reduction of morbidity and mortality in relation to noncommunicable diseases can also improve the health of the underprivileged. The common understanding is that most of the noncommunicable diseases are diseases of affluence and therefore do not affect the poor and the underprivileged to the same extent. This is not necessarily true. First, it is important to recognize that there is a masking of the effects of such diseases as hypertension, IHD, RHD, cancer, etc., by larger prevalence of communicable diseases. The underprivileged and vulnerable sections of the population suffer from unhealthy diet, unsatisfactory social and working conditions, unemployment, etc. They are also more susceptible to the lure of advertisement for cigarettes or other habit-forming substances. Even in relation to occupational health hazards and environmental health hazards, this section of the population is at a greater risk. It is, therefore, important to introduce both direct and indirect measures to reduce morbidity and mortality associated with noncommunicable diseases occurring in the underprivileged sections of the population.

In addition to the reorientation of the health policy to provide for greater emphasis towards the underprivileged, there is a dire need to improve the process of health education using modern means of communication and information dissemination. This will not only increase the sensitivity of all population but also improve the political bargaining power of those who are at the greatest risk. Ultimately, however, it is a potential for self-realization which has to be ignited in each individual so that he or she takes adequate measures for the protection and improvement of his own health and that of the community of which he is a member.

5.2 Actions

In the light of the above considerations, the following actions within the health sector could be undertaken to bring about greater equity:

(1) A rapid appraisal to assess the health needs of the underprivileged. This can be done by a suitable modification of the methodology already available for a rapid appraisal to assess community needs that focuses on low-income urban areas. From the data gained by such a rapid appraisal, an information pyramid will have to be built. This rapid appraisal can be done in selected areas in about ten days.

(2) A sentinel surveillance of the underprivileged population and monitoring of their health status using a maximum of five selected indicators.

(3) Giving more attention to promotive and preventive activities, especially for the care of the underprivileged population.

(4) Adopting a holistic approach to the health of the population rather than focusing on individuals.

(5) Increasing awareness among decision-makers and planners in the health sector of the importance of living conditions and lifestyles of the underprivileged on their health status.

(6) Study of the relationship between poverty, malnutrition, education, and infectious and parasitic diseases on the general health of the underprivileged population.

(7) Earmarking of specific health resources for the underprivileged and developing well-defined programmes and activities in identified geographical areas giving special emphasis to water supply and sanitation programmes for the underprivileged population.

(8) Remodelling information and education for health towards the underprivileged. In this process, special attention to psychosocial behaviour and the use of habit-forming substances such as drugs, alcohol etc. needs to be provided.

(9) Undertaking surveys to determine noncommunicable disease problems of the underprivileged population.

(10) Taking steps to change the behaviour and attitude of health providers so as to give priority attention to the underprivileged from the time of planning, through implementation up to the stage of monitoring and evaluation.

(11) Ensuring that decentralized planning and management with adequate community participation becomes a reality.

(12) Improving the potential in the realization of individuals, particularly of the underprivileged population, so that they can protect and promote their own health as well as the health of the community.

(13) Developing an outreach strategy through the health services and involving nongovernmental organizations and community organizations in the care of the underprivileged population.

6. APPROACHES AND ACTIONS BEYOND THE HEALTH SECTOR

That health depends on a variety of factors and actions in other sectors is self-evident. The intersectoral dimension of health and the concomitant actions that could and need to be taken formed the theme of the Technical Discussions at the Thirty-ninth World Health Assembly in May 1986. It was recognized that improvement in health is a major goal of development in its own right and the improvement in the changing health situation of a country provides a crucial indicator of the quality of life and development. Equity in health is closely interwoven with the attainment of equity in other sectors. The health hazards facing the population, apart from intrinsic elements, are compounded by poverty, lack of education, poor housing, unemployment, environmental health hazards, etc.

In recent years, economists have been dealing with the issue of equity in a more concentrated manner. Opinions, however, seem to be divided. Some economists claim that the attainment of equity per se should not be the sole objective, and, furthermore, that the concept of equity is utopian and not attainable. Yet another group passionately pleads for the development of economic policies which would lead to a greater measure of equity. Since the health sector in most Member Countries has little or no say in decision-making on economic development, it can only be hoped that political thinking and policy development towards the equity approach will not get stunted.

There is a direct correlation between low per capita income and poor health in many of the developing countries. Food available to such segments of the population is yet another matter of concern. Thus, while disparities in health status can be analysed within the health sector, some of the contributory factors which lie outside the health sector also need to be taken into account. Since the countries are still in the midst of economic crises, resources allocated to health and, particularly as percentage of the national budget, have been shrinking. The consequence of adjustment policies undertaken as a result of recession has also adversely affected government spending on the social sector. This has directly led to a deterioration in nutritional status in the developing countries and, in some cases, increase in infant and child mortality. This is particularly true of the least developed countries. Consequently, there is a need to deal with the ill-effects of economic adjustment policies reflecting on the resources directed to health in particular and well-being in general. While the short-term myopic approach of reducing resources available to health may be a partial solution to the economic crisis, it is to be recognized that this could in fact lead to not only greater suffering but to a situation where additional resources will have to be made available in future years. Historical experience shows clearly that even in times of acute financial crisis, improvements in health could be achieved by following a policy of reduction of inequities.

The extent to which improvements in health status contribute to development as a whole has not been studied in great detail. This area is

clouded by subjective perceptions about the effects of ill-health. The economic impact of inequities in health has not so far received any attention though it might seem obvious that economic effects due to poor health must be considerable. Since improved health is a major goal of development in its own right, efforts to eradicate poverty, which is otherwise an obstacle to improved health, are worthy of support and are welcome. It must, however, be ensured that economic growth does not lead to increase in poverty of sections of the population. The equity-oriented health policies must, therefore, be also concerned with the analysis of inequities in terms of income and economic resources since the ill-effects of such economic inequities cannot be overcome by measures in the health sector alone.

There are a number of related sectors in which health elements need to be introduced. In the Technical Discussions at the World Health Assembly in 1986, particular attention was given to areas of agriculture including food and nutrition; education including culture, information and life patterns; environment including water and sanitation, habitat and industry. The linkage between low income and malnutrition is well known. It was recognized that issues of choice of crops, introduction of labour-saving techniques and pattern of land ownership, can affect the health of the population. In particular, landless farm labourers were identified as a group at great risk. In regard to education, the crucial role played by education in the promotion of health at all levels in schooling, and emphasizing the responsibilities of education in the health sector to protect and promote health, was noted. Equity-oriented educational policies giving priority and resources for PHC and female participation in schooling were identified as areas with which interaction between the health and the education sectors, was emphasized. UNESCO has embarked on a programme of "APPEAL" (this acronym stands for "Asia and the Pacific Programme of Education for All"). It would be useful for the health sector to get involved at the national level in the evolution and implementation of equity-oriented health education policies. Related to education is the whole process of health education. This needs to be targeted to vulnerable population groups, whether it be females denied literacy skills, urban poor in a period of rapid urbanization or adolescents and the elderly in urban societies.

Intersectoral strategies in the communication and dissemination of health knowledge are required for improving health behaviour and lifestyles. The whole issue of environment is taking a new dimension. The Director-General, in his statement has, inter alia, emphasized the need to keep the environmental aspect at the centre of all health development efforts. While the ill-health effects of inadequate housing, the non-availability of clean water, and the lack of sanitation facilities are well known, efforts to improve these have been stunted by the lack of resources. In addition to these, the health sector can be closely involved in protecting occupational health, particularly of unorganized labour. It has also to monitor the health hazards of industrial workers by keeping tabs on pollution and developing safeguards.

In sum, it can be said that there are myriads of opportunities for close interaction with other sectors to ensure that the policies adopted in these sectors are also directed at protecting and promoting the health of all people, particularly the underprivileged sections of the society.

Actions

(1) Undertaking studies to establish and portray the linkage between poverty and ill-health.

(2) Improving the availability of food to the underprivileged sections of the population.

(3) Supporting measures for improving the income of the underprivileged sections of the population.

(4) Studies to assess the impact of price policies on the health of the underprivileged and interceding with the concerned sectors to ensure that the consumption patterns do not become adverse.

(5) Working with the education sector to ensure adequate literacy and education for mothers and girls.

(6) Monitoring of environmental factors so that they do not adversely affect the underprivileged population.

(7) Giving greater attention to occupational health.

(8) Reviewing legislation, rules and regulations that can have an adverse effect on health.

7. CONCLUSIONS AND RECOMMENDATIONS

As we enter the last decade of the century, it is patent that a number of crises are looming on the horizon which, if not recognized in time, can lead to disruption of the entire social fabric. While this is true in respect of all countries in the world, developing countries in this Region have also to recognize that there is a need to reshape the goals of development and introduce equity-oriented policies in all sectors including the health sector. This is required not merely from a sense of righteousness but from a recognition of the common danger in allowing such inequities to persist.

The following recommendations would, therefore, seem appropriate:

(1) Member Countries should, in the context of their national definition of poverty line, attempt to develop an understanding of the term "underprivileged" in so far as it relates to the health sector. "Underprivileged" does not refer to individuals as such but a congregation of individuals - be they families, communities, clusters, villages or other recognizable groups of population.

(2) Using nationally-accepted parameters, information should be gathered on the social and geographical distribution of the underprivileged, their health problems and the like. This requires improvement of the health information system and the establishment of linkages between the health status and socioeconomic variables.

(3) Each Member Country should develop indicators or measures and their surrogates for measuring inequities in health.

(4) The existing health policies and strategies should be reviewed to ascertain the extent to which they address the problem of health of the underprivileged. Health policy analysis and health policy research should also be undertaken. This implies the need to avoid potential conflict between short-term needs and long-term requirements as also to overcome the resistance to change.

(5) Targets for improving the health of the underprivileged should be formulated. Such targets need not be uniform all over the country but can be tailored to suit the needs of different sections of identified underprivileged populations. The promotion of equity-oriented health targets should vigorously review the organizational structure, financial resources and manpower needs.

(6) Health status data should be disaggregated to the extent necessary. It is important to recognize that too much disaggregated quantitative data cause strain and information overload to decision-makers. On the other hand, overly aggregated data hide information vital to decision-makers. There is, therefore, a need for judicious presentation of information geared to the problem of health of the underprivileged.

(7) Close interaction with other sectors must be established to stimulate and assist in formulating policies which tend to improve the health of the underprivileged. For this purpose, health policy elements of sectoral policies should be identified and assessed from the equity point of view.

(8) The possibility of introducing legislation to secure rights in terms of health rights of all population including the underprivileged, should be explored.

(9) The present methods of normative increase in health care services coverage, while providing for greater access, does not necessarily cover all population. The reorientation of health system infrastructure, with stress on matching the needs of the underprivileged, would seem a prerequisite for reducing inequities in health. Till such reorientation becomes effective, the health system should seek to educate the underprivileged population in the advantages of utilizing the available health services and taking steps to encourage them to do so. An important element would be the linkage to the district health system development. The ongoing experiments on the district health system need to be strengthened managerially with a view to achieving the basic level of health for all major groups of the population within the existing financial constraints.

(10) The experience gained in the risk-oriented approach can be applied to identified health-underprivileged segments of the population.

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Annex

GLOBAL INDICATORS

The proposed reformulations, arrived at by consensus between technical programmes at HQ and the Regions and adopted with amendments by the Executive Board by Resolution EB85.R5, are shown below. Changes from the original versions are underlined.

No. 1 The number of countries in which health for all is continuing to receive endorsement as policy at the highest level.

No. 2 The number of countries in which mechanisms for involving people in the implementation of strategies are fully functioning or are being further developed.

No. 3 The percentage of gross national product spent on health.

No. 4 The percentage of the national health expenditure devoted to local health services.

No. 5 The number of countries in which resources for primary health care are becoming more equitably distributed.

No. 6 The amount of international aid received or given for health.

No. 7 The percentage of the population covered by primary health care, with at least the following:

- safe water in the home or with reasonable access, and adequate excreta-disposal facilities available;
- immunization against diphtheria, tetanus, whooping-cough, measles, poliomyelitis, and tuberculosis;
- local health services, including availability of essential drugs, within one hour's walk or travel;
- attendance by trained personnel for pregnancy and childbirth, and caring for children up to at least 1 year of age.

The percentage of women of child-bearing age using family planning.

The percentage of each-element should be given for all identifiable subgroups.

No. 8 The percentage of newborns weighing at least 2 500 grams at birth, and the percentage of children whose weight-for-age and/or weight-for-height are acceptable.

No. 9 The infant mortality rate (IMR), maternal mortality rate (MMR) and probability of dying before the age of 5 years (q5), in all identifiable subgroups.

No. 10 Life expectancy at birth, by sex, in all identifiable subgroups.

No. 11 The adult literacy rate, by sex, in all identifiable subgroups.

No. 12 The per capita gross national product.