Third World Legal Studies

Volume 1 Article 10

1-10-1982

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by

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Introduction

The effects of centuries of colonialism, dependency and unequal world exchange can be seen particularly clearly in the area of human health. For example, of the 1978 world total of 17 million early childhood deaths (i.e., those under five years of age) around 97% took place in the Third World. If all the countries of the world had the same early childhood mortality rates as those of Northern Europe, there would have been only 2 million such deaths. The relationship between such appalling health conditions and wider social structures is highlighted in the Sixth World Health Situation Report (1973-1977), prepared by the World Health Organization.[1]

> The most important social trends during the period of this report are reflected in the still low, and in some areas worsening, nutritional level of the bulk of the population. The employment situation, including access to land, has not improved in many countries and is partly, but not primarily, affected by continuing high rates of population growth, although there are signs of a slowing down of such growth in many parts of the world. The decline of rural life in many countries has led to unacceptable rates of urbanization and social and health problems on a mass scale in the world's cities and larger towns. Although some progress has been made in reducing illiteracy, a significant proportion of children in developing countries still do not attend primary school. The needs of women are being discussed to a greater extent than ever before, but there has been little practical achievement in this domain. In spite of significant economic growth in some areas, incomes in many countries remain blocked at unacceptably low levels. In addition, even when economic growth has taken place, the distribution of the resultant benefit has sometimes been such as to widen the social and health gap within countries. In such countries it is possible to see what has been termed "growth without development." In spite of some important areas of progress during the period under review, poverty remains the lot of substantial parts of the

> population of the Third World and it is of course this continuing poverty that is at the root of the world's most pressing health problems. Here, it is important to note that a number of developing countries have managed to reduce overall levels of poverty dramatically and improve health indices significantly, despite having per capita income levels comparable to those of other countries in the same regions, in which the health indices remain unsatisfactory.

The policy implications for the health sector which arise out of the situation described above are considerable. Perhaps the most important is the explicit recognition given to the view that health development is a reflection of conscious political, social and economic policy and not merely an outcome of the application of health technologies. This recognition is at the heart of intensive discussions, now taking place, about the political, social and economic links between health and development on the one hand, and the consequent health policies to be followed by governments, on the other. The changing definition of "development"--to include more social objectives than mere growth of national product--reflects the view that an increase in technological and economic capacities alone will not automatically produce health.

Basic Needs and Primary Health Care (PHC)

The "overthrow" of GNP as the key development indicator in the '70s opened the way for the needs of the poor, especially as seen in terms of income redistribution, employment creation and the provision of basic needs, to emerge as the central and immediate development goal. In addition, there is the perceived need for "community participation" in the development of nations and for a New International Economic Order (NIEO) to enable the peoples of the Third World to gain a greater share of the benefits resulting from world economic relationships. Basic needs have been defined as access to (1) goods (foods, clothing, etc.), (2) social services (education, clean water, health services, etc.), (3) employment (including access to land--the major determinant of good nutrition). Satisfaction of these needs require not only a growing national industrial capacity, but popular participation in (many would speak of popular control over) the processes of development.

Within the health sector, primary health care (PHC) has emerged as the "new" priority; as such, it represents the major basic needs related concept and planning instrument for change within the sector, expressing national political commitments to a "new health order" and the goal of "health for all by the year 2000." However, PHC is not considered as

something apart from the overall socio-economic or health system, nor as a perfect solution to all health problems, and certainly not as the sole creator of "health for all." At the very least though, it offers the health sector an instrument for the organization of more relevant and effective health care systems.

In September, 1978 the World Health Organization and UNICEF jointly sponsored the first International Conference on Primary Health Care which was held at Alma-Ata in the Soviet Union. The Declaration of Alma-Ata stated that primary health care:

1. Reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience.

2. Addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly.

3. Includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

4. Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors.

5. Requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate.

6. Should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need.

7. Relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as

applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

Of course, the idea and practice of primary care itself are not new. What is new is the priority such care should receive now that the international health care community has (belatedly) agreed on its importance. The significance of this recognition reflects not only growing understanding of the technical, economic and social issues involved, but also evolving political and economic relationships, both within and between nations, that have taken place during recent years.

To be successful the basic needs' approach must be much more than merely "food stamps" for the poor, and PHC must be more than second-class health care for selected population groups, more than an extension of the services offered by a conventional Ministry of Health, more than simply development of new types of community health activities. The intrinsic philosophy of PHC carries implications for overall economic and social policy, and for all the component aspects of the health sector, all aspects of the work of a Ministry of Health. Planning for health requires that one continuously ask questions about effects on the health of the entire population, and especially its weakest parts, of all governmental and governmentally-influenced decisions and activities. This implies a democratic, integrated and generally decentralized approach to planning and decision making, program implementation, and administration.

One problem now confronting those international agencies and governments which are serious about primary health care is the need to bring PHC into the mainstream of health and health sector development. In its earliest development there was a strong theme of separatism inherent in the PHC concept. This policy was encouraged by some of the bilateral and voluntary agencies. There was an implication that the poor should be "allowed" to take care of themselves, even as they continued to bear the major brunt of paying for national health care systems to which they had little or no access.

Some elaborations of basic needs and related PHC strategies assume that significant changes will follow from such innovations as the use of village level workers, or indigenous health practitioners, for the delivery/creation of basic needs. And yet all too many of these types of activities appear only as projects--that is, an isolated activity (often non-governmental in character) carried out apart from conventional national health systems which continue to absorb virtually the whole of ministerial budgets. In the absence of changes in the whole of national planning and delivery systems--if not entire political structures--such projects can (at best) only

lead to disappointment and frustration. In fact, even apparently quite radical proposals directed toward the training of "barefoot doctors" or other types of village workers, or concentrated activity directed toward the most scattered desert and nomadic populations, avoid the more central problem: the present unsatisfactory pattern of allocation of resources and resulting absence of basic needs satisfaction even for those who already have reasonably adequate physical access to, say, health and educational facilities. In some ways it appears that these long-standing problems are to be addressed by strategies which avoid reliance on existing health, education and other systems, which reflect disillusionment with these structures as they now exist in so many quarters. But such disillusionment should not be allowed to become the basis of two-tier systems, one for the minority with access to an expensive high technology system and one for the rest of the population. While village workers may very well be potentially important instruments of change, they can only be so in the context of extensive political, social and economic adjustment at national and international level. At this moment there is at least as much possibility of the basic needs and related PHC strategies becoming in most countries nothing more than a "dodge" to avoid change, as of their becoming positive instruments in the creation of change.

Basic Needs and Community Participation

Income redistribution and greater equity have been central themes of much recent development discussion--leaving aside various Marxist approaches; and these themes underlie various "basic needs" strategies. In its less carefully elaborated forms, the basic needs' approach has tended to degenerate into not much more than the provision of certain designated basic needs "stuff" for the poor. Conversely, in its better forms the current discussion of basic needs emphasizes the participatory element in the "provision of basic needs." What is not so often explicitly addressed is the relationship between participation and democratic control, and the nature of the wider national context required to create an environment in which both community participation and community control become realities.

A strong case can be made to the effect that basic human needs are unlikely to be satisfactorily "provided" in the absence of participation, and that genuine participation is highly unlikely in the absence of democratic controls. The availability of increasing amounts of basic needs "stuff" in Europe, North America and elsewhere has certainly increased life expectancy and improved the quality of life considerably for the majority in those countries. However, these changes took place under highly favorable economic and demographic conditions, at least when compared with those of Africa and Asia today, and in any event under conditions of increasing political and social participation and control by the middle and working

classes. It is also the case that recent years have seen increasing skepticism over the basic nature and value of the "provisions" being made under welfare state conditions. In sum, then, although it may be economically and technically possible to provide basic needs for all, it is highly unlikely to happen in the absence of increasing popular participation and democratic control at all levels of governmental and other institutional life. This issue will be illustrated below in the context of community-based health care services.

The advantages of locally-based health care services are very considerable; they include, at least potentially, physical proximity, resource inputs by the community, lower costs, and community participation in the development and management of the services. If fully developed, locally-based services would assure an improved rural-urban balance, the use of more appropriate technologies, additional resources and their more efficient use, greater equity in the distribution and utilization of resources, and higher levels of participation and democratization.

Before proceeding it is necessary to distinguish between central, district or local government services--often known as "basic health services" and comprising health centers and sub-centers and sometimes rural hospitals--and those services which are specifically community based. Basic Health Services are usually provided by some level of government, or sometimes by a semi-governmental agency (e.g., social insurance) or voluntary organization, with facilities and staff being supported and controlled primarily by them. The most clearly distinguishing factor between such services and community-based ones is that the latter are directly developed and controlled from within the concerned community. The principle that public service activities must be accountable to the communities they serve is well established (if not always honored). Of course, this principle applies to all levels of governmental activity, but it is more easily understood and applied at the level of the community: at this level it is possible to observe more clearly the direct links between community contributions to the services, and their consequent development and utilization. The extent of voluntary community contributions to the development and support of PHC activities is likely to be directly related to the community's capacity to influence decisions with regard to those activities. Because control over funding (or voluntary labor inputs) and control over decision making are complementary functions, they should always be considered jointly. Community controls over local PHC activities offers, at least potentially, the best guarantee of their successful development. To be successful, PHC will have to make use of technologies which result in services that are affordable to low-income populations. It is precisely the fact of community development and control over limited resources, both those contributed directly by the local community itself as well as by

higher levels of government, which offers the best assurance that appropriate technological choices will be made so as to assure the equitable and efficient use of those limited resources.

There are many ways in which the community can participate in the different stages of PHC development and implementation, from the definition of problems and the setting of priorities, through the planning and implementation of the entire range of locally-based PHC activities. It is in the course of such participation that precise judgments could be made which would determine the nature, cost and utilization of PHC activities; judgments concerned with such activities as labor contributions to construction, the training of village health workers, collaboration with traditional healers and birth attendants, the creation of local social insurance funds, etc., etc. As already stated, it is the net results of such decisions which would determine the basic costs of PHC.

Technical supervision of PHC comes from the more specialized levels of the health system, primarily through guidance, education and the supply of appropriate information. Managerial control of PHC activities comes primarily from the community itself; for example, with regard to staff discipline, the supply and safekeeping of drugs, and to community links with traditional healers and birth attendants. In addition to its contribution to the management of PHC, the community can contribute its labor for the construction of clinics, or pit latrines, or supplies of clean water, etc. Labor and time can also be contributed to vector control programmes, e.g., mosquito or snail control activities. Another important form of labor contribution by the community is the community health worker. If these health workers come from the community in which they live and are truly chosen by it, they will be more likely to have its support.

One other critical area of community participation in the creation of additional resources is that of finance: a few examples of this type of activity will be provided here. A fairly common method is special contributions, usually on a once only basis, by members of the community of cash or materials. Obviously enough, this method is of only limited usefulness. Probably the most potentially successful way of financing PHC at community level is through the development of various sorts of social funds. These can be based upon forms of communal production, certain types of community taxation schemes, or savings and loan cooperatives. These funds can be used (in cash or kind) as payment to community health workers, or for the purchase of drugs or other supplies. Another possibility is that of family insurance groups based upon monthly prepayments, or other types of self-help associations including religious groupings. A third possibility is user fee payments (in cash or kind) at time of illness. A major weakness of this system is that it tends to reproduce most of the

problems of conventional fee paying health care systems (especially its curative orientation and episodic character). The major new element appears to be the extension of this system to the countryside so as to pay for "modern"/"western" types of health care. The last example offered here is that of a mixed system, based upon a social fund which contributes to the upkeep of a community health worker and possibly pays for the initial purchase of a stock of drugs, and user fees which cover the cost of replacing the drugs (a revolving fund) as they are withdrawn from the community stock. A similar arrangement might be worked out based upon family or other voluntary association-type insurance schemes.

The Current Situation in Basic Needs Planning

In most countries formal social sector and other plans bear little relationship to actual happenings. The rhetoric of the plans is usually about the poor and the need for rural based activities, but spending programs mainly continue to benefit the better off in the urban centers. The so-called "implementation gap" in planning has at least two major bases. One is the general political difficulty of redistributing income and power from the rich to the poor and thus the "implementation gap problem" actually may be more of a "false rhetoric problem." The other related issue is the framework and ways in which planning is usually conducted in Third World countries. This planning generally begins from the national center which is heavily influenced by international agencies, these in turn are--or at least have been--heavily dominated by the major powers. In its turn, the national center dominates the state or region, which plays the same role with regard to the district and other local authorities. These authorities are generally in the hands of local vested interests having no great interest in the basic needs of the bulk of the population. In practice then, formal planning, in non-socialist countries anyway, tends to be a far less significant activity than it is usually perceived to be; in fact, it is often no more than an exercise in rhetoric having the intention of giving the appearance of activity and progress. It is not surprising then, that the Alma Ata commitment of "Health for All by the year 2000," to date at least, has resulted, in most countries, in a mounting pile of documents and proposals for research, definitions of criteria, methods of evaluation, etc. Of course, it is still early, and action beyond documentation, research and isolated projects may be in the offing. However, the political and economic realities of all too many Third World countries--and most industrialized country assistance agencies--are not such as to encourage too much optimism in this regard.

There are at least several different ways (and jargons) of formulating the fundamental requirements needed for the successful creation/planning of basic needs, including PHC. One rather crude way of grouping these

requirements is as follows:

1) Central planning policies and decisions directed toward the needs of the whole population, beginning with the poorest.

2) Individual ministries and other government bodies offering maximum support to "basic needs" in their respective areas, e.g., agriculture, education, health, etc.

3) Appropriate decentralization of planning, implementation and administrative decisions and activities.

4) Popular participation/control, and democratization of the nation's institutions.

With regard to these requirements, it is important to keep closely in mind the fact that the great advances in the state of human health to be seen in the industrialized countries of the world have stemmed largely from other factors than the provision of medical services, and especially curative ones. The provision of clean water supplies, generally improved hygienic standards and, perhaps particularly, increased incomes for the lower social classes leading to better nutrition, education, housing, etc., during the late nineteenth and early twentieth century all made important contributions to improved standards of human health. The very drastic fall in the levels of morbidity and mortality in the technologically advanced parts of the world which preceeded the development of potent modern drugs bears ample testimony to this fact.

From the above it follows that the most important aspects of "health planning" are those directed toward improving the capacity of the poorest in the population to care for their own most basic needs. Thus a more equitable distribution of land and the fruits of that land would in many countries have the most profoundly positive effect upon health status: or an industrial policy which emphasized the creation of employment, especially for those with few formal skills. In sum, it is clear that the overarching character of "good health"--as distinct from the absence of any specific disease--means that government policy on virtually any question will have important effects on the health of the population, and especially those in the population with least access to curative health services.

More specifically, the "health sector" as such is generally taken to include not only preventive and curative health care services, but discrete nutrition programs, community water supply and sanitation activities, aspects of housing and educational programs, and many elements of planned rural and community development. These various programs and

activities need not be governmental in character, but would also include various semi-governmental and private sector developments.

With regard to the activities of most Ministries of Health, these are concentrated upon the provision of curative health care services and the management of certain "vertical" disease control programs. In some countries water supply programs may also be an important component of health ministry budgets. Virtually all countries also have some elements of a general preventive health program built into their work, even if often only to a limited degree. In any event, in reality most Ministries of Health in most of the world might more correctly be termed Ministries of Disease: they are doing relatively little in relationship to health itself; instead, they primarily provide services for those already suffering from disease. It is probably the case that Ministries of Health could do considerably more for health, as opposed to disease, than they are now doing, but it is also probably the case that the bulk of health inputs, as opposed to anti-disease inputs, are in fact beyond the scope of their conventional activities. There are two reasons for this. One is that the major factors influencing human health arise out of the type of activities with which such Ministries as Agriculture or Industry are concerned, rather than Ministries of Health. The second reason is that much of that which has to do with health is not provided (in the conventional sense) by governments at all; that is, people basically "do for themselves" with regard to their own health requirements. Of course, governments and ministries may help to create the circumstances in which people can better help themselves, but they cannot substitute for the actions of people. It may be that Ministries of Health can best facilitate the development of the health of national populations by: 1) being supportive of the physical, social and environmental needs of (particularly rural and poor) populations as they are now being supported by other ministries than health, and 2) helping to create social and economic conditions which allow people to care for themselves in a health promoting way.

Some Administrative and Legal Implications

A. Decentralization and Local Control

1. Decentralization of planning, management and administration of health sector institutions and facilities, to the maximum degree consistent with overall national policies directed toward equitable development (it is obvious that many legal issues would arise in such a process).

2. Legal and procedural changes--in such areas as accounting and building standards--which allow financial management to remain in the hands of community-level health agencies, and construction standards to be determined locally so as to encourage the granting of (at least) smaller

health sector construction contracts to builders and artisans who are members of the community.

3. The creation of community groups (and the legal bases for them) having the responsibility of overseeing the management of local level health institutions and programs.

B. Health Workers

1. Changes in legislation and regulations which impinge on the ability of paramedicals, various types of community health workers, and traditional healers to expand on their role in health care, where it is judged desirable that they do so. In such cases, clear legal suthorization should be given them to extend their areas of practice.[2] In many countries this would be an act of recognition of already existing realities.

2. Because of the technical, social and political strengths of the medical profession, legislation and regulations which affect their qualification and practice often carry with them profound implications for the whole of the health care system. Many issues arise in this context: some of the most significant are those concerned with private medical practice either by employees of government health agencies (most notably the Ministry of Health) or those entirely in private practice; controls over place of practice by medical graduates either at home (e.g., compulsory rural service) or by limiting their ability to become part of the international "brain drain;" restricting the recognition and use of particular types of foreign examinations and qualifications.[3]

C. Some Legal Implications

It should be readily apparent that community-controlled PHC systems represent an "alternative" approach to rural health and development, an often radical departure from reliance on centrally controlled state structures to develop and manage local health care systems. Obviously, it may be difficult for rural communities and sympathetic local officials to develop alternative PHC structures unless there are analogous structural changes in other crucial sectors of rural development, unless there is a more general recognition by governments of the basic importance of participatory, community organizations. Not only must communities enjoy the right to form organizations, but governments must empower these structures to plan and manage facilities and allocation of other resources.

I must leave it to appropriate persons in other fields to explore the legal and administrative implications of these policies. Certainly, lawyers (among others) may be uniquely challenged to develop new kinds of

legal arrangements--perhaps "legal environments" is a better term--to make this kind of alternative development possible. I shall conclude by simply indicating in a summary way my perception of the nature of some of these challenges. Obviously, too, the kinds of legal changes suggested below will have to be adapted in one way or another to local and national circumstances, but there are probably some core principles which lawyers, working with and for the rural poor should use to help promote community-based, democratically-controlled PHC systems.

1. The development of community organizations. Laws must be developed--where necessary--to enable, indeed encourage, people in rural communities to form participatory organizations free from the direct control of local or state officials which can provide genuine participatory bases for planning and managing primary health care services. These organizations might well be multi-purpose groups: they might exist as structures for the allocation of other resources (such as credit) as well as health care services. The important point to be emphasized is that, in order to develop community-based PHC, people must have the right to determine for themselves, collectively, their primary health needs and to form locally managed institutions to meet those needs; and governments must assume the complementary obligation to aid this kind of development, not divert and control it.

2. Community-state relations. Similarly, community organizations must have access to the Ministry of Health and to other governmental bodies which control resources needed for PHC activities, and these agencies must be obligated by law to work with community groups to establish appropriate community facilities by furnishing technical personnel and material resources. The creation of genuine collaborative working arrangements between state and community organizations may be difficult, but that task will be less complex if it becomes the clear policy and purpose of the law (and those who administer it) to help communities become more self-reliant in the field of health care. Community groups themselves must not only be empowered to plan and construct facilities, but they must be empowered to employ and control the medical and other personnell needed for PHC facilities; for it is essential that these technical people be accountable to those they serve and not only to a bureaucracy of the Ministry of Health. Similarly, community organizations and not only state officials and agencies must be empowered to regulate local health hazards; for example, unsanitary water or sewage facilities, or other conditions or activities within the community which can be controlled by community action.

3. Health care personnel. Laws governing recruitment, training and control of persons who provide health care services must be changed to

reflect realities of community needs in rural areas and the importance of local control of this personnel.

4. Support groups at regional and national levels. In order to encourage the development of effective community-based primary health care systems, governments must recognize the right of both local organizations and other groups working with them--or for them--to form regional or national associations which can provide important back-up services to local groups (e.g., information) and represent their interests in provincial or national capitals. In some Third World countries this activity may be very important, for, as suggested earlier, sometimes development policies which encourage some kinds of industrialization or exploitation of resources have environmental effects (for example, pollution of water resources) which in turn have negative health or nutritional implications. National organizations, working for and with local organizations, may provide the most effective way--sometimes the only way--by which victims of the health harm done by such projects can fight back, for example, by asserting in the courts or other government forums their rights to environmental protection of resources essential to their most basic needs.

5. Legal resources for more effective international "people's health" lobbies. At the outset of this paper we noted the appalling health conditions which prevail in most Third World communities and which affect a significant part of the world's peoples. These conditions are the product of neglect, or worse, partly by the governments concerned, but also by the international community. Health care conditions are often exacerbated by the activities of international firms and other organizations; for example, companies which export dangerous substances to Third World countries. Recent years have seen the increasing penetration into rural areas of advertisers who seek to create markets for products which, at best, are of dubious value to the rural poor. All too often the poor lack information to evaluate these products. Of course, one way to counter these threats is to press for better regulatory laws, more effectively enforced, by governments. But governments are not always fully able, even if motivated, to protect the interests of the poor. Frequently, countermeasures undertaken by people themselves might be more effective. But certain of these measures must take place in international arenas too. The problem again, is to help people undertake these measures. Just as national "back-up groups" to aid PHC may be important to deal with central state institutions, so both national and international support groups may be necessary with regard to international organizations. These international support groups might sometimes lobby in international forums (such as WHO); they might also seek to develop new remedies (e.g., injunctive relief) against the foreign firms. Clearly, concerned lawyers are an important resource for these actions.

6. The relationship between human rights to health care and other human rights. The international community, through the Alma Ata declaration and in the UN covenants, has recognized human rights to some basic level of health care and protection. Realization of these human rights seems to me to depend on recognition of other more traditional civil and political rights, notably the right of communities to form organizations which in turn can become the agencies for community-based primary health care. Realization of these rights seems essential if there are to be changes in the deplorable health conditions described at the beginning of this paper.

In short, I think, health care in strategies for alternative development are significantly dependent on developing new legal strategies for a legal order geared to alternative development.

Conclusion

As was pointed out earlier, it would be good indeed if the successful meeting of everyone's basic needs could be accomplished by no more than the provision of these needs to a given, predetermined "basic" level. There are at least two basic problems involved, however. One, which ought to be at least somewhat less difficult to deal with, is that of squeezing enough out of the better off and powerful who now control the allocation of resources and directing it towards the needs of the poor and less powerful. Perhaps the better off will become wiser in the future than they have tended to be in the past and will actually give up or forego--or have taken from them as has happened before--enough so as to make possible the provision of basic needs for all. The other still more fundamental issue lies within the concept of "the provision of basic needs." Is it possible, in fact, for basic needs to be "provided?" This brings us back again to the basic issue of community participation and control; or rather, democracy, a term which seems to have gone out of fashion amongst many of those currently discussing the problems of underdevelopment. Although there may be additional reasons for this, it is difficult to avoid the conclusion that one of these reasons is the clear lack of democracy or interest in democratization (political, social or economic) of many, perhaps most, Third World regimes and their principal external supporters. I trust it will not be out of place to suggest that an appropriate subject for a future symposium might be "the relationship between democracy and development," with emphasis on the role of law in helping to create and strengthen this positive relationship.

FOOTNOTES

1. Sixth Report of the World Health Situation, 1973-1977, Part I: Global Analysis, Geneva, WHO, 1980, pp. 2 and 3.

2. For a useful discussion of the issues involved see: J.M. Paxton, F.M. Shattock, N.R.E. Fendall, The Use of Paramedicals for Primary Health Care in the Commonwealth: A Survey of Medical-Legal Issues and Alternatives, Commonwealth Secretariat, London, 1979.

3. For further discussion of these and related issues see: O. Gish and M. Godfrey, "A Reappraisal of the 'Brain Drain'--with special reference to the medical profession," Social Science and Medicine, vol. 13c, pp. 1-11; and O. Gish, A Study of the Mechanisms for Recognition of Foreign Qualifications and Experiences, World Health Organizations, WHO/EDUC/80. 180, Geneva, 1980, 20 pp.