ACHIEVING HEALTH FOR ALL?

GEOGRAPHY, DEVELOPMENT AND THE EPP REPORT

by

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GEOGRAPHY, DEVELOPMENT AND THE EPP REPORT

ABSTRACT

The Epp Report proposes health promotion as an organizing concept to address fundamental health status issues while at the same time complementing and strengthening the existing health care system. It sets a national direction for health promotion, identifying three challenges not adequately addressed by health policies and practices: to reduce inequities in health, increase prevention of illness, and enhance people's ability to cope.

The Framework emphasizes individual and community effort combined with public intervention to address these health challenges, but it ignores the context in which health experiences are shaped because the Framework is abstracted from space.

This paper describes the recent history of land use change in Vancouver's Downtown Eastside and analyses this change in light of the Epp Framework to illustrate how and why the Framework is deficient.

The essay will show that the Framework fails to identify such factors as economic and market forces that play such an important role in shaping the use of space, thereby conditioning the context of health promotion. These external factors can influence the health challenges and have the opposite effect of what the Framework is promoting.

QUOTATION

By Garry Gust,
Carnegie Newsletter
December 15, 1989

Welfare Hotel

Home is where your rent allows you to lay your bones at the end of the day. It's made out of materials provided by Nature, it's constructed by human effort and is in the custody of a deed holder. It may be one room with a bed, table and chair but it holds the small treasures of your existence: old letters from your family, a picture you taped to the wall, maybe a mouth organ or guitar, perhaps a souvenir from a happy day.

You may be 25 or 62 but the feeling is the same when the eviction or rent increase notices come. First you feel sick to your stomach, then you get very depressed. You thought you were already at the bottom of society's ladder, but now 'they' want you to go deeper.

Someone tells you to go to DERA, because they have homes in their custody. The good people there tell you 'yes, we have homes but they're full right now and there's 2,000 people ahead of you on the list.' Your depression is replaced by anger but you have no choice in the matter, no rights! All you have is the instinct to survive under the power of the Rulers. But, you'll find another 'home'. It may be smaller than you're used to and it might have drunks puking in the hallway and maybe someone next door bangs on the wall...but who cares; you'll find another home.

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CHAPTER 1: INTRODUCTION

Over the last decades the definition of health has undergone a significant change. In today's view, health is not seen as the absence of disease, but as the capacity of individuals to carry out prescribed roles within their physical and social environment. Multi-sectoral factors have become recognized as determinants of health. Such factors include the environment, nutrition, occupational health, lifestyle and socioeconomic status. This new health perspective was brought to the public policy agenda in Canada with the release of the report, A New Perspective on the Health of Canadians, also known as the Lalonde Report (1974). The report is seen as being important in promoting a re-examination of the determinants of health in Canadian health care policy.

Subsequent to the Lalonde Report, the Honourable Jake Epp, then Minister of Health and Welfare Canada, chose the forum of the First International Conference on Health Promotion, held in Ottawa in 1986, to release the document Achieving Health for All: A Framework for Health Promotion (1986), which has come to be known as the Epp Report.[1]

What is health promotion? In the words of the World Health Organization: "Health promotion is the process of enabling people to increase control over, and to improve their health" (Achieving Health

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[1]What must be kept in mind is that the Epp Report is a federal document. According to the Canada Health Act, the federal government is not responsible for providing health care and social services. This responsibility lies within provincial governments.

for All, 1986). The Epp Report proposes health promotion as an organizing concept to address fundamental health status issues while at the same time complementing and strengthening the existing system of health care. It advocates empowerment of individuals to make decisions about matters affecting health status. The Epp Report sets a national direction for health promotion initiatives for Canadians, identifying three challenges not adequately addressed by health policies and practices: inequities in health, continued existence of preventable diseases, and high prevalence of chronic disability combined with lack of adequate community support. The Report identifies three health promotion mechanisms to deal with these challenges (self-care, mutual aid, and healthy environments) and three strategies for implementing these mechanisms (fostering public participation, strengthening community health services, and coordinating healthy public policy).

In the Report conservative ideologies are used in emphasizing individual aid and self-help efforts to address health challenges, thereby reducing state involvement in the production of health status. The Epp Report framework consists of key phrases which are only loosely defined so as to appeal to various interest groups without alienating any specific interest. As a consequence, there are no explanations as to how the strategy might be implemented in any specific case.

The Framework also ignores the context in which health experiences are shaped because the Framework is a-spatial, i.e., the Framework is abstracted from space. The Framework also fails to identify such factors as economic and market forces that play such an important role in shaping the use of space, thereby conditioning the context of health

promotion. Who gets what in a given spatial context depends upon a permanent tension between national bureaucracies, committed to obtaining and distributing larger resources, and the interests of private capital manifested through the economic pressures of the city, private industry and the political party in power (Smith, 1979).

Space matters when looking at economic life because spatial differentiation is important for the way in which economic activities in a city operate (Massey & Allen, 1984). For example, financial and retail districts tend to be clustered within cities rather than randomly distributed across space. Similarly, city neighbourhoods tend to be relatively homogenous with respect to the socioeconomic attributes of residents.

Spatial differentiation within urban areas creates the possibility of an unequal distribution of facilities across space. For example, some areas might have good health care facilities while others are poorly provided. Some areas may contain very good housing, while in others housing may be of very poor quality. As social groups are unequally distributed across space, localities of multiple deprivation are likely to arise. The less spatially mobile are likely to suffer the most from such an uneven distribution. They are also likely to be lower income people, who are unemployed, or disabled and unable to look for work or housing in other areas of the city as transportation costs make travel difficult (Ball, 1984).

Spatial factors can also enhance the influence of landowners within development schemes and give landowners a monopoly over land (Massey & Allen, 1984). In the context of Vancouver, large-scale land

development proposals exert up-market pressures on downtown land, an area that previously had been neglected and had deteriorated over time. The increased demands on land by developers and their effects on land costs make it difficult to sustain low income centre city accommodation.

The causes of spatial patterns such as urban renewal cannot be sought simply in other spatial patterns; the causes have to be found in wider changes going on in a state's society and in society as a whole. There is a need to understand economic, social, and political mechanisms underlying the operation of such important health-related factors as housing conditions and changing housing markets (Massey & Allen, 1984; Soja, 1985, 1989; Gregory & Urry, 1985).

The precise impacts of economic and social restructuring are contingent upon the circumstances of specific locales (Cox & Mair, 1989; Giddens, 1985; Massey & Allen, 1984). Economic and welfare state restructuring at the level of the locale can generate spatial changes in the use of land (Wolch and Dear, 1989). Reorganization of inner city neighbourhoods, for example, occurs when the existing housing stock is gentrified by high-income households, or converted to non-residential uses as the demand for central land rises and as capital becomes available for construction of high-rise offices, and shopping and hotel facilities. This situation exacerbates a low-cost housing shortage, which may result for a growing number of the most marginalized households in homelessness.

The rising number of homeless people in Canada and the United States has prompted social scientists to investigate the dimensions of the problem and the complex nature of its causality (Wolch, et al, 1988;

Bingham, <u>et al</u>, 1987; Dear and Wolch, 1987). Many homeless individuals suffer from mental disorders and substance abuse problems, but significant numbers have become homeless solely due to economic circumstances. For most, homelessness is the end stage in a process of increasing marginalization driven by larger structural forces, including deinstitutionalization, restructuring of the welfare state, and in many cities, skyrocketing home prices and rents (Rowe and Wolch, 1990; Dear and Wolch, 1987; Baer, 1986).

This political-economic context has increased the chances that economically marginal and dependent people will face eviction, loss of welfare benefits, or failure to gain access to appropriate community-based support services (Wolch, <u>et al</u>, 1988).

Spatial structure can also be seen as a medium through which social networks are produced (Gregory and Urry, 1985). These networks are crucial to an individual's psychological well-being (Rowe and Wolch, 1990; Willmott, 1986; Sinclair, <u>et al</u>, 1984). Social networks are composed of those individuals whom one knows. These networks may also be comprised of several sub-networks which can overlap: kin, friends, and neighbours are important sources of social interaction and informal support (Fischer, 1982; Pearlin & Schooler, 1978). Also, social institutions such as government, community, voluntary, and self-help groups often provide an arena for social interaction.

These social networks are utilized in the course of an individual's daily path (Wolch & Dear, 1989; Hägerstrand, 1976, 1978; Giddens, 1985). Together, the daily path and social network constitute an individual's locale which contains both the physical space defined by

the daily path, and its social context. It thus includes environmental features, social institutions, and individuals present in the space. Space, therefore, cannot be ignored (Smith, D.M. 1979).

To illustrate the importance of context with regard to the dimensions identified by the Epp Report, one may consider Vancouver's Downtown Eastside (DES). The area is one of the oldest communities in Vancouver, but it is also the poorest with major problems of substance abuse and violence, where the majority of residents live below the poverty line and are on some form of fixed income (either social assistance, old age pension, or veteran's pension) (Leary, 1989). The majority of area residents are single, middle-aged males who live in single room occupant residential hotels and rooming houses (SRO's), are unemployed, and have not worked in many years. This is an area where many health inequities continue to exist. Many residents are chronically disabled or have some other form of health problem. It is also an area where soup kitchens and emergency shelters exist and where many deinstitutionalized mental patients and ex-prisoners end up without appropriate social support, adding further strain to the community. Many end up as shelterless persons. These events are a product of a number of forces: enormous rent increases; increased demand for existing affordable housing; a decrease in supply of affordable housing; deinstitutionalization; redevelopment pressures; etc.

Vancouver's DES is the community that became the target of massive evictions and speculative redevelopment proposals in an overheated housing market with the announcement of an international fair, EXPO '86, that was to be located in the area. Grief, hardship and deaths occurred

in the community due to massive evictions of long-time older residents, many of whom had health problems to begin with, from SRO's, or to horrendous rent increases that would force tenants to leave the area. Social networks were disrupted. People were left in limbo and the rate of homelessness increased. Community groups such as the Downtown Eastside Residents Association (DERA) tried in vain to stop the evictions. No policies were in place to protect the victims. There were no compensations.[2]

At the time, tenants were covered under the Hotel Keepers Act, which gave them no security of tenure. Legally, they were considered to be licensees so did not have the right to exclusive possession. As licensees, they were considered to be hotel guests even though they might have lived in the hotel room for many years. As such, they could be evicted at any time with only 24-hour notice required. They may have faced rent increases at any time and in any amount. Their goods may have been seized and their use of the room may have been regulated by the landlord (Hotel Keepers Act, 1979). Even today, tenants have little security, despite changes in municipal by-laws (Lee, December 30, 1988) as rent review, rent control and the rentalsman's office for the City of Vancouver have been abolished.

This essay will show that events like these have an effect opposite to what the Framework is promoting: they do not help people

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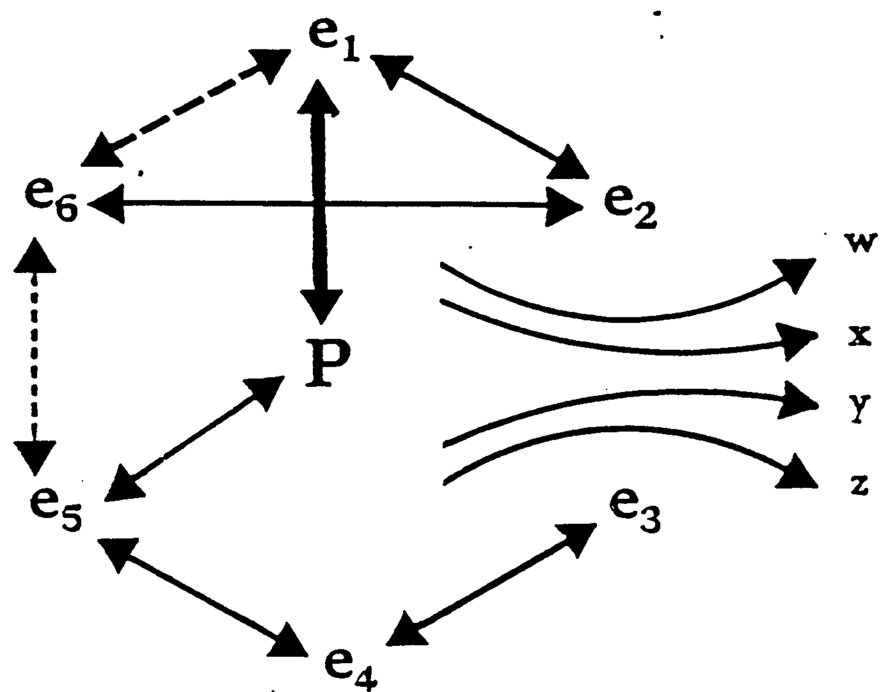
[2]The governing Social Credit Party strongly supports a capitalist free-market approach to public policy, rejecting rent freezes and uniform tenant rights.

cope with their lives, nor do they help them prevent further illnesses. Instead, they decrease a person's sense of worth and self-esteem and give people little or no incentive to be healthy. This story demonstrates the inability of the state to coordinate healthy public policies in the face of market pressures. The mental and social stress of such rapid and extreme change, of despair, isolation, loneliness, and crushed hopes, lead to mental and social diseases. Alcoholism increases. Suicide may take place. These development pressures and their consequences are beyond an individual's ability to prevent or control.

Various models have been proposed to illustrate the interactive and multidimensional relationships between the individual and the environment in relation to the determinants of health. For example, White's (1981) Socio-Ecologic Framework (Figure 1) presents an abstract idealization of the ways in which various environmental factors (labelled e_1 through e_8) interact with the person (P) and with each other to produce various outcomes (w, x, y, z). The model proposed by Smith (1982) (Figure 2) extends White's model by identifying specific entities relating to the state, the individual health services and the environment within the same interactive, multi-dimensional conceptualization. For purposes of this essay, these models have been reduced to the simplified form presented in Figure 3.

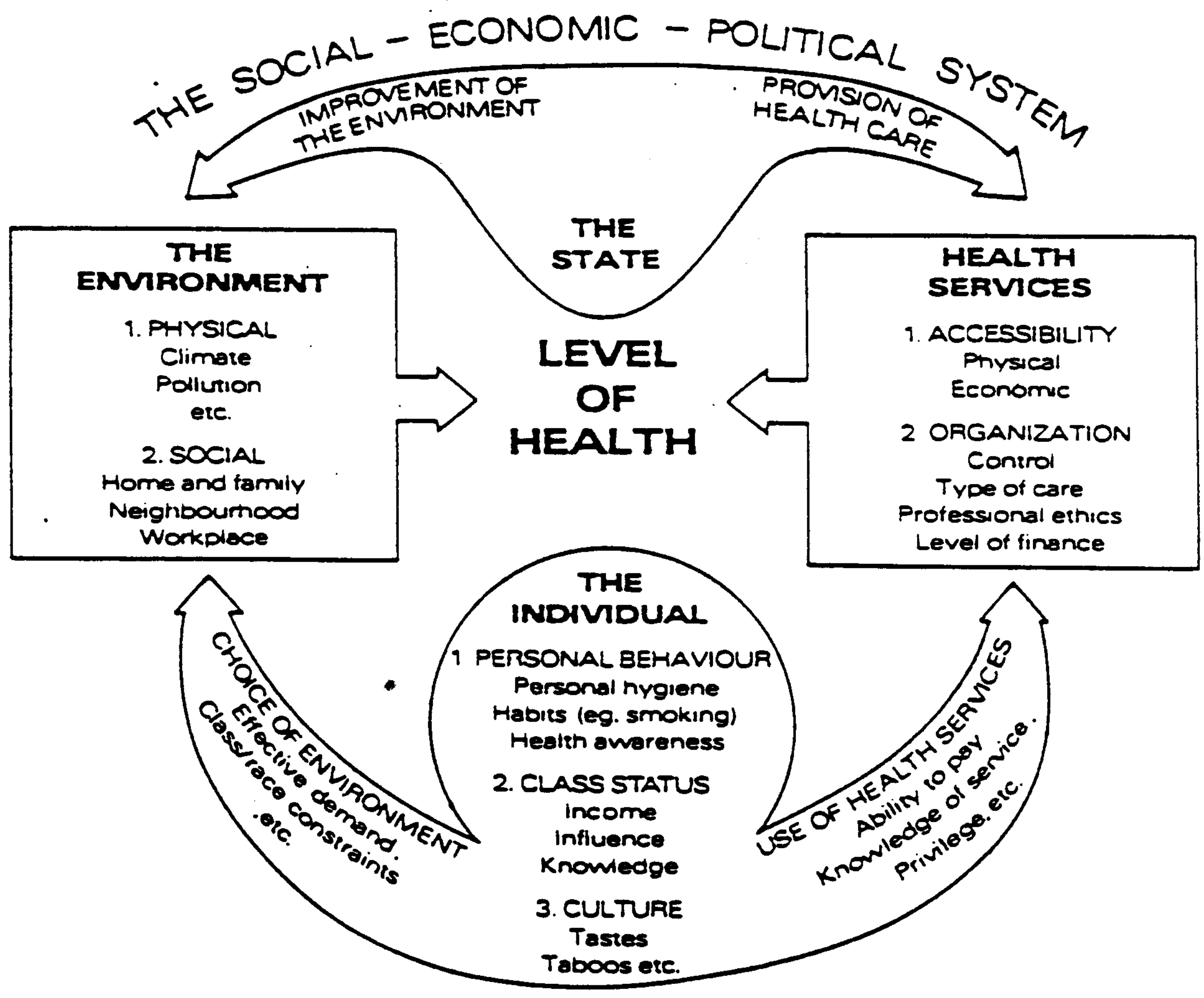
Figure 1

THE SOCIO-ECOLOGIC MODEL OF HEALTH



Source: White (1981)

THE SOCIAL CONTEXT OF HEALTH AND HEALTH CARE



Source: Smith (1982)

Figure 3 Simplified Model of Health

```
Health -----------------------------------------------> Socio-

                  --------->Health<--------

                 <---------Policies-------->           Economic

Status <----------------------------------------------- Status
```

Against this backdrop, the purpose of the paper is to describe development processes in the DES and to analyze these processes in light of the Epp Framework to illustrate how and why the Framework's failure to account for context, or to make reference to the importance of economic and market forces in shaping individual health experiences, results in an inadequate view of factors leading to health for all.

The structure of this essay is as follows. In Chapter Two, a brief historical account of health promotion in Canadian health policy is offered. Vancouver's DES is described in detail in Chapter Three. In Chapter Four, redevelopment pressures in the DES past and present are discussed. This discussion includes description of EXPO '86 and its impact on the community, post-EXPO redevelopment proposals for the area, and the population projections for the area as a result of proposed redevelopment. Chapter Five analyses the Epp Framework in light of these development pressures. Special attention is given to the loss of social networks and stress. Community efforts at self-help and an analysis of healthy public policies are also presented. The conclusion of this analysis is presented in Chapter Six.

CHAPTER 2:
THE CONCEPT OF HEALTH PROMOTION IN CANADA

A. A BRIEF BACKGROUND

The concept of health promotion in Canada can be traced to A New Perspective on the Health of Canadians (The Lalonde Report of 1974). The report identified the health field concept in which health is seen as a multidimensional phenomenon conditioned by lifestyle, the environment, human biology, and health care provision.

In the Lalonde Report greater responsibility for health was placed upon the individual. This individual approach to health care placed an emphasis on ill effects of particular types of lifestyles, for example, smoking, alcoholism, and dietary patterns. Such behaviours were seen as things over which the individual exercised control. This view of health was supported through the federal program, 'Participaction', in which individuals were urged to be more active (examples: jogging, cycling, walking). There was little attempt to view health as related to the life experiences of different social states or classes, to the workplace, to income inequality or to existing social policies and practices. Canadian health policy was largely based on improving access to health care services.

Following the Lalonde Report, "Health for All By the Year 2000" was adopted by the World Health Organization (WHO) at Alma-Ata (WHO 1978). Health was declared to be a fundamental right for each individual, to be attained through health promotion. Health promotion was defined as the process of empowering people to make decisions

regarding their health (WHO 1978). An application of the multi-sectoral perspective on health was adopted in several countries to meet new emerging health challenges (WHO, 1985; Health and Welfare Canada, 1988; Knowledge Development for Health Promotion: A Call for Action, 1989).

In Canada, a global conference on understanding health promotion resulted in the Ottawa Charter for Health Promotion (1986). The Ottawa Charter for Health Promotion has provided a clear vision of current health promotion concepts, such as achieving equity in health, improving quality of life (adding life to years), reducing morbidity (adding health to life), and reducing mortality (adding years to life), as well as achievements of health referring to lifestyle, to environment, and to health care (Health For All Ontario, 1987). Health is seen as a resource (an equity) and in terms of quality and not quantity of life. Healthy communities would be created by involving their members in devising and implementing strategies to enhance their own health (Hancock and Duhl, 1986). Such strategies include health promoting programmes and services that affect the community at all levels, as part of a coordinated public policy with health improvement as an objective (Milio, 1986).

Canadian and European approaches to health promotion have led to a variety of initiatives at the community level and various levels of government which seek to apply the health promotion perspective to improve health. The WHO - Europe's Healthy Cities Project (WHO, 1988b) and the Canadian Healthy Communities Project (CHCP) (Canadian Healthy Communities Project Start-Up Kit, 1988) (which is an outgrowth of the Ottawa Charter for Health Promotion) sponsored jointly by the Canadian

Institute of Planners, the Canadian Public Health Association, and the Federation of Canadian Municipalities (Spasoff, 1988; Mathur, 1989) are examples. The importance of the healthy city concept (Duhl, 1985) derives from the assumption that city governments have wide-ranging responsibilities and opportunities to influence health in order to achieve the objectives of Health for All.

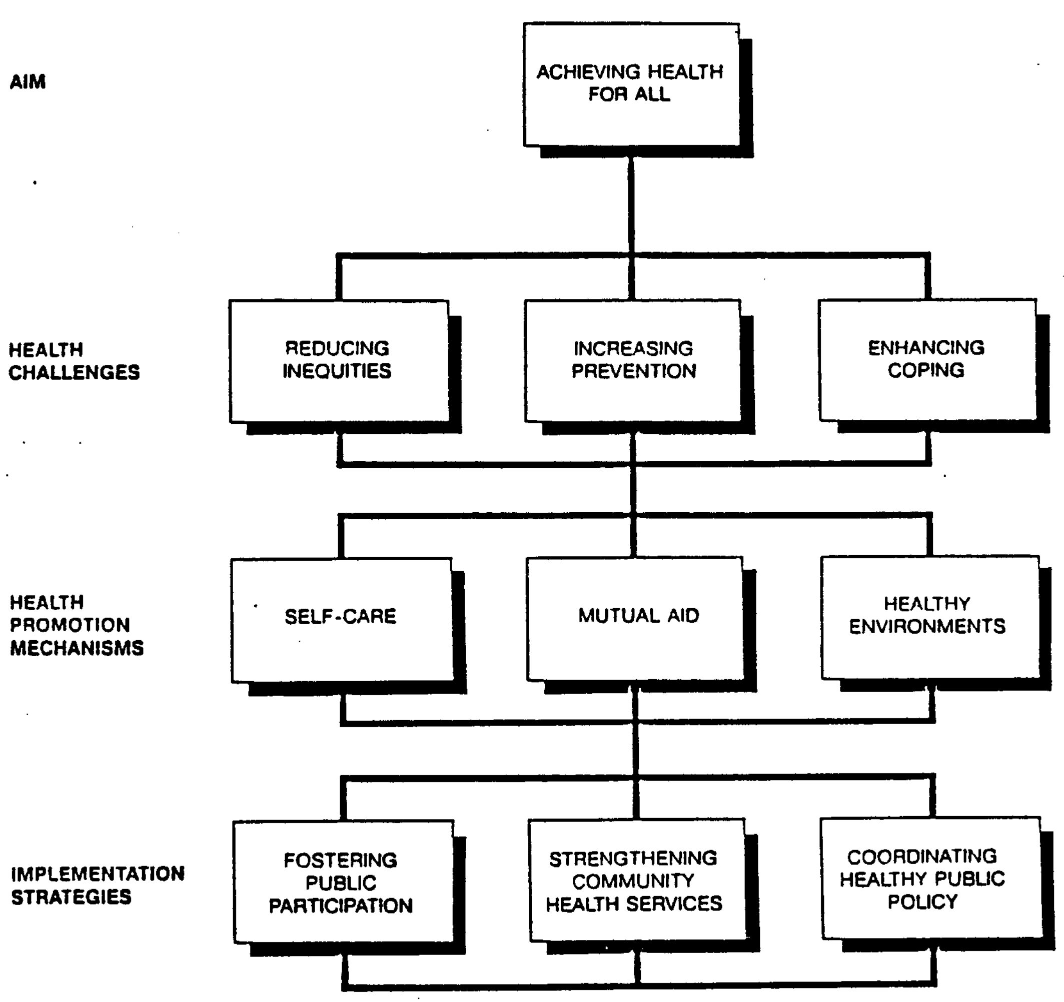
The goal of the CHCP is to improve the health and well-being of Canadians by adoption and implementation of a specific municipal policy or strategy for health which is multi-sectoral and which addresses the health challenges through meaningful public participation, as described by Berlin (1989a & 1989b). Quebec has the distinction of being the first Canadian province to have set up a provincial healthy communities network called "Villes et Villages en Santé" (National Conference on Major Health System Issues, held in Victoria, 1989).

B. OUTLINE OF THE EPP REPORT

1. Health Challenges

In 1986, the federal Framework for Health Promotion (Epp Report) was released. The Framework (Figure 4) identifies three challenges regarding the health of Canadians: reduce inequities in health status, increase prevention of illnesses, and enhance coping with day-to-day living of persons with chronic conditions. To meet these challenges, three mechanisms are identified: self-care, mutual aid, and healthy environments. Implementation of the mechanisms requires strategies based on increasing public participation, strengthening of community health services, and coordination of healthy public policies at all

Figure 4



Source: Achieving Health for All: A Framework for Health Promotion (1986)

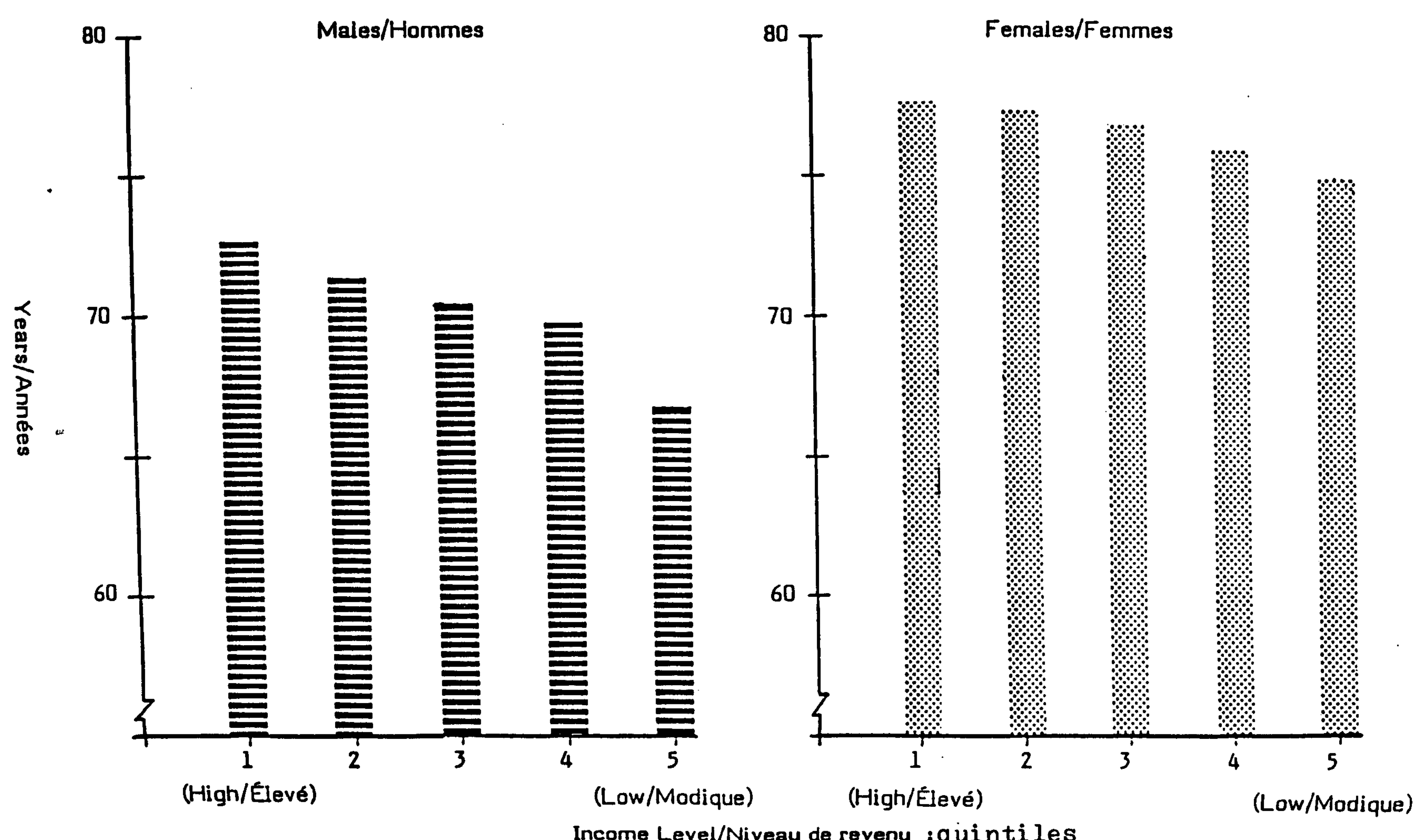
levels of the state. The Epp Report proposed health promotion as an approach to help Canadians meet emerging health challenges. It is not intended as an alternative to existing health care systems, rather it is meant to complement and strengthen the existing system.

Health is portrayed as a resource for everyday living, one which gives people the opportunity to make choices to change their surroundings in order to gain satisfaction from living. This view of health recognizes freedom of choice and emphasizes the role of the individual and the community. Viewed from this perspective, health becomes a state which individuals and communities strive to achieve, maintain or regain (Achieving Health for All, 1986). Components of the Framework are described in greater detail below.

(i) Reduce Inequities: Gains in the Canadian health care system have not been shared equally by all segments of the population. The health of the economically disadvantaged has not improved relative to that of the advantaged in Canada (D'Arcy, 1989). There is an abundance of evidence that suggests that the poor continue to experience distinctly inferior health status compared to the non-poor. Disparities in life expectancy are among the most common and graphic expressions of the inequalities in health conditions among the various socioeconomic classes of society (Kitigawa & Hauser, 1973; Wigle & Mao, 1988; Wilkins, 1988; Townsend & Davidson, 1982; Wilkins & Adams, 1983; Ross & Shillington, 1989; White, 1985; Statistics Canada and Health and Welfare Canada, 1981; Hay, 1988). An analysis of mortality in urban Canada in 1971 (Wigle and Mao, 1980) indicates a significant relationship between life expectancy and household income (see Figure 5). Life expectancy

Figure 5

Life Expectancy at Birth by Sex and Income Level/
Espérance de vie à la naissance selon le sexe et le niveau de revenu



Source: Wigle, D.T. and Mao, Y. (1980), p. 8

for males in the highest income class is six years greater than that of the lower income class; for females, it is about three years difference.

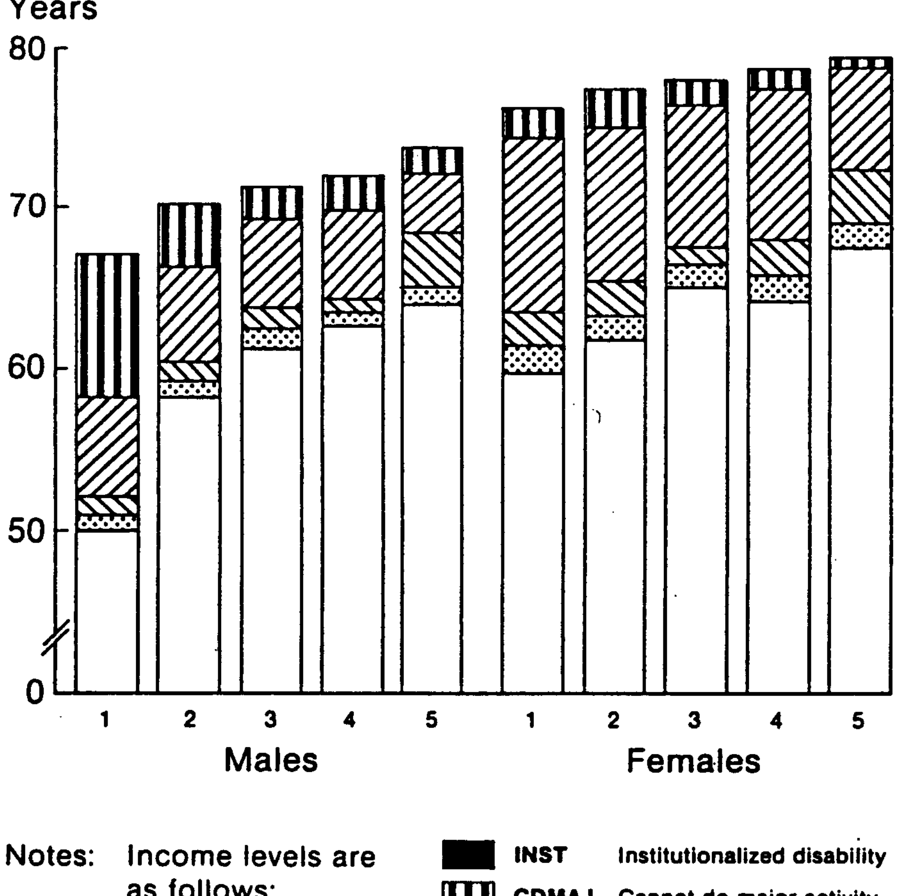
The Canadian Health Survey (Statistics Canada and Health and Welfare Canada, 1981) provides considerable evidence of the poorer health status of the lower socioeconomic groups. The poor suffer from a greater incidence and prevalence of virtually all kinds of medical complications, diseases and health risks. Wilkins and Adams (1983) demonstrated that healthfulness of life is directly related to income. "Whether the measure is overall life expectancy, disability-free life, or quality-adjusted life expectancy, the pattern is similar: the poorer you are, the less healthy you are likely to be, over a shorter lifetime" (Wilkins & Adams 1983, p. 93) (see Figure 6). They further demonstrate that income-related disparities in health status and health expectancy are exacerbated when disability is taken into account. The poor experience disability more frequently and with greater severity than the non-poor.

> Taking into consideration the degree of health enjoyed as well as overall length of life, we see that Canadian males from the highest income group can expect an additional fourteen years of life free of activity restriction, or eleven more years of quality-adjusted life compared to Canadian males from the lowest income group. For wealthier females, the corresponding advantages are an additional eight years of life free of activity restriction, or six years of quality-adjusted life (Wilkins & Adams, 1983, p. 95).

There is no trade-off between life and health expectancy and activity restriction or disability between the rich and poor. The shorter life of the poor is not compensated for by less disability.

Such disparities are by no means unique to Canada. In the United

Health Expectancy by Income Level, by Sex, Canada, 1978



Notes: Income levels are as follows:

1. Lowest quintile
2. Second quintile
3. Third quintile
4. Fourth quintile
5. Highest quintile

■	**INST**	**Institutionalized disability**
▥	**CDMAJ**	**Cannot do major activity**
▨	**RMAJ**	**Restricted in major activity**
▧	**MINOR**	**Minor activity restriction**
░	**OSTD**	**Only short-term disability**
□	**NODIS**	**Not restricted in activities (no disability)**

Source: Wilkins, R. and Adams, O.B. (1980), p. 96

Kingdom, there remain marked differences in mortality rates between occupational classes for both sexes and at all age categories. The poor also suffer more from a higher incidence of chronic illnesses and generally experience sickness with greater severity or seriousness. Infant mortality rates are markedly higher for the lower socioeconomic classes relative to the other groups (Townsend & Davidson, 1982).

In the United States, men in lower-income families report more than three times as many days of restricted activity as their upper-income counterparts. The prevalence rates per 1,000 persons for arthritis are 297.8 in low-income families versus 159.8 in upper-income families; for diabetes, 74.1 versus 30.5; for heart conditions, 139.3 versus 66.6; for hypertension, 172.7 versus 105.3; for impairments of back and spine, 102.8 versus 52.2 (Starr, 1981).

Much of the morbidity afflicting the poor, as the Black Report stressed, is a result of rather diffuse consequences of poverty, working conditions and deprivation in its various forms, such as poor housing, unemployment and the lack of education, recreation, and so on (Townsend & Davidson, 1982). As well, many of the risk factors faced by the poor, such as cigarette smoking, alcohol consumption, occupational hazards and poor nutrition, are derivative of a socioeconomic environment that is not amenable to quick or easy correction by the poor themselves.

(ii) Increase Prevention: Prevention involves identifying the factors which cause a condition, and then reducing or eliminating these factors. Today, prevention is aimed at the individual's lifestyle and behaviour (e.g., smoking and alcohol consumption are harmful and should be avoided). The focus is to try to reduce risk behaviour by changing

people's lifestyles. The realization that today's illnesses and injuries are the results of numerous interacting factors means that new and more effective ways of preventing injuries, illnesses and chronic conditions need to be found (Achieving Health for All, 1986).

(iii) Enhance People's Ability to Cope: Mental health problems and chronic conditions (chronic depression, drug dependence, arthritis, respiratory diseases, etc.) are today's predominant health problems among Canadians of all ages. These conditions can severely hinder people's enjoyment of life and performance of activities of daily living. Canada is experiencing rapid social changes. For example, the demographic structure of society is such that the number of persons age 65+ will more than double within the next thirty-four years. This older population is at greatest risk of experiencing chronic morbidities and disabilities. Also, many people of all ages, both men and women, find their lives stressful. Job burnout and factors such as unemployment have had an influence on the emotional well-being of people. Anxiety, tension, sadness, loneliness, insomnia and fatigue are often symptoms of mental stress which may find outlets in drug and alcohol misuse, family violence and suicide. Problems associated with mental stress may occur in times of crisis, or be the result of accumulated life circumstances. The challenge is to provide the community support needed by people with physical and mental health problems, and to help them improve the quality of their lives (Achieving Health for All, 1986).

2. Health Promotion Strategies

Existing policies are not sufficiently effective to ensure that

all Canadians of all backgrounds have an equitable chance of achieving or maintaining health. Therefore, a wider application of health promotion is needed.

Three mechanisms are involved in health promotion which are intrinsic to its success. They are focused on individuals or on groups.

i. Self-care: This refers to the individual's decisions and actions taken in the interest of his or her own health (for example, choosing a balanced diet). It is important for the individual to have access to appropriate information and to live in surroundings that are manageable.

ii. Mutual aid: This refers to people's efforts to deal with their health problems by working together; people helping each other and supporting each other. It's a kind of social support that arises in the family, neighbourhood, the voluntary organizations, or the self-help groups. There is strong evidence that people who have social support are healthier than those who do not (Stein et al, 1982; Berkman & Syme, 1979; Berkman and Breslau, 1983; Berkman, 1984; Blazer, 1982; Hanson et al, 1989; Auslander, 1988; Orth-Gomér & Undén, 1987). Social support may enable people to live interdependently within a community while still retaining their independence. Self-help groups, such as Alcoholics Anonymous (AA), help people to deal with a situation of crisis.

iii. Healthy environments: This refers to the creation of conditions and surroundings conducive to health. It means ensuring that policies and practices are in place to provide Canadians with a healthy environment at home, school, work or wherever else they may be.

Communities and regions are required to cooperate to create healthy environments. The environment is very complex and includes the buildings people live in, the jobs they do, education, transportation, and health systems (Achieving Health for All, 1986).

3. **Implementation of New Strategies**

To foster the success of health promotion, the following three implementation strategies have been proposed:

i. Promotion of public participation centers on the individual. It means ensuring that Canadians are able to act in ways that improve their own health. Encouraging public participation means helping people control factors which affect their health, enabling them to act in ways that preserve or improve their health. An example is the "Be Well" (Achieving Health for All, 1986) program in Vancouver, a network of services that established a self-help model to encourage participants to preserve their own health.

ii. Strengthening community health services: Here the aim is to give community health services a key role in promoting self-care, mutual aid and the creation of healthy environments. In order to create health environments, communities need to be adequately supported financially and with technical aid (such as public health workers) by the state. This will enable communities in helping physically and mentally disabled people to cope with everyday life through community programs. Examples for community programs are home care, counselling, and assessment.

iii. Coordination of healthy public policy: In order to provide physically and mentally disabled Canadians with a healthy environment,

coordination of healthy public policy is required. Public policies such as housing, welfare rates and community services, for example, need to be coordinated to provide people with opportunities for health. Without such coordination, self-care, mutual aid and healthy environments are not likely to occur. A number of these policies require joint federal, provincial, and municipal effort (Achieving Health for All, 1986).

C. ASSESSMENT OF THE EPP REPORT

The Framework for Health Promotion emphasizes individual and community effort and public intervention to address the health challenges. It individualizes health, ignoring the social, economic, and political causes of behaviour and disease. Such an approach is unjust (Tesh, 1988). It supports a political predisposition to ignore questions about the structure of society and the distribution of wealth and power; instead, it concentrates on questions about the behaviour of individuals within that structure. But individuals can only choose from among the options which are available to them. Access to these options is defined by income, environment and ultimately by public policy.

The Framework ignores the context in which health experiences are shaped because it is a-spatial, i.e., it is abstracted from space. It also fails to identify such factors as economic and market forces and existing public policies and practices that can have significant influences on people's lives and ultimately on their health. The health promotion Framework seeks to increase individual control through enhancing coping with day-to-day life, increasing self-help, and increasing mutual aid -- all of these presuppose security of tenure in

housing, individuals with resources to make decisions, and with some vested interests in themselves (a sense of worth, esteem, etc.). However, as will be described in subsequent chapters, persons living in the DES have very little control, little security, little self-esteem; they are also the most disadvantaged with regard to health. How relevant is the Framework to these persons?

CHAPTER 3:
VANCOUVER'S DOWNTOWN EASTSIDE:
A PROFILE OF A COMMUNITY

The DES of Vancouver, B.C., is an area that is bounded by Clark Drive, Campbell Street and Gore Street to the east, and Burrard Street to the west, Burrard Inlet to the north and False Creek, East Pender Street and Venables Street to the south (see Maps 1 & 2, Appendix A).

A. A PROFILE OF THE AREA

1. A Brief History

The DES is predominantly a working class area; it is also the oldest area of Vancouver. In the late nineteenth century it was the heart of the city, providing immigrant families and low-income, blue collar workers with a cheap place to live, close to the mills and canneries on the waterfront. As time went on, the central business district shifted to the west, and the area was zoned for heavy industrial use during the 1940's. Residential land values fell. The community "headed down the road of neglect and deterioration" (Olds, 1988, p. 81), decreasing the quality of life for residents and acquiring the "Skid Road" label (Green, et al, 1989, p. 7). This led to further neglect of the area. Undesirable institutions were dumped in the area by politicians as little resistance or protest would be faced from the residents. The community was, and still is, the poorest in Vancouver. It is home to 10,000 people, several thousand of whom have lived in the SRO residential hotels and rooming houses for many years (see Table 1) (Green et al, 1989).

Table 1

"Market Housing Survey" City of Vancouver, Social Planning Department, February 1986.
Random sample of Downtown Eastside residents, 5295 monthly renters surveyed:

	Length of Time in Hotel		Time in the Downtown Eastside	
6mo or less	1532	28.9%	848	16%
6-11 months	779	14.7%	382	7.2%
1-2 years	557	10.5%	265	5.0%
3-5 years	1118	21.1%	906	17.1%
6-10 years	779	14.7%	848	16.0%
11-20 years	334	6.3%	906	17.1%
20+ years	196	3.7%	1140	21.5%
	5295	100%	5295	100%

Source: DERA (1987) p. 9

In 1973, residents of the DES, who were tired of the indifference, neglect and exploitation which increased their poverty, formed a residents' organization: the Downtown Eastside Residents Association (DERA). They renamed their neighbourhood "The Downtown Eastside", (DERA, 1987, p.9). Since 1973, DERA has worked on dozens of social issues, ranging from welfare problems and alcohol substitutes, to housing needs, Expo evictions and redevelopment of the area, including construction of more social housing. From the time the Expo evictions started, DERA has assisted in the relocation of area residents. This assistance includes follow-up with the Medical Health offices, coordinating homemaking services and meals on wheels delivery, finding furniture and household items, conducting daily or weekly checks on relocated residents and arranging volunteer movers and trucks to move evicted residents.

DERA has fought for decent housing, park space, recreational facilities, a library, safer streets. The residents felt that their neighbourhood would be improved if more affordable units were built and existing rooming houses were fixed up, if streets were cleaned up and if public safety was increased. They argued that drug dealers be eliminated from the community, that drunks not be served in beer parlours, and that some of the parlours should be closed as there are too many of them. A big campaign led to the closure of a government liquor store in the area which specialized in cheap wines.

2. Residents of the Area

A recent survey of the DES conducted by DERA (Green et al, 1989)

showed that 82.7 percent of all residents are people who live alone (singles); 77.3 percent of them live in private market housing, while 22.7 percent live in non-profit housing. 80.7 percent of the population are males; 19.3 percent are females. The majority of the people are over 51 years old. 20.7 percent of residents were born in British Columbia, 47.7 percent were born in other Canadian provinces, and 31.7 percent were born in other countries. The population of the community is 67.5 percent caucasian, 18.3 percent oriental, 11.7 percent native Indians, 0.6 percent East Indian, and 1.9 percent are from other groups. 87.5 percent of the surveyed people were unemployed; only 4.9 percent were working full-time, and 2.2 percent work part-time. The average period since residents had last worked was over 7 years (Green et al, 1989).

An example of an area resident is sixty-three year old Jack Chalmers who has lived in the area for 12 years. It wasn't where he planned to be and it wasn't drinking or drugs that originally put him there. His story shows how easily anyone can find themselves in a rooming house wondering what they did to deserve it. For a lot of people, it is just a chain of circumstances. Chalmers now works at the Downtown Deposit Project (a DERA project), helping low-income residents get bank accounts.

Born in Scotland, raised in Montreal, he moved to Vancouver to work as a florist. After a heart attack and a small stroke, he had to give up his job and moved to Calgary to find another occupation. When he returned to Vancouver a few years later, he could not afford the rent for an apartment in the area where he had lived before and moved to the

Eastside where he still lives (Arnott, August 11, 1989).

3. An Area of Inequities

Many inequities exist in the DES, in income, accommodation, and health. As the housing survey conducted by DERA (Green <u>et al</u>, 1989) shows, the majority of area residents are single, middle-aged males who live in the many SRO's and social housing projects in the area. The majority of the residents are also unemployed and have not worked in years. The average annual income in 1987 was about $5,268, less than half the estimated poverty line for single persons in Vancouver, which was $11,079 (Goldberg, 1989).

Accommodation in these residential hotels is poor; about 50 percent of the lodgings have no cooking facilities and those with facilities only have a single hot plate. Most units do not have private toilets, baths or showers. There are no telephones in the rooms and very few amenities, if any. Many of the residential hotel rooms are neglected, bug infested, and in violation of the municipal building codes, yet rents are among the highest in the city per square foot. The average monthly rent is $225.91, 51 percent of the monthly income of about $439.

SRO residents have little security of tenure, despite recent changes in municipal by-laws (Lee, December 30, 1988). They may be evicted at any time or face rent increases in any amount with only 24 hours notice. This leaves the typical Downtown Eastsider vulnerable to any speculation by hotel owners interested in cashing in on an overheated housing market. As these residents have no tenancy rights or

security of housing, live in minimal living space, have no property of their own, and are also socially isolated, they are considered homeless by some authors (Cohen et al, 1988; Ropers, 1988; Dear & Wolch, 1987; Oberlander & Fallick, 1988).

Four temporary shelters for homeless people in Vancouver provide dormitory accommodations, with a total of 199 beds (Lookout, n=63; Triage, n=26; Dunsmuir House, n=30; and the Catholic Charities, n=80) (Buckley 1990).

There is little information on the health status of area residents. The DERA housing survey (Green et al, 1989) reported some physical disability for about half of the SRO residents; about 15 percent reported serious disabilities. In the United States, the major health problems among the homeless are respiratory ailments (including tuberculosis), peripheral vascular disease, lice and scabies, trauma, substance abuse, hypertension, mental illness, and nutritional deficiencies (Cohen & Sokolovsky, 1989; Ropers, 1988; Dear & Wolch, 1987; Committee on Health Care for Homeless People, 1988; Brickner et al, 1985; Ropers & Boyer, 1987; Cohen et al, 1988; Breakey et al, 1989; McLaughlin, 1986; Buckley, 1990).

The DES has only 7.7 percent of Vancouver's population, but of the 207 homicides that occurred in Vancouver between 1980 and 1986, 104 (51 percent) occurred in the DES (Coburn, 1988).

B. A COMMUNITY

Community has been defined by Ahlbrandt Jr. (1984) as a "community of action" (p. 1). It is the location where primary and secondary

relationships of residents take place as well as all other activities in which people are engaged. Primary relationships are identified as those relationships between providers of social support, friends, and family members. Secondary relationships involve the process of neighbouring: provision of help, information and social interaction, a "locality of place dimension" (Olds, 1988, p. 91). This concept can be applied to the DES. Here, residents rely upon the various services which were developed for their special needs. The services include a food bank, food stores, a health centre and a community centre. Disability and age hinders many residents from travelling outside of their community.

Social networks are also part of this community. Most people live in the DES because they are poor. Studies done on SRO populations indicate that these individuals maintain their independence without much outside help and are very self-reliant (Eckert, 1980). This perception of self-reliance is very important to the positive self-image of these people. Stephens (1976) found these people to have a high need for privacy and independence even to the detriment of health. Although they are very independent individuals, they do rely on social networks (social support systems).

In summary, the DES is a residential community that has a life of its own. Its residents are mostly elderly and poor, suffering from inequities in income, space and health, among other problems. They are not normal, healthy elderly people and they do not meet middle class standards. Their socioeconomic status makes them vulnerable to potential housing impacts, leading to further inequities and inability to cope with their everyday life.

CHAPTER 4: A CHANGING LANDSCAPE: REDEVELOPMENT IN THE DOWNTOWN EASTSIDE

A. THE WORLD'S FAIR AS AN INNER CITY REDEVELOPMENT TOOL

> For six months in 1986, all eyes will be focused on Expo, its attractions, events and structures. By 1987, Expo will be gone and the 220 acre site dismantled. Expo is really a gigantic urban redevelopment, an expenditure of more than one billion dollars to spur public and private land developers....Because of Expo Vancouver will never be the same (Gutstein, 1986, p. 65).

In January 1980, B.C. Premier Bill Bennett announced a proposal to redevelop the north side of Vancouver's False Creek area, a 220-acre (82.5 hectare) former industrial area, and turn it into a high-density, instant 'city within a city' with a domed 60,000 seat stadium (B.C. Place), 6 million of square feet in office towers, miles of roads, and rapid transit stations. The redevelopment of the False Creek north shore would be North America's largest urban redevelopment scheme; a plan to place Vancouver among the world's great cities (see Appendix B).

The provincial government began designing its long range grandiose redevelopment of Downtown Vancouver with a World's Transportation Fair (Expo '86) as an integral part of the plan to attract visitors and ultimately public and private land developers and investors for the area. The government's focus was on job creation, employment, and economic renewal, since these were B.C.'s major problems in the early 1980's (DERA, 1987).

Bill Bennett said: "Expo will be a turning point in B.C.'s history....When Expo closes, you will see a surge of construction on the site far bigger than the fair itself and will confirm Vancouver's

reputation as one of Canada's most dynamic cities" (quoted in Anderson & Wachtel, 1986, p. 61).

World fairs have been used to stimulate trade between cities, regions and nations, particularly during an economic depression. They have also been used as an inner city redevelopment tool; redevelopment has become one of the most important reasons for governments and local business elite to become involved in such a costly endeavour. The fairs' role in the physical restructuring of the inner city, together with all the physical, economic and social impacts associated with major urban redevelopment projects have been widely ignored, although the origins of almost every world's fair are rooted in the redevelopment potential of a fair (EXPO 62, Seattle, Washington; EXPO 67, Montreal, Quebec; EXPO 68, San Antonio, Texas; EXPO 82, Knoxville, Tennessee; EXPO 84, New Orleans, Louisiana are some examples) (Olds, 1988). "Blighted" inner city areas are cleared or the fair is situated in close proximity to such an area in order to stimulate redevelopment. Bordering communities experience the impact fairs have on land use. Tenants living in houses, apartments, residential hotels and lodging houses are evicted because of the market dynamics. Viable communities are destroyed. Residents' abilities to cope with the stress of everyday living are reduced. Carefully built social networks are disrupted as housing is demolished. New higher income housing is built. For example, Seattle's EXPO 62 Fair was held on publicly owned city land which was surrounded by a "blighted area of slum dwellings" (Ibid., p.32). The area was cleared and the fair was held. In San Antonio, Texas, a run-down residential area of substandard and dilapidated houses

was cleared to make way for the World's Fair. According to Montgomery (1968):

> The urban renewal process provided the vehicle that made possible the land assembly and clearance necessary to get the fair up on time; at the same time the fair provided impetus that picked up the pace of public development action. Now...private investment on a massive scale has started in downtown San Antonio (p. 85).

Referring to the Vancouver Expo '86 Fair, Bennett (1980) stated: "We see in this Exhibition an opportunity to host both a major World Fair and to proceed with developments that suit our present and future needs" (pp. 6-7).

B. EXPO '86 AND ITS IMPACT ON THE COMMUNITY

With the Expo - B.C. Place announcement in Vancouver, developers and speculators suddenly began to descend on the DES, the community in which the fair was to be located.

Hotels, previously neglected in upkeep, were sold several times in succession at escalating prices. New owners evicted the long-time residents, gutted buildings, and renovated. Rooms that had been rented for $175 a month were soon advertised at $30 a night. Almost 2,000 units of low-cost housing were lost in the area. Those who were evicted and displaced were left to search for other homes (DERA, 1987). Redevelopers argued that they were bringing amenities to the community. Some hotel owners poured thousands of dollars into their properties, often to renovate a bar while leaving the rooms without basic improvements. In an attempt to draw in the B.C. Place stadium crowds and tourists, enterprising citizens also brought in strip shows,

pornographic movies and video games. A significant number of hotels and rooming houses were renovated or converted to different and higher priced units.

Other rooms were never rented again. A number of hotels and rooming houses were demolished, and the residents were given short notice to pack and vacate the units. The absolute numbers of evictees resulting from this market activity is not known. City staff's figure of 377 people, who sought relocation services, is considered low as many people did not seek relocation help or did so before records were kept. DERA places the number at 791 people (Hume, March 8, 1986).

Between 1980 and 1983, plans were drawn for a massive hotel (over 580,000 square feet), office, retail complex, and ALRT (rapid transit) station to be located right next to several hotels and rooming houses. The land, zoned industrial, was flipped, and huge profits were made in anticipation of the planned development. This land was first bought by car dealer Dan Docksteader for $3 million. It was resold nine days later for $4.9 million, and resold again two years later for over $6.5 million, more than twice the original purchase price. For the hotel project (25 storey, 356 rooms) to proceed, the land, zoned as industrial, had to be rezoned. Within three months Vancouver City Council approved the development permit for the station site and rezoned the entire False Creek area (Gutstein, 1986, p.87).

Poverty, disability and aging had produced special needs among many DES residents. They have come from widely different backgrounds, but over the years became neighbours in small, cheap hotel rooms. The rooms they rented with their welfare or old age pension cheques, had a

security of home until they were evicted to make room for Expo tourists.

Many of the long-term and low-income residents of the area lived in an atmosphere of uncertainty and fear during Expo '86, as they had an average monthly shelter allowance of $200 a month, and when they were forced to relocate, they had only few options, e.g., find another home in the same price range or become homeless. There were no healthy public policies in place to prevent this from happening (such as rent control, tenants' rights, or affordable housing in the area so that people could remain in their familiar surroundings). Their viable community with its social networks was disrupted, turning people's lives upside down, creating further stress and sometimes leading to further health decline.

Inequities that were already endured by the residents of the DES were further increased as the provincial government seemed disinterested in the plight of these residents. The goal of the provincial government was to clear away the "slums", in the words of Premier Bill Bennett ("Bill Won't Take Blame", The Province, April 25, 1986). How are people supposed to cope under these circumstances? How do these conditions create healthy environments or promote an interest in self-help?

C. POST EXPO REDEVELOPMENT PROPOSALS FOR THE AREA

1. Expo Site

Although the events triggered by Expo '86 precede the Epp Report, the impacts of this event continue to be felt by residents of the DES.

The first phase of 48.8 hectares of the post-Expo redevelopment site was called North Park, a joint provincial/city project. The

proposed site is bounded by Beatty Street, Pender Street, Quebec Street and False Creek. The North Park proposal included office space, an elementary school, a retail department store, and housing for 4,500 people, including 20 percent for non-profit social housing to alleviate Vancouver's severe housing shortage. But in April 1987, Deputy Premier Grace McCarthy cancelled the project due to the province's economic problems.

Rather than postpone the project for further development by the provincial government, the Expo lands were offered for sale to private entrepreneurs. McCarthy announced that

> ....[an] absolute requirement for a commercial return from the land is the government's priority. And the Board of B.C. Enterprise Corporation, the Crown Corporation that now owns it on behalf of the taxpayers, is stacked with private businessmen who have had a lot of experience in making money (Lee, July 18, 1987).

In April 1988, Concord Pacific Developments Ltd. won the bidding on the former Expo site. Concord Pacific, a private "Canadian" company, was established for the purpose of purchasing and developing the Expo lands. Its major shareholders are the Canadian Imperial Bank of Commerce, Lee Shau Kee, Cheng Yu Tung, and Li Ka-shing. The company is planning a united residential, retail and commercial development on the site, called Pacific Place. The 204-acre (82.5 hectare) site comprises 166 acres (67 hectares) of land and 38 acres (15.5 hectares) of water lots. The $2 billion Pacific Place project is expected to start construction in 1990 and will likely continue over a period of 10 to 15 years. It will incorporate some 9.18 million square feet of residential space and 3 million square feet of retail/commercial space (Concord Pacific

Development Ltd., 1989). Concord Pacific is working in cooperation with the Vancouver Planning Department and the following major developments are expected (see Figures 7 & 8).

Residential: A total of 7,650 units of low- and high-rise apartments and townhouse units for approximately 13,500 people, 42 residential towers, including 2 with 34 stories. Twenty percent of the residential units are to be government-sponsored social housing (Ibid.).

Commercial: A major office complex located between the Georgia and Dunsmuir Viaducts, a low-rise office complex at the Cambie Bridge, a 400-room hotel at the International Village, and commercial space of about 3 million square feet (Ibid.).

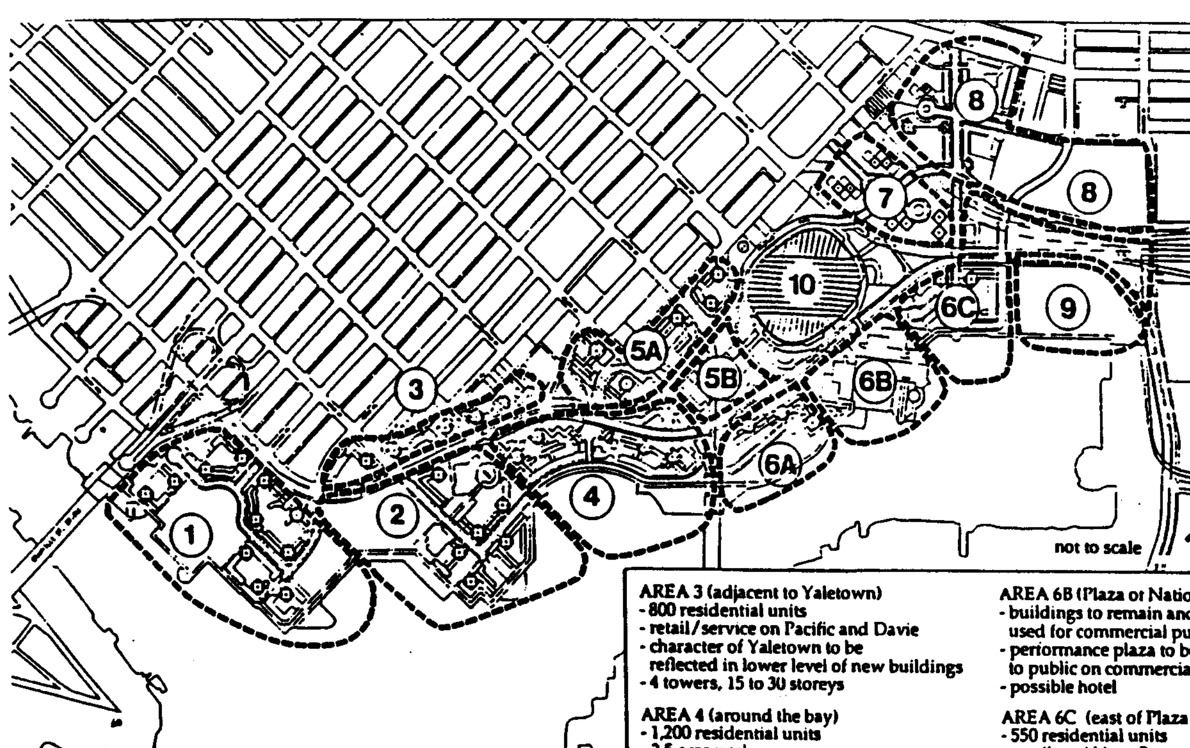
Parks: About 42 acres of public park, including two 9-acre parks in the northeast and a major 11.5 acre park connected to the historic Roundhouse in the west. An additional 9 acres of public open space will include a 1.5 mile waterfront walkway extending the length of the site (Ibid.).

Public Facilities: Two schools (kindergarten to grade 7), eight day-care centres, community centre and gymnasium at the Roundhouse, and a library are proposed. (Ibid.).

On June 23, 1989, Concord Pacific received zoning approval for the first area development plan, a 10.5 acre residential, retail and commercial development at the International Village (see Appendix B). Two adjacent parks totalling an additional 10.5 acres (4.25 hectares) are to be developed. Construction is expected to begin by mid 1990.

International Village is bordered by Pender Street, Pacific Boulevard North, Beatty Street and Taylor Street. Eight hundred residential units are to be constructed; 25 percent are to be set aside for families with children and another 20 percent are to be set aside for non-market housing, with a total population of approximately 1,400

Figure 7



FALSE CREEK NORTH

PROPOSED OFFICIAL DEVELOPMENT PLAN

Generalized Description

October, 1989

City of Vancouver Planning Department

owner: Concord Pacific Developments
architects: Pacific Place Design Consortium

TOTAL AREAS
- 7650 residential units
- 2 million sq. ft.—office use
- 385,000 sq. ft.—retail use
- 300,000 sq. ft.—hotel use
- 265,000 sq. ft.—service use
- 42 acres of park
- 3 marinas
- continuous 25 ft. wide waterfront walkway
- 2 elementary schools, community centre, 8 day cares, multi-purpose rooms, field house

AREA 1 (most westerly area)
- 1800 residential units
- 6 acre formal park
- retail/service use on Pacific
- marina for 100 boats
- 10 towers, 13 to 34 storeys

AREA 2 (around the Roundhouse)
- 900 residential units
- 10 acre waterfront park
- retail/service use on Pacific and near Roundhouse
- community centre, elementary school, day care
- 6 towers, 13 to 30 storeys
- next residential area developed after Area 3

AREA 3 (adjacent to Yaletown)
- 800 residential units
- retail/service on Pacific and Davie
- character of Yaletown to be reflected in lower level of new buildings
- 4 towers, 15 to 30 storeys

AREA 4 (around the bay)
- 1,200 residential units
- 2.5 acre park
- retail, public roadway, and public walkway along waterfront
- marina for 200 boats
- boat launching area
- 4 towers, 15 to 30 storeys

AREAS 5A and 5B (Cambie bridgehead)
- 1,000 residential units
- 200,000 sq. ft. office use
- major civic plaza
- 5 towers, 15 to 34 storeys

AREA 6A (west of the Plaza of Nations)
- 500 residential units
- 2 acre park
- 3 towers, 17 to 33 storeys

AREA 6B (Plaza of Nations)
- buildings to remain and be used for commercial purposes
- performance plaza to be available to public on commercial basis
- possible hotel

AREA 6C (east of Plaza of Nations)
- 550 residential units
- retail on Abbott Street
- marina for 80 boats
- 2 towers, 22 and 30 storeys

AREA 7 (between the viaducts)
- 1.85 million sq. ft. office use
- covered connection from ALRT to B.C. Place Stadium
- Georgia and Dunsmuir Street edges extended along viaducts
- 3 towers, 20 to 28 storeys

AREA 8 (International Village)
- 800 residential units
- 200,000 sq. ft. retail, 265,000 sq. ft. commercial
- 400 room hotel
- 10.5 acre park
- elementary school, day care
- character to reflect Chinatown and Gastown
- 4 towers, 22 to 32 storeys

AREA 9 (park)
- park of 9 acres

AREA 10 (stadium)
- B.C. Place Stadium remains as is

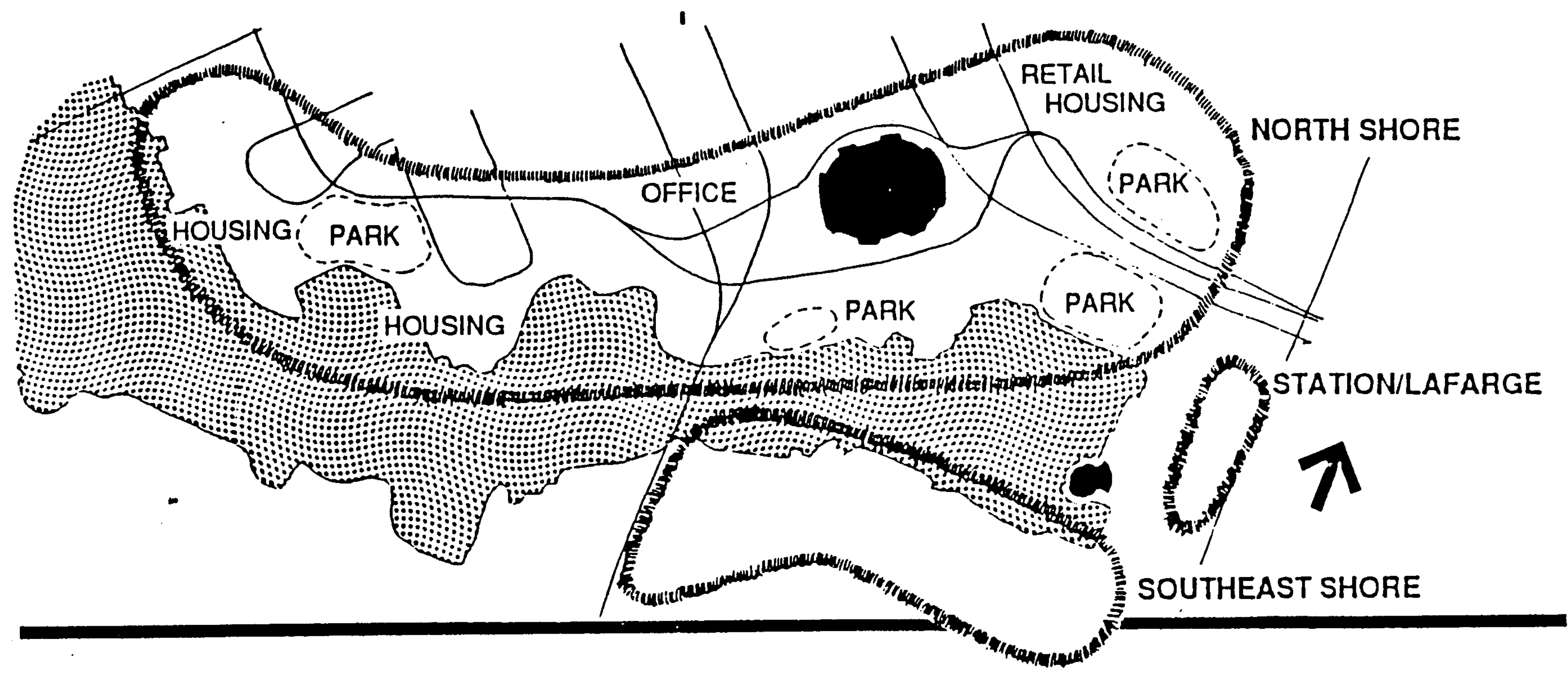
FALSE CREEK GROUP

The False Creek Planning group members are Larry Beasley, Craig Rowland, Jeannette Hlavach, Ian Smith, Joanne Baxter, and Coralys Cuthbert. For more information, contact Coralys Cuthbert at 873-7237.

Source: False Creek Planning News, October 1989

Figure 8

FALSE CREEK NORTH PROPOSED DEVELOPMENT PLAN



Source: False Creek Planning News, Vol. 1, No. 1, April 1989

people. It will contain an elementary school (kindergarten to grade 7), day-care centre, and a community centre. The highest building is a 32-storey apartment. The Village is to have a pedestrian link between the ALRT Stadium Station and Chinatown, Gastown and Hastings Street. Twenty one hundred parking spaces will be provided (Concord Pacific Development Ltd., 1989).

At the eastern end of False Creek, another large redevelopment site is under construction. The Bosa Development Corporation of Burnaby is developing the Station/La Farge site (see Appendix B). The site is mainly residential. On the southerly parcel, the Station site, approximately 400 residential units are proposed in a combination of 4-6-storey buildings and three high-rise residential towers. The northerly parcel consists of a rezoning of the former industrial La Farge site. Approximately 600 housing units are proposed and four residential towers (see Appendix B). Limited grade-level retail is proposed at Main Street. The $400 million commercial/residential complex will be completed in 5 to 7 years, and will provide housing for approximately 2,500 residents; 20 percent will be non-market housing, and another 25 percent will be for families.

2. Other Developments in the DES

Although the Expo site has not yet been developed, the area west of it - South Granville Slopes - has been, with major developments being built on the land between the Granville and Burrard bridges, and land prices have been rising. In June 1987, Vancouver City Council endorsed the idea of transforming Downtown South (which is also part of the DES)

into a new high-density residential (HDR) neighbourhood, to increase Vancouver's housing capacity and to revitalize the Granville Street commercial area. At present the area serves low-income residents of the SRO's. Given the fact that their purchasing power is very limited, the commercial space is of relatively low quality, with numerous cheap restaurants, pawnbrokers, pubs and some convenience grocery stores. What is desired for the area is an HDR neighbourhood which would attract a large number of high income residents with sufficient purchasing power to support a vibrant street retailing precinct. There is a market for the HDR in Downtown Vancouver capable of sustained growth; it includes people without children wanting a downtown lifestyle as well as 'empty-nesters', and young singles and couples working downtown, satisfying population groups that are gradually increasing, but are now not well served. There are about 1,800 people currently living in SRO's in the area. Many of them will be displaced as redevelopment occurs (Downtown South Towards a New Neighbourhood, August 1988).

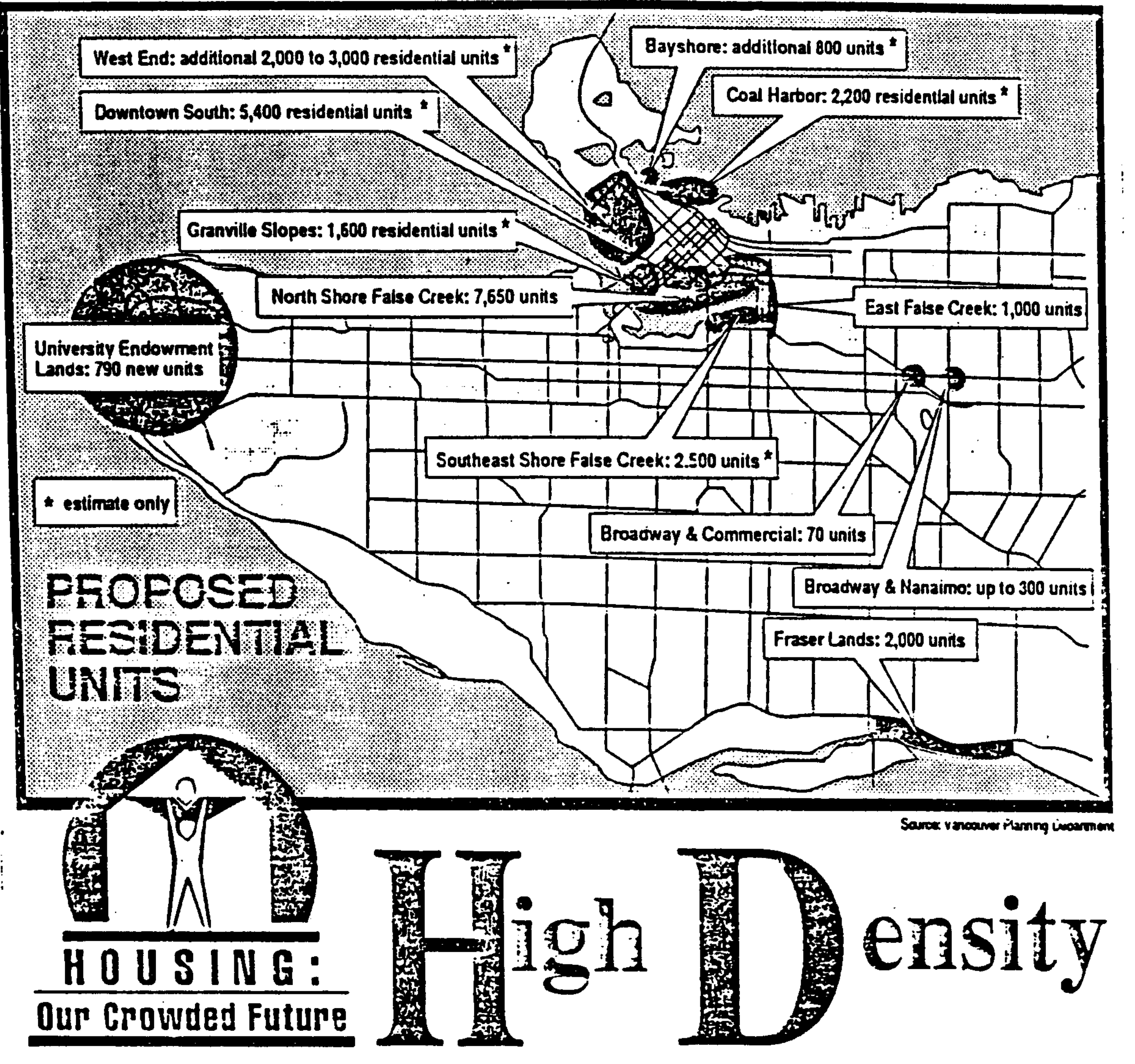
Other communities in close proximity to the DES may also be impacted by the development of the area. Mt. Pleasant and Strathcona (Chinatown) are such communities. Strathcona is an ethnic district that contains a number of low-income hotels and rooming houses. It is also primarily a lower-income family area. Through loss of low-end housing in the DES and a domino effect in which tenants displaced from more well-off neighbourhoods are filtering into new neighbourhoods, rents increase and long-term residents may be displaced.

D. PROJECTED POPULATION FOR THE AREA

Downtown population growth will result from the new residential and major commercial developments around False Creek and the South Granville Slopes. Population increases will occur over many years (10-15 years), and are estimated at 15,000 for the Pacific Place and Station/La Farge sites. With the inclusion of the southeast shore of False Creek, Downtown South and Granville Slopes areas, the projected population is 30,000 (False Creek Development Projects Community Facilities Study, 1989). This projection includes the small number of people already living in the area and the new population that is expected to move to the area. There is an unprecedented demand for housing (Figure 9), and this demand is spreading throughout the city, a housing report prepared by the Planning Department showed. Two-thirds of the demand is from "baby boomers" with new families looking for homes and older "empty-nesters" looking for condominiums or apartments to replace their single-family homes (Bramham, November 29, 1989).

Figure 9

PROPOSED RESIDENTIAL UNITS



Source: The Vancouver Sun, Friday, January 12, 1990

CHAPTER 5: HEALTH CHALLENGES IN THE DOWNTOWN EASTSIDE

The purpose of this chapter is to analyze the Epp Framework and health challenges in the DES in light of the development pressures described in the previous chapters.

A. ECONOMIC DEVELOPMENT PRESSURES AND INEQUITIES

1. Homelessness

The revitalization of older neighbourhoods in the "grey" areas of North American and Australian cities has today become commonplace. Some literature (Smith, 1979a, 1979b, 1984, 1986; Badcock & Urlich-Cloher, 1980; Ley, 1988; Sternlieb & Hughes, 1983; Badcock, 1984) attributes such transformation to major shifts in urban economy or demography or to changing tastes and lifestyles. These factors are evident in Vancouver, and are most apparent in the DES.

Following Expo '86, Vancouver is experiencing a period of rapidly rising real estate prices, the development of many new office and condominium towers, and the start of several large-scale downtown mixed residential/commercial developments. The economic pressures in Vancouver have led to a severe problem of housing affordability. In the period between 1980 and 1986 over 2,500 units of the cheapest form of shelter, rooming house units, were lost in the southern and eastern edges of downtown Vancouver (Ley, 1988; Hulchansky, 1989). The inner city has historically provided the single largest stock of affordable housing, but this resource has been eroded substantially through pre-

and post-Expo developments and other neighbourhood change. Condominium redevelopment has caused the loss of thousands of affordable housing units. The problem is most severe for particular groups: the elderly, the unemployed, single parents, the working poor, people who are already burdened with inequities in our society.

Low income people do not stimulate "market demand". They do not have the money to pay rents necessary to stimulate private rental housing investment. Rather than market demand, poor people generate social need. Yet most of the housing is provided by the private sector which can only respond to the demand stimulated by higher income households. Real estate - land and housing - are prime speculative commodities (Badcock, 1984). It is not economically viable for the private sector to supply new low-rent housing or replace any housing stock lost to demolition, condominium conversion or conversion to up-scale offices in Vancouver's downtown area unless significant subsidies are provided by government. This situation exacerbates a low-cost housing shortage, which may result, for a growing number of the most marginalized households in the DES, in homelessness.

Homelessness in our society is, at root, an economic problem (Wolch, et al, 1988; Bingham, et al, 1987; Dear & Wolch, 1987; Baer, 1986; Rowe & Wolch, 1990). The structure of our economy sets up a conflict between the needs of low-income people for housing and the profit requirements of private enterprise. It is more profitable to build or rent housing for those with higher incomes, leaving the provision of affordable housing to public or voluntary sector developers. The Epp Report fails to recognize such important factors,

factors over which poor people in the DES have no control.

Homeless people are the most obvious manifestation of the failure of public and private institutions as well as federal and provincial social housing programs designed to house all Canadians. Large projects such as Concord Pacific and other central area projects provide an excellent opportunity to link development of office and luxury condominiums with a variety of affordable housing allocated by the developers, if the federal and provincial governments provide the money. Developments should reduce inequities - not increase them. The private sector has an essential role in the downtown's future as it dictates economic development, which again provides funds for social services. However, it will be up to different levels of government to ensure the inner city remains affordable to all income groups, e.g. reduce inequities and create a healthy living environment for all income groups.

The threat of becoming homeless continues for the people in the DES. Not only is there a loss through demolition of low-end housing in hotels and rooming houses in the Main and Hastings area, there is also a domino effect in which tenants displaced from more well-off neighbourhoods are filtering into the DES resulting in higher rents, and displacing long-term residents. The domino effect is being felt even at the lower economic levels, where DES hotels are filling up with tenants from other neighbourhoods, leading to a further round of rent increases, squeezing out the tenants who are already there (Rees, Dec. 19, 1989), who face the prospect of ending up homeless. The ability to cope with everyday life is decreased as social networks are disrupted. This,

again, may increase the risk of mortality and depression (Berkman, 1984; Auslander, 1988).

Another factor in the threat of becoming homeless is that more patients are being released by Riverview Psychiatric Hospital and finding their way to the DES just at a time when several psychiatric boarding houses have been converted to other uses because of rising property values (Sarti, Dec. 8, 1989). Fallick (1987) reports that the number of patients at the Riverview Psychiatric Hospital has declined from 2,500 in the late 1960's to about 800 in recent years.

Many of these homeless people require special kinds of assistance and support. They have difficulty living on their own and require at least an adequate transition period. But the support network has never been properly developed, leaving these people without help. They cannot cope on their own and healthy public policies that are recommended in the Framework for health promotion are not in place to help these people. As a result, the Lookout Emergency Shelter is forced to turn away homeless people each night because it is now completely full almost all the time, overwhelmed by the rental housing squeeze and the increasing number of former mental patients released from hospitals who end up in the DES. Increasing numbers of homeless referred from other agencies outside the Downtown Eastside are also squeezing out local people. Five years ago, 80 percent of Lookout's beds were occupied by people from the Main and Hastings area, but now the majority come from outside the immediate area. In some cases, clients from outside Vancouver are given bus tickets or even cab fares and sent to the Lookout Shelter because of a lack of proper facilities in their own

communities (Sarti, Feb. 20, 1990). But there should be a way for these people to stay in their own communities, as the DES has enough problems of its own. Lookout has seen only the tip of the iceberg of homeless, ex-mental patients since the provincial government started discharging large numbers of patients from Riverview and Tranquille hospitals. If the government wants to put these people into society, it should also provide them with a place to stay or they will ultimately end up on the streets. The provincial government promised to put $20 million into mental health, but this money has not yet become available (Easton, Feb. 28, 1990). New facilities and boarding homes are needed. There have to be more community services and housing in a supportive environment.

In recent years, community-based organizations, such as the First United Church Housing Society, DERA, and other non-profit developers such as Affordable Housing, have been able to build new housing and renovate existing residential stock in the downtown area. DERA has built 400 units of social housing in the past five years. But with 1,000 people on its waiting list, it is falling behind.

B. A HEALTHY COMMUNITY?

1. Continued Evictions in the DES

Since Expo, evictions are continuing in the DES, due to increased property values and large redevelopment schemes. In November 1989, 60 tenants were evicted from the Hamilton Hotel, 519 Hamilton Street. The hotel was demolished to make room for a new office complex by B.C. Hydro (Sarti, Nov. 29, 1989). In October 1989, residents of the Fraser Hotel

were evicted for the $1.5 million restoration of the heritage building. Earlier, another hotel, the Cambie Rooms, evicted its tenants, renovated the building and replaced the residences with architects' offices (Bramham, Oct. 21, 1989). Earlier this year three DES hotels with a total of more than 125 rooms faced closure for health and safety violations. One of the hotels, the 72-room Columbia Hotel at 303 Columbia, raised its rents as much as 50 percent effective February 1, 1990, despite substandard renovations (Sarti, Jan. 5, 1990). Another hotel, the 26-room Veille Hotel, was forced to close by the end of January, 1990, leaving 12 residents to be relocated (Austin, Jan. 11, 1990).

"Healthy" public policies should be in place that would allow these hotels to be upgraded while the tenants still live there and not be closed and increase the already severe housing shortage in the area. For example, city permits and licences director, Roger Herbert, would like to see City Council order city crews to do proper renovations and then bill the hotel owners through their tax assessments (Sarti, Jan. 3, 1990).

2. Evictions in Kerrisdale

Across town from the DES, in Kerrisdale, Vancouver, massive changes in that neighbourhood are also affecting people's lives and health. Unlike the DES, Kerrisdale is an upper- and middle-class neighbourhood which has not been built up to the density that current zoning allows. The resulting pressure in an over-heated housing market makes tenants victims as 25-year-old apartment buildings are being

demolished to make room for luxury condominiums. Between May and July, 1989, 255 tenants, half of them senior citizens, were evicted from apartments (Bramham, Oct. 27, 1989).

3. Health Effects of Loss of Familiar Environments

i) Loss of Social Networks

Relocation poses both financial and human costs. The financial cost involves the process of moving, and often, the cost of higher rent. The human costs are the stress of moving, especially for the elderly, and the potential loss of social networks.

Forced displacement is the most extreme form of displacement. It appears to be impersonal: market trends cause increased prices and individual landlords only seem to be doing what all other landlords are doing when they raise rents or demolish apartments for higher income clientele. The tenant is forced to leave. This aspect of external force has been ignored in the Framework for Health Promotion. An individual who is quite content living in his environment is unable to stop this force. A viable community is destroyed. Public participation cannot occur when people have to leave the community.

Dr. J. Blatherwick, Vancouver's Chief Medical Health Officer commented:

> ...we dislodge them [older persons] from their social surroundings. So you're taking people who are in their 60's, 70's and 80's and you are taking away things like food stores and the food bank which they had started to build [their lives] around and the Downtown Community Health Centre for health services and Woodward's Store and little stores in the Eastside who cater to these people and who know how to take care of them...plus all the support systems that were build in (Olds, 1988, p.113).

The loss of a familiar environment and social networks can have devastating effects on individuals, whether they live in the DES or in Kerrisdale. The relationship between social networks and well-being has been investigated by several authors. Stein _et al_ (1982) found that isolated, depressed, elderly community dwellers are at the greatest risk of morbidity and mortality when social networks are lost. A study by Berkman & Syme (1979) of the impact of social networks on morbidity and mortality found that people with the fewest social contacts experienced the highest rates of morbidity and mortality. Contact with friends and relatives provides immediate potential support to individuals and is associated with decreased mortality rates and depression, especially among older persons (Berkman and Breslau, 1983; Berkman, 1984; Blazer, 1982; Hanson _et al_, 1989; Auslander, 1988; Orth-Gomér and Undén, 1987). The loss of a familiar environment and social networks can have devastating effects on individuals (Buck, 1985; Pearlin & Schooler, 1978).

Buck (1985) emphasized the importance of providing environments which support all aspects of health and which do not contribute to illness. Environments include all levels of the social and the physical environment which can affect an individual's health. The social environment consists of people and their interactions and provides social resources. These social resources consist of interpersonal networks which are a potential source of crucial supports: friends, family, fellow workers, neighbours, and voluntary associations (Pearlin & Schooler, 1978). With destruction of the social environment, social

networks are lost. In the DES, as well as in Kerrisdale, people are left in limbo, unable to cope with the stress of displacement. In the Framework for Health Promotion, an emphasis is placed on the creation of healthy environments by means of altering or adapting the social, economic or physical surroundings not only to preserve but also to enhance people's health. Reality appears to be far removed from this concept as circumstances in the DES and Kerrisdale prove. Policies that ought to be in place for these residents that would prevent destruction of viable communities are not in place. The ruling Social Credit Party strongly supports a capitalist "free market" approach to public policy. And although the Socreds promised in their last Throne Speech (Baldrey, April 6, 1990) more support for amendments to the Residential Tenancy Act, among others, (more support for emerging shelters for the homeless), these remain only promises to date. Meanwhile, individuals have to cope on their own.

ii) Facing an Increase in Stress

In the context of evictions, University of British Columbia social work professor, Mary Hill, commented that:

> ...the likelihood of death or illness is increased by involuntary relocation, the depression and hopelessness that comes with that kind of change. Study after study shows that.... All change involves stress, but these precisely combine the three factors that are dangerous to the elderly: the relocations are involuntary; they are sudden, without any preparation; and, they bring about a major change in the environment (Sarti, March 8, 1986).

Two types of psychological stress can be identified. One arises from the increased anxiety and uncertainty that accompanies the

relocation process - both the worrying about relocation before the move and the uncertainty that weighs upon the relocatees during the process of adaptation to their new surroundings. The other is called the "grieving for a lost home" syndrome (Stanley & Alpers, 1975) which describes relocation in connection with urban renewal. Psychological stress weighs especially on the elderly. Old people may find themselves moved to a completely strange locale where they have no friends, and where they must establish links with new landlords, health and other service personnel, almost entirely on their own. It is not surprising that morbidity and mortality rates go up. Causes of disease and illness lie not only in micro-organisms but also in the diseases of adaptation and the increased susceptibility to disease brought about by a person's psycho-physiological reactions to his environment. The current dominant general model of the stress process is the "stress-illness" model (Coburn et al, 1987). It portrays a complete interactive process that sees a variety of precipitating factors such as life events, changes, interacting with mediating factors (buffers) such as social support and coping resources in affecting health outcomes for individuals (Pearlin et al, 1980). Studies demonstrated that the greater the number of life changes a person has experienced, the more likely he is to become ill. Life changes such as relocation demand adaptations, arouse emotions, and cause stress. A number of studies indicate that age, poor physical health, and psychiatric disturbances are positively associated with risk (Aldnich & Mendkoff, 1963; Brand & Smith, 1974). Subsequent studies indicate that social participation and close personal relationships provide a buffer against a stressful environment (Cobb, 1976).

The psychological stress of coping with relocation leads some old people to die at an earlier age than would have been the case if they had remained under familiar surroundings in their old homes. In 1974, Brand and Smith compared a control group of community dwellers to older people who were forced to move into senior housing because of urban renewal. The respondents showed personal maladjustment and an increase in morbidity. In another study, Kasl et al (1977) also reported adverse health outcomes for older people who were forced to move to senior housing. Ferraro (1983) examined both the degree of voluntarism and the type of the new environment to interpret the results on relocation of low- and middle-class non institutionalized older people. The findings of this study indicated that relocation resulted in health decline as physical disability increased among the relocated people; the ability to participate in daily activities of self-care decreased; and the time spent ill in bed increased. Movers were more likely than non-movers to be institutionalized because of illness. Although most previous research suggests that the stress associated with moving is the cause of the health decline, there may be other factors that confound the relationship between relocation and health, such as the qualitative changes in the environment itself (i.e. changes in type of housing). Ferraro's results indicated that the decline in health is not due to environmental change and strengthens the interpretation that it is the stress of moving that causes health decline. Moving is characterized by a considerable amount of social disruption as previous social networks are threatened. It has been assumed that if the move was voluntary, the desire to adjust is greatly facilitated. But Ferraro (1983) concludes

that relocation, whether voluntary or involuntary, adversely affects the health of the elderly. Relocation effects vary and can be dramatic. Schulz and Brenner (1977) maintain that relocation effects can be lessened by the degree to which individual relocatees feel that the events are predictable and controllable.

Clearly, in the DES, elderly tenants in single rooms do not have control over an eviction. Over the years, a major problem in the area has been the lack of tenure - despite recent changes in municipal by-laws (Lee, Dec. 30, 1988). Without legal protection, slumlords were able to evict long-term residents at any time. While evictions have been a commonplace occurrence in the community, their numbers peaked with the hundreds of evictions during Expo '86. The provincial government seemed to have little interest or care for the lives of these people affected by Expo or about the DES as a viable, established community. By denying the tenants' legal tenure, the developers were able to clear away the 'slum', in the words of Premier Bill Bennett, and begin redeveloping the area. Even after a resident had died as a result of an eviction, Bennett stated that legislation aimed at preventing eviction would also stop redevelopment: "Handling problems of people and also encouraging the removal of areas that in many communities could be called slum areas, are the government's priorities" ("Bill Won't Take Blame," The Province, Apr. 25, 1986).

Although these events precede the Epp Report, impacts of this magnitude continue to happen in the DES.

4. Health Problems of Some Evictees

i) Residents of the DES

Many evictees (thirty-four out of 300 as of March 25, 1986) had serious health or handicap problems and were at risk from the increased stress brought on by the relocation, according to Vancouver's Health Department (Sarti, March 25, 1986).

Health problems of some evictees are described below:

- A stable chronic schizophrenic person had been admitted to hospital after receiving her eviction notice. This could have occurred at any time, but after three years under control, the hospital admission did occur after receiving the eviction notice (Health Department, 1986).

- Saul Kahan, age about 80, a long-time (30 years+) resident of a hotel in the DES, received his eviction notice on December 2, 1985; admitted to St. Paul's Hospital; died December 9, 1985 from longstanding respiratory problem (Ibid.).

- Alexander Mairs, evicted from his hotel of about 15 years' residence; died in his new hotel on December 16, 1985 of chronic obstructive lung disease (Ibid.).

- Lorne Inkster, age 57, a 14-year resident of the Olympia, died from cancer after being evicted (Health Department, 1986).

- Thomas Tapping, age 78, a 26-year resident of the Patricia, died shortly after his eviction, cause unknown (Ibid.).

- Harold Scarrow, age 61, committed suicide by throwing himself under the wheels of a moving dump truck a week before he was to have vacated his room at the Lotus Hotel (Ibid.).

- Daniel Stephen Ponak, age 50 years, leapt to his death from a third-floor window the day after he received his notice (Ibid.).

- Considerable stress was caused to one elderly man, who, while in the hospital, was evicted. There was no place to send him and it was important to go back to familiar surroundings to recover. Clearly it was not in his best interest to not have a home to go back to (Ibid.).

- Olaf Solheim, 88 years, evicted from his hotel of about 62 years. His life was destabilized by the eviction (Ibid.).

The evictions prompted Vancouver Mayor Mike Harcourt to ask: "Why should you move people like cattle so some can make a quick buck for five and a half months?" (Eng, March 10, 1986).

Two deaths were linked to the evictions: the suicide of Daniel Stephen Ponak and the death of Olaf Solheim, according to Dr. Blatherwick (Olds, 1988). But the other health problems cannot be considered uni-causally. Clearly, the cancer death of someone such as Lorne Inkster is probably not related to the effect of the eviction. Many factors need to be considered before an eviction alone can be blamed as a precipitator to death. Age, environment, and health of organisms are critical variables. However, some people do die after moving. Blenkner (1967) states that this may be due to "transplantation shock".

ii) Residents of Kerrisdale

Residents of Kerrisdale faced with eviction are also experiencing health problems.

85-year-old Ivy Burford cannot imagine how she is going to cope if the Kerrisdale apartment she has called home for the last 18 years is torn down.

> I can't sleep nights. You have no idea what this does to you when you are alone. I am very unhappy and I haven't a clue what I am going to do....Unless the good Lord takes me, I don't have an answer (Hamilton, April 6, 1989).

Her neighbour is now in hospital after suffering two heart attacks since the 36 tenants in their three-storey apartment building were given six months notice to vacate. A second neighbour, a nurse, said he has seen the deterioration in health that has set in since the pensioners received eviction notices. Four have been taken out of the building by ambulances. The emotional effect is so devastating it has a physical effect. The developer plans to build an exclusive 12-storey condominium in place of the 27-year-old apartment (Ibid.).

Hazel Dingwall, 75, lived in Kerrisdale for 8 years. When her apartment was demolished she moved to Marpole. The trauma of the move gave her a case of dermatitis. "I'm still disoriented in this area" (Anderson, Dec. 15, 1989).

5. Summary

Events described in this section do not suggest that the DES and to a different extent, Kerrisdale, are healthy communities. Achievement of optimal health requires positive individual and community choices, according to the Epp Framework. It requires that people be empowered, i.e., that they be in a position to act on health issues, if they choose to do so. However, as has been described in previous chapters, persons in the DES have very little control over their lives, they have little security and due to poverty are subjected to decreased self-esteem.

Their socioeconomic status makes them vulnerable to potential housing impacts, factors that are ignored by the Epp Framework, because the Framework is a-spatial; it ignores the context in which health

experiences are shaped. External factors such as economic and market forces lead to increase in demand for affordable housing, and exorbitant rent increases; this leads to further inequities such as homelessness and therefore to further inability to cope with everyday life. They prevent people from making healthy choices, destroy viable communities, and prevent people from public participation due to displacement.

The mental and social stress of rapid and extreme changes that are occurring in the DES and in Kerrisdale, of despair, isolation, loneliness, and crushed hopes, lead to mental and social diseases. Alcoholism increases; suicide might take place. Many of these change events are beyond an individual's ability to prevent or control.

C. COMMUNITY EFFORTS: SELF-HELP/MUTUAL AID

The Framework for Health Promotion is predicated on the belief that individual and community effort are required to address health challenges. But in light of the events that have been and still are happening in the DES of Vancouver as well as in Kerrisdale, one has to ask oneself how this is possible under the described circumstances.

Community-based attempts to improve the quality of life for DES residents were periodically supported by City Council. The City of Vancouver's Social Planning Department has provided strong support for attempts to improve the quality of life for residents. This has included the conversion of the vacant and deteriorating Carnegie Public Library building into a community centre, and the construction of social housing (Sarti, June 26, 1984). While funded by the governments

(federal, provincial and municipal), the social housing projects are sponsored, developed and managed by community-based organizations such as DERA, the First United Church Social Housing Society, and the Chinese Benevolent Association.

The announcement of a mega-project such as Expo '86, was quickly recognized by community representatives for its potentially destabilizing effects. Considerable time and effort had been spent preparing for impacts, lobbying politicians, working with planners, and raising public awareness, although this could not prevent the evictions (DERA, 1987).

The provincial government was set on its redevelopment scheme for the downtown area. Bill Ritchie, then Minister of Municipal Affairs, stated that "despite hardship of individuals, development must take place" (Olds, 1988, p.135).

The community groups did their best to assist people in relocating but without adequate funding for affordable housing, their efforts were limited; again it is the disadvantaged people who pay the price.

Lack of adequate financial government assistance limits the ability of this community to assess its own needs and abilities to improve the health of its residents.

It is clear that the Epp Report fails to address such problems and only talks about "how it ought to be" and not how it is in reality. Instead of reducing inequities, further inequities are created and the economically disadvantaged people pay the price.

D. ANALYSIS OF HEALTHY PUBLIC POLICIES

1. Low Welfare Rates

The Epp Framework suggests that coordination of healthy public policies is essential to achieve "Health for All". Yet the evidence in British Columbia suggests that the welfare state has been severely eroded over the past decade. Fewer services are being provided, and those offered are not adequate to meet individual need.

In British Columbia, the Guaranteed Available Income for Need (GAIN) Program was adopted to relieve poverty, neglect and suffering. The Program has the effect of officially legislating poverty by paying income and shelter support rates well below the level necessary to meet average basic living costs. For GAIN rates to equal the average basic costs of living, increases between 30 percent and 70 percent are necessary (Fallick, 1987), depending on the size of the household. The inadequacy of the provincial welfare program is a major reason for the food banks, soup kitchens, the growing number of inadequately housed people and the large number of homeless and shelterless people. Many GAIN recipients and people on other fixed incomes cannot adequately feed and shelter themselves, since rates are so low that recipients lack the income necessary to meet average basic living costs (Fallick, 1987). Poverty subjects people to decreased self-esteem and fewer healthy choices. This leads to unhealthy environments and contributes to health inequities that exist in the DES: housing that is far too expensive for the area residents, that is usually badly heated and ventilated, and often too small. Continued cuts to welfare rates continue to maintain

inequities for the residents of the area.

In the early 1980's, the provincial government of B.C. made a political decision to eliminate dozens of government services and programs. This 'restraint' program was aimed at the poorest citizens, the seniors, women and children. Both the welfare and unemployment rates grew, with 1 in 5 British Columbians being either unemployed or on welfare. Service cuts included the elimination of social services such as the child abuse team, the office of the Rentalsman, the Renter's Tax Credit, funding to 23 senior citizens' organizations, elimination of social, childcare and financial aid workers. Welfare rates were frozen from 1981 until 1987 (DERA, 1987). Since 1983 and the birth of the restraint program, the DES has established food banks. These food banks developed as a response by the community to the growing number of hungry people, continue to exist. Food banks, as a private or charitable response to a failure of social policy and inadequate level of income support, are not an acceptable response. Access to adequate food for all is a must.

What is required are policies that will increase social assistance and other fixed incomes to allow residents of the DES to meet basic living costs.

2. Lack of Housing

Affordable housing for older singles, disabled, elderly households, and non-elderly single-parent families is also required for the area. Yet neither the federal nor the provincial government has an established program directly aimed at alleviating homelessness.

Shelters in the area have to turn away people every day because they are always full. A person who is homeless and drifts from temporary shelter to temporary shelter is cut off from the networks which eventually lead to obtaining a good-quality social housing unit. The social housing policies that exist at the present are aimed at providing residential buildings and generally lack the flexibility to be of use to organizations which seek to help provide shelter to homeless people. At present, there is little coordination between housing policy and social policy (Fallick, 1987).

To alleviate the problem of homelessness, DERA is recommending a freeze on demolitions, (in Victoria, City Council agreed to ban the demolition of any rental accommodation for at least six months (McLintock, Jan. 5, 1990)), rent control and rent reviews, special needs housing for the disabled, and a demand that the government fund the 20 percent of social housing provided for in mega-projects planned for the city (Watt, Feb. 12, 1990). Yet none of the recommendations has been adopted.

3. Cuts to Community Services

Dr. Trevor Hancock, one of the major proponents of healthy communities in Canada, pointed out that there is a need to analyze the health impacts of existing policies and to research, develop and propose alternative and more health-promoting policies. There is a need to strengthen the community's own capacity and help people develop the skills that will enable them to take community action to improve their health (*Challenge*, May 1988). But lack of adequate financial government

assistance to community groups such as DERA hinders them in strengthening their services to improve the health of their residents. Deinstitutionalization of mental patients in recent years has freed considerable financial resources that can be applied to support health. Policies that are required to allow a reallocation of such resources to the community groups are not in place.

A number of these policies required joint federal, provincial and municipal action. Without such policies, "Health for All" will not be achieved for the residents of the DES. Inequities will continue to exist, decreasing people's ability to cope with everyday life in an unhealthy environment. This demonstrates the inability of the state to coordinate healthy public policies in the face of market pressures.

CHAPTER 6: CONCLUSION

The proposed Framework for Health Promotion stresses the individual's responsibility for health and health care. This individualist approach is a convenient posture for government and can be used as justification for cost-cutting, for reducing the universal features of access to health resources, and for individualizing what are at base problems of social structure and national policy.

It also fails to recognize the importance of geography and space, the context in which health experiences are shaped. The Framework fails to identify such factors as economic and market forces that play such an important role in shaping the use of space, thereby conditioning the context of health promotion. Such key factors are acting in Vancouver's DES where changes to the landscape through massive redevelopment schemes have affected people's lives and health.

When economic development began to take place in Vancouver, large-scale land development proposals exerted up-market pressures on the downtown land market, in an area that previously had been neglected, and had deteriorated over time. This led to gentrification and urban renewal.

Such economic pressures undermine the objectives of the health challenges identified by the Epp Report. Inequities are not reduced when poor people on fixed incomes are faced with horrendous rent increases or when they are displaced either through demolition of low-end housing in hotels and roominghouses or by a domino effect in which tenants from other areas are filtering into their neighbourhood because

of an overheated real estate market. An influx of deinstitutionalized mental patients and ex-convicts has created more special needs--but services and policies are lacking to serve these needs.

Events like these put further stress on people, many of whom are already afflicted with some kind of health problems, and increasing prevention of illness and enhancing coping with everyday life appears impossible under the described circumstances. The added stress can lead to anxiety, tension, sadness and loneliness, all symptoms of mental stress. This can result in unhealthy behaviour such as drug and alcohol misuse, violence or even suicide.

Self-care and mutual aid, public participation and community effort cannot be created if the community is not there tomorrow. The loss of a familiar environment, mutual aid, and social networks can have devastating effects on individuals, leaving people in limbo, unable to cope with the stress of displacement.

In the Framework for Health Promotion, an emphasis is placed on the creation of healthy environments by means of altering or adapting the social, economic or physical surroundings not only to preserve but also to enhance people's health. Reality appears to be far removed from this concept as circumstances described in earlier chapters show.

Events happening in the DES are not conducive to health. Healthy environments are not created when people live in small and inadequate, bug-infested and substandard hotel or roominghouse rooms because their welfare rates are kept too low. Poverty subjects people to decreased self-esteem and fewer healthy choices which combine with the adverse environmental factors to which they are subjected.

The proposed Framework assumes that all Canadians are equally able to change to healthy behaviour. But healthy lifestyle changes may be too much to expect of individuals and groups who have little control over their quality of life, such as the people of the DES.

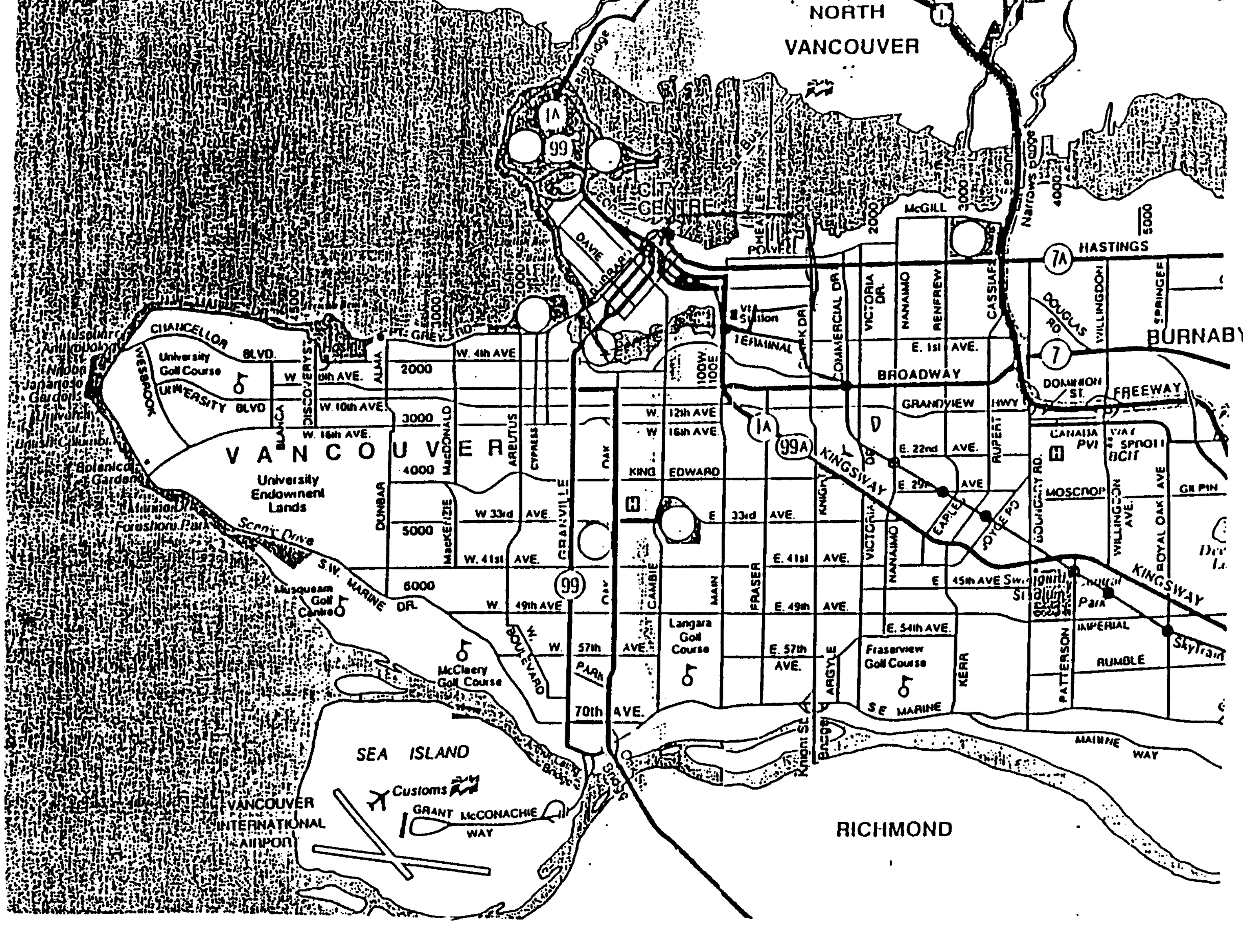
Achievement of optimal health requires positive individual and community choices. It requires that people be empowered, i.e., that they be positioned so that they can act on health issues if they choose to do so. However, as described in previous chapters, persons living in the DES have very little control, little security, little self-esteem and they are also the most disadvantaged with regard to health. Evictions, enormous rent increases, low welfare rates, and lack of affordable housing for the residents in their community are testimony to this.

Public and social policies and practices that ought to be in place and coordinated continue to be non-coordinated. This demonstrates the state's inability to coordinate healthy public policies in the face of economic development pressures.

A number of these policies require joint federal and provincial action. Without such policies, "Health for All" will not be achieved for the residents of the DES. Inequities will continue to exist, decreasing people's ability to cope with everyday life in an unhealthy environment. If all these circumstances are taken into account, it is clear that the Framework for Health Promotion is failing to address these problems. Therefore, it is not adequate as a conceptual tool in helping people to meet emerging health challenges.

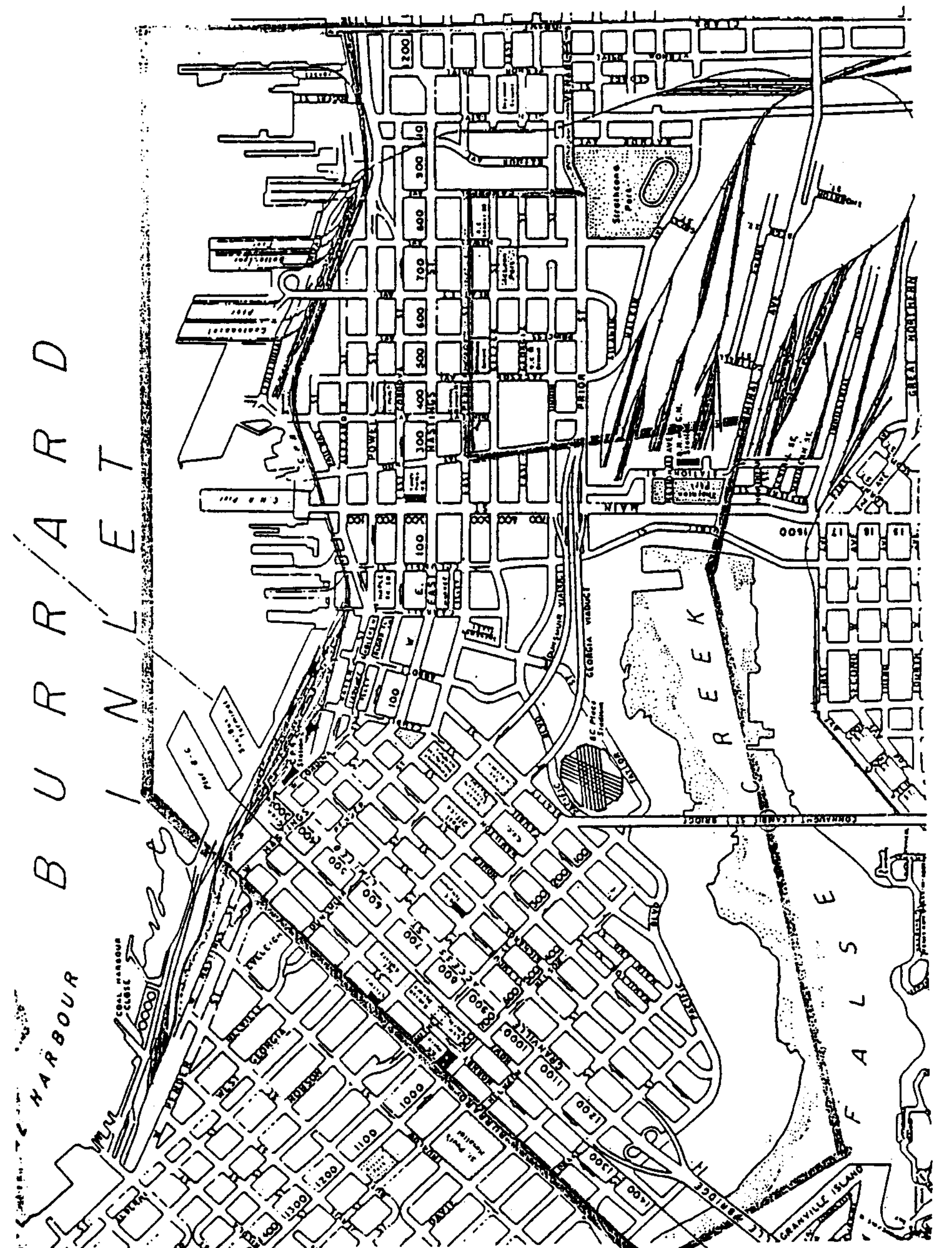
APPENDICES

APPENDIX A
MAP 1



Source: Green, et al (1989)

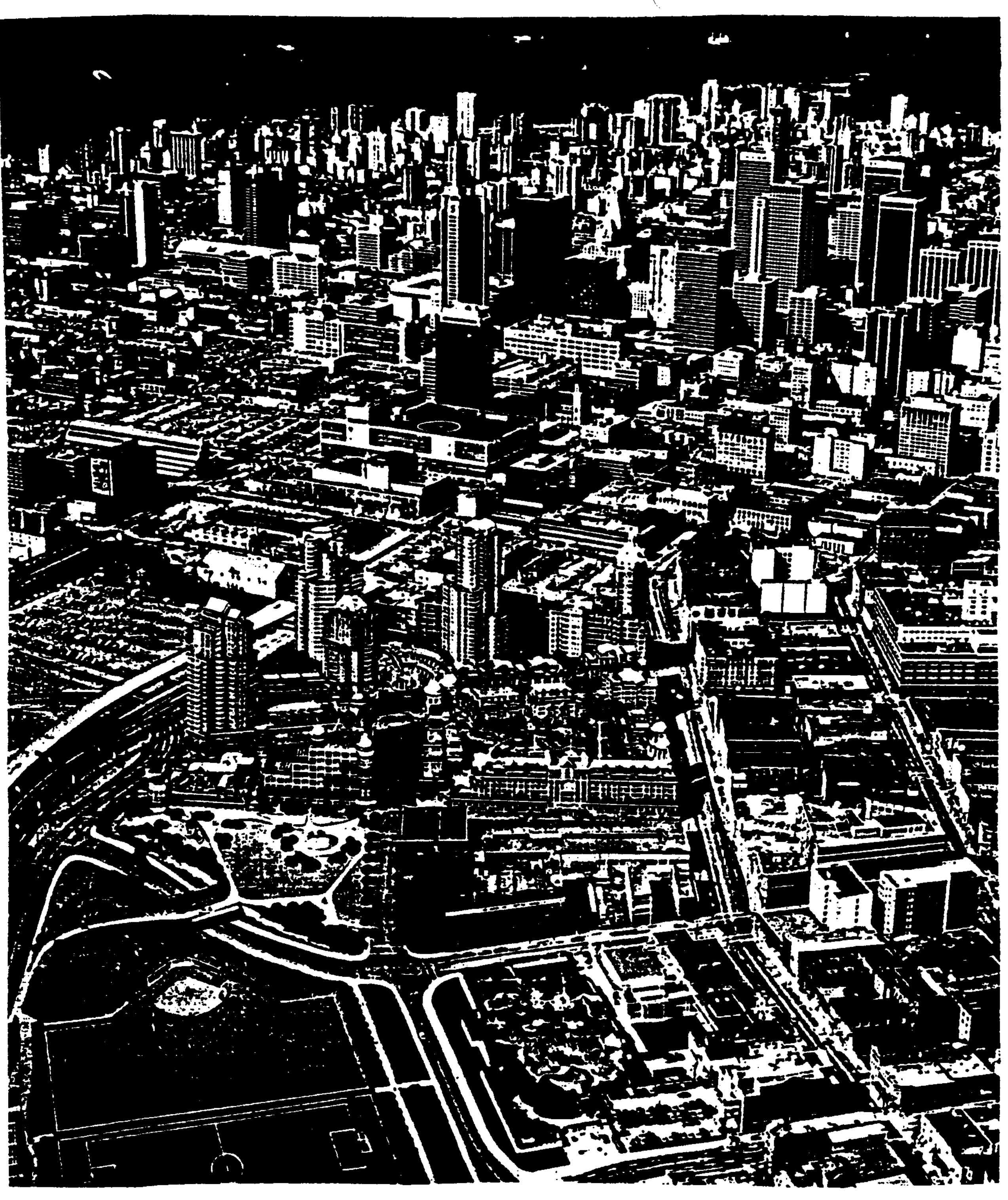
APPENDIX A
MAP 2



Source: Green, et al (1989)

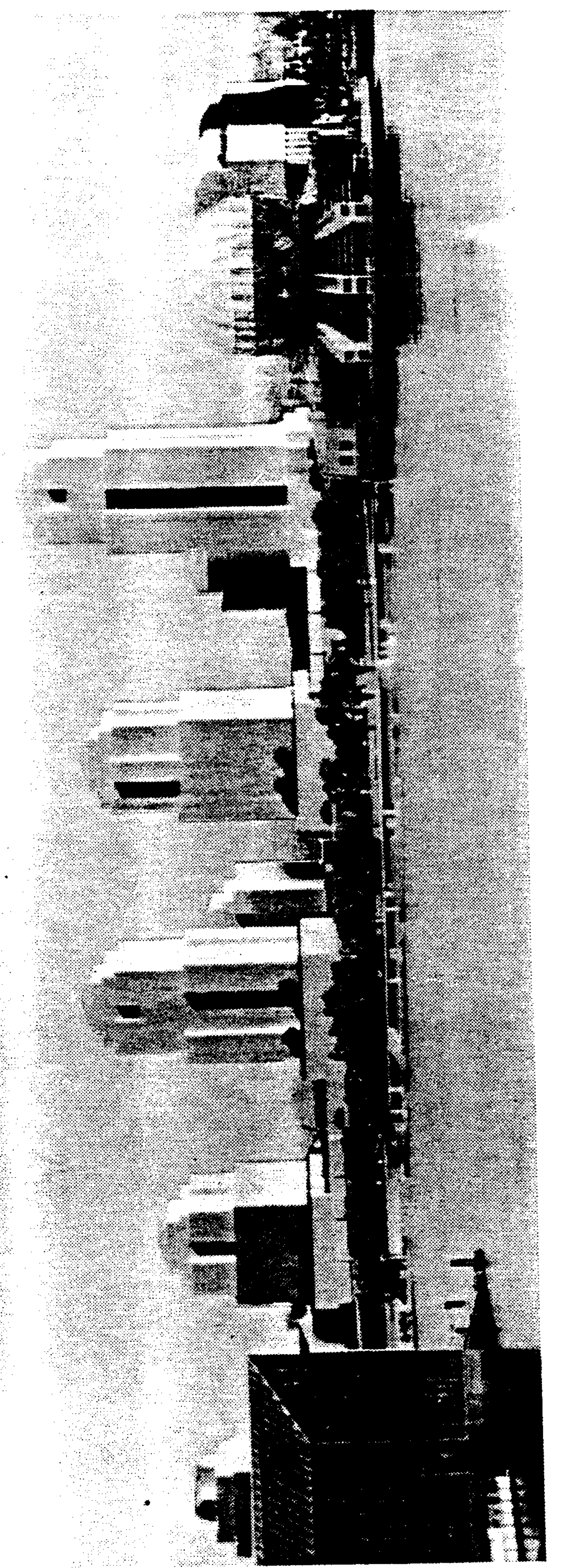
We've Got A Great New Resource In British Columbia.

Source: DERA (1987)



Aerial View of International Village (Foreground)

Source: Courtesy of Concord Pacific Development Ltd., Dec. 1989



EAST FALSE CREEK-STATION/LaFARGE

Source: False Creek Planning News, Vol. 1, No. 2, June 1989

John Stefaniczan, May Heginbotham being evicted from Regal Place Hotel. (May died in February 1987, one year after her eviction.) Photo courtesy of the VANCOUVER SUN, Saturday, March 1, 1986.

Source: DERA (1987)

OLAF SOLHEIM
(1898-1986)

On April 18th,1986, longtime Downtown Eastside resident Olaf Solheim died. He was 88 years old. Six weeks before his death, Olaf was forcibly evicted from the Patricia Hotel, his home of 62 years. Olaf's home became just another rented room for Expo's faceless tourists.

Photo of Olaf Solheim, courtesy of the VANCOUVER SUN, March 27, 1986.

Source: DERA (1987)

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HEALTH FOR ALL BY THE YEAR 2000:
IS LATIN AMERICA MEETING THE CHALLENGE?

by

Gabriele R. M. Mathers

B.A. (Geography), Simon Fraser University, 1984

EXTENDED ESSAY SUBMITTED IN PARTIAL FULFILLMENT

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in the Department

of

Geography

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HEALTH FOR ALL BY THE YEAR 2000:
IS LATIN AMERICA MEETING THE CHALLENGE?

ABSTRACT

In May 1978, the Thirtieth World Assembly adopted a resolution at a conference in Alma-Ata, U.S.S.R., which specified that the main social goal of governments and the World Health Organization (WHO) in the coming decades would be the attainment of "Health for All by the Year 2000" (HFA/2000). This goal was to be attained through primary health care (PHC). National governments were recognized as responsible agents for developing and implementing primary health care plans. Global indicators were used to monitor the progress made by each country.

This paper describes the efforts of five Latin American countries to meet the challenge of attaining the HFA goals as specified by WHO/PAHO. The author measures the progress made by these countries and comments on the appropriateness of the global indicators.

The author concludes that PHC has been successful in some of the countries of the region. But extreme disparities remain from country to country and within countries. In order to achieve health for all by the year 2000 much more than better medical care is needed: it requires broader structural change leading to more equitable distribution of resources and sharing of decision-making power.

QUOTATION

A peasant child with diarrhoea and malnutrition may require antibiotics to stop the infection, but his long-term health needs will be much better served by environmental measures such as clean water and good waste disposal. He will be better off if his mother learns how to feed him properly or if his father gets more land on which to grow food or is helped to become more productive.

...in general a rising standard of living and higher incomes have had a greater influence on health status than anything the health services or medical science have done: this is true as much for Britain over the last 100 years as for developing countries over the last 25...in the last analysis people will mainly become healthier as a result of social and economic change.

de Kadt (1976), p. 526

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CHAPTER ONE:

Introduction

Distribution of health care resources is of central concern in contemporary medical geography (Paul 1985, Gesler 1984, Mayer 1982, Pyle 1974). The basic issue of health care distribution is inequality, or unequal access to material and non-material resources and unequal development of these resources. Studies have shown that there are significant inequalities in the resources available for health care to different groups or areas (Eyles 1987, Brockington 1985, Gesler 1984, Smith 1979, Benyoussef 1977). A major source of inequity is the rural-urban imbalance evident in most developing countries. Health care resources are concentrated in towns while rural health care needs are neglected, even though the majority of the population typically lives in the country. Given that most of the middle class in developing countries live in urban areas, these inequalities are also related to class structure (Mörner 1985, Nyrop 1984, Steltzer 1983, Smith 1979, Roemer 1964).

In many developing countries of Latin America, the general standard of living is tending to deteriorate, largely due to uneven distribution of resources between urban and rural populations (James, et al 1986, Alonso 1984, Nyrop 1984, Gish 1973), due to obsolete methods of development and a galloping population increase (Smith 1979, James, et al, 1986, Alonso

1984).

The population of Latin America grew from about 165 million in 1950 to 406 million in 1985 (United Nations 1985), and now exceeds the combined population of the United States of America and Canada (264 million) by more than 140 million (James, et al 1986). On the basis of the recently revised medium-variant projection of fertility, it is estimated that the population of Latin America will increase to 550 million by the year 2000, by which time it will exceed the population of Europe (492 million). This represents an increase of 144 million over the next 15 years (PAHO 1986). As a consequence of such rapid growth, the age structure population pyramid of the Region has acquired the characteristic shape found in developing countries. The pyramids have a very wide base with between 31 to 46 percent of the population under fifteen years of age and only small percentages over age 65 (Alonso 1984).

This rapid population growth further adds to the burdens faced by the social and economic systems of the Region. It is at least partly responsible for deteriorating nutritional levels and for absolute increases in the number of illiterates. Population growth is also a factor in the extremely poor housing situation and in the high levels of unemployment and underemployment. It also adds to the pressures on the land that force many rural people to migrate to the cities (James & Minkel 1986, Brockington 1985, Alonso 1984, Nyrop 1984).

One notable phenomenon in the Region over recent decades

has been the enormous growth of the urban population, which has proceeded at an uncontrolled pace, growing from 68 million in 1950 to 280 million in 1985--a four-fold increase (Alonso 1984). During the same period the rural population grew from 97 to 126 million. The urbanization process, while largely induced by population growth, has also been determined by uneven patterns of regional economic development and structural imbalances. A disproportionate share of public and private investment capital has gone to the cities, thus enhancing the differences in living conditions between urban and rural areas. Marked differences in access to land in rural areas and, more recently, agricultural modernization and increased land concentration have also contributed to the migratory process. One consequence is that the agrarian sector has not generated enough jobs to absorb the rapidly expanding rural labour force. High unemployment and underemployment forces many peasants to migrate to the cities in search of work (Alonso 1984).

A particular manifestation of this urbanization is the growth of squatter settlements. These are known as ranchos in Venezuela, or barriadas in Peru (Smith 1979). Living conditions in these barriadas or ranchos are extremely poor as public and private investment capital is not invested in these areas. A very high proportion of dwellings are built with non-permanent materials. Basic services such as water supply, sewage disposal and electricity are lacking. The water is contaminated by human waste. Bathing and washing of clothes is

usually done in polluted places. Faulty disposal of human excreta is the chief cause of the immense amount of intestinal infection in these countries. Water used for domestic consumption taken from shallow wells and surface supplies contaminated by seepage is the commonest cause of intestinal infections and infestations. Refuse, carelessly discarded, makes breeding grounds for flies, which feed on human faeces and carry pathogenic intestinal organisms to exposed food (Learmonth 1988, Brockington 1985).

In the poor environmental conditions of semi-urbanization, communicable diseases such as pneumonia, bronchitis, diarrhoea and tuberculosis are common. These are also frequently fatal conditions among infants and children. Malnutrition is also aggravated by migration particularly among babies who are weaned early. Enjoyment and fulfillment are denied to millions. The frustrating thing is that most of these diseases are preventable. But progress towards their prevention is slow, largely because of the lack of an adequate infrastructure to facilitate public health and health care (Fry & Hasler 1986, Akin, et al 1985, Brockington 1985, WHO 1980, Benyoussef, et al 1977, PAHO 1974).

The poor health status of these people and millions of others around the globe has created a global collective effort, spearheaded by the WHO, to achieve a level of health by the year 2000 in which all people can lead socially and economically productive lives. The WHO has adopted the slogan

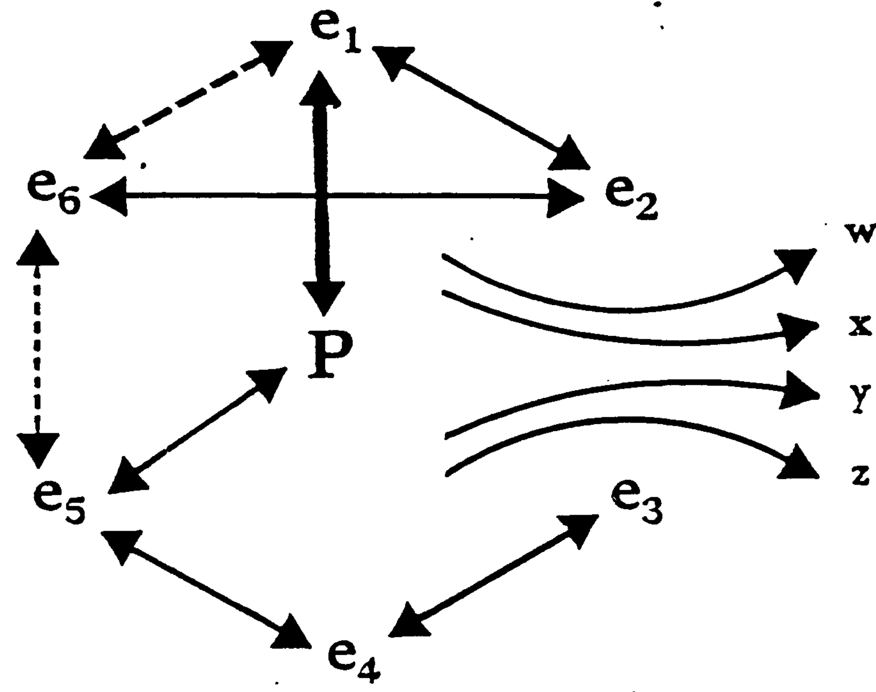
"Health for All By the Year 2000" (HFA/2000) (WHO 1989).

Primary health care (PHC) is the vehicle through which this goal is to be achieved. PHC is part of the fabric of socioeconomic development. It involves fundamental changes in national priority such as radical changes in the distribution of power and organization of health care services. These changes depend on comprehensive social and economic development and this in turn requires that those at the decision-making levels of the national economy recognize that their actions directly influence and affect the health and well-being of their people (Fry & Hasler 1986).

The identification of change at the socio-economic and political level identified by the PHC approach is consistent with contemporary models of determinants of health. White's (1981) Socio-Ecologic Model (Figure 1) shows an abstract idealization of the ways in which various environmental factors (labelled e_1 through e_m) interact with the person (P) and with each other to produce various outcomes (w, x, y, z). The model proposed by Smith (1982) (Figure 2) extends White's model identifying specific entities relating to the state, the individual, health services and the environment within the same interactive, multidimensional conceptualization. For purposes of this essay, these models have been reduced to the simplified form presented in Figure 3.

Figure 1

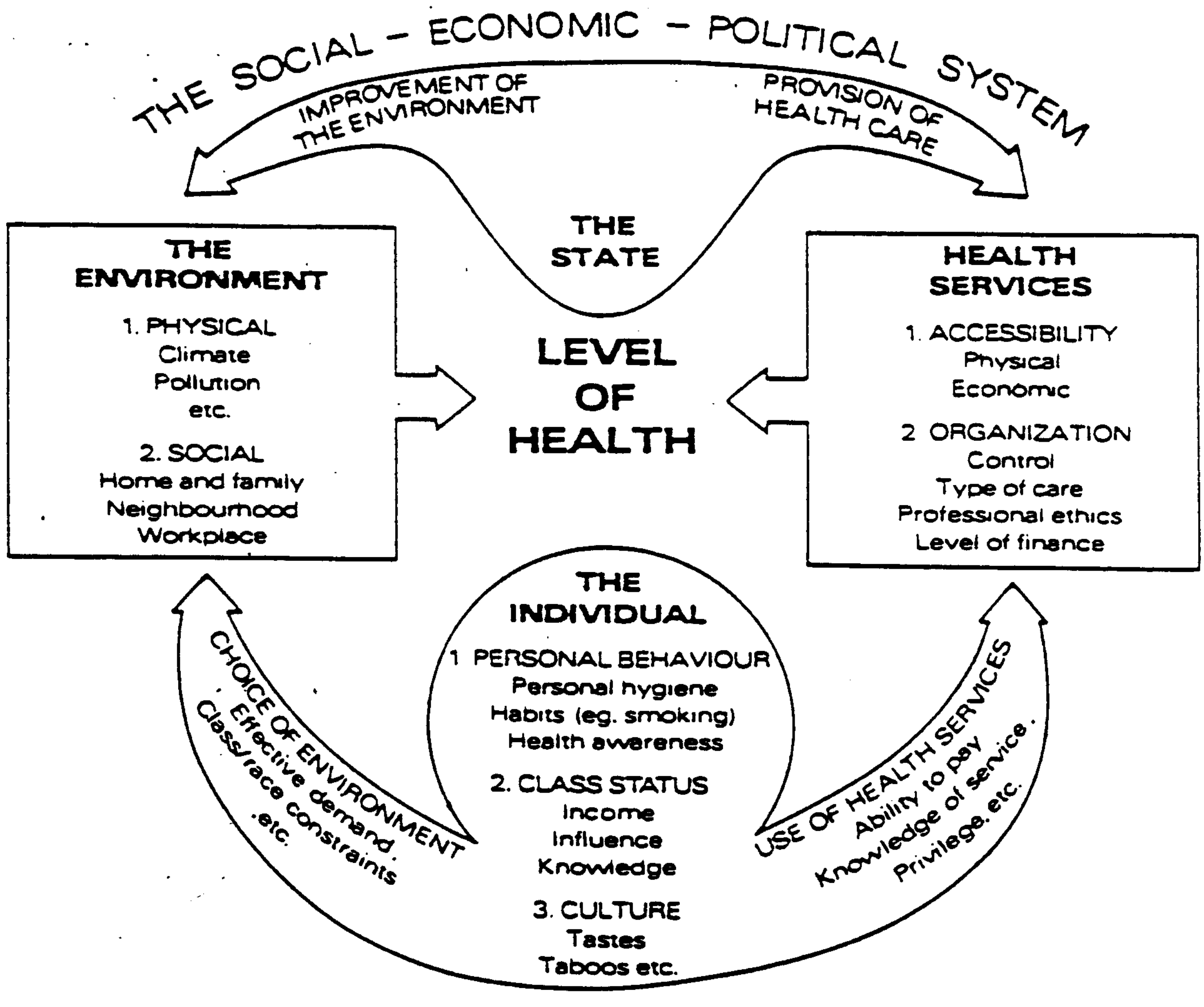
THE SOCIO-ECOLOGIC MODEL OF HEALTH



Source: White (1981)

Figure 2

THE SOCIAL CONTEXT OF HEALTH AND HEALTH CARE



Source: Smith (1982)

Figure 3 <u>Simplified Model of Health</u>

```
Health --------------------------------------> Socio-

                 --------->Health<--------

                 <--------Policies------>        Economic

Status <-------------------------------------- Status
```

The push toward PHC was formalized at a 1978 conference in Alma-Ata, U.S.S.R., sponsored by the WHO and UNICEF (WHO 1978). At the conference, national governments were recognized as the responsible agents for developing and implementing the PHC plan. Health was declared to be a fundamental right, and existing inequalities in health care provision were deemed unacceptable (Primary Health Care 1978, Mahler 1977). Goals were set forth to achieve universal health care which have medical, social, economic, and political implications. Twelve global indicators were identified to monitor and evaluate the progress made by each country toward meeting the goal of HFA/2000.

Since 1981, the Region of Latin America has had a Plan of Action adopted jointly by the WHO and its sibling organization, the Pan American Health Organization (PAHO) that serves as a frame of reference for national health policy and for developing regional strategies for HFA/2000. These strategies spell out specific targets considered essential to the overall goal of HFA/2000 (PAHO 1986).

But: 1) How well are countries in Latin America doing with respect to HFA/2000? 2) How appropriate are the goals/indicators identified by the WHO/PAHO Directing Council? Were these indicators used because of a genuine concern of governments to meet the goals of HFA/2000? Or were they chosen because they were already in place and were easy to measure? Is Latin America progressing toward HFA/2000?

The purpose of the essay is to 1) describe the efforts of five Latin American countries (Venezuela, Costa Rica, Guatemala, Nicaragua, and Cuba) to meet the challenge of attaining the HFA goals as specified by WHO/PAHO; 2) to evaluate the progress made by these five countries with respect to the declared targets, and 3) to comment on the appropriateness of the global indicators used by WHO/PAHO.

The essay is structured in the following way: In chapter two, the current status of Latin American countries is given in relation to populations and health conditions and the need for PHC is discussed. Also, the WHO/PAHO health indicators are presented and difficulties with some of the indicators are described. In chapter three, the current status of the five selected countries of the Region is discussed in relation to population, health programs and indicators. Evaluation of progress toward stated targets is discussed in chapter four. A summary of the findings of this evaluation is presented in chapter five.

CHAPTER TWO

HFA/2000

A. CURRENT HEALTH STATUS AND HEALTH CARE IN LATIN AMERICAN COUNTRIES

1. Health Status in the Region

Among Latin American countries wide variations exist in economic and social conditions, political structure and geography. These variations are reflected in differing health systems and health statistics. Infant mortality rates show a great disparity between countries such as Guatemala (66.0 per 1,000 live births) and Costa Rica (19.1 per 1,000 live births) for 1980 (Latin American Health Handbook 1984). However, common endemic diseases due to lack of hygiene or adverse environmental conditions prevail in all countries of the Region. The provision of safe and adequate water supplies or sewage disposal is often beyond the available resources in many Latin American countries. Enteric diseases account for 92 percent of the deaths in children under five years of age in some areas. Half of the children will have at least ten attacks of diarrhoea before they reach five years of age, and some will have five or six attacks in a single year (Stanley, et al, 1975). Poor housing is an important factor in the prevalence of Chagas disease (American trypanosomiasis or sleeping sickness), a tropical parasitic disease that is transmitted by certain mosquito species and which affects some

seven million people in South and Central America, in some areas (WHO 1985, PAHO 1982, Stanley _et al_ 1975).

The diseases most common in the Region are infectious and parasitic diseases. Malnutrition is widespread. While a daily intake of 2,850 calories is considered a minimum nutritional standard for an adult male (Mörner 1985, p. 245), the average diet of poor people is between 1,700 and 1,850 calories per day (as compared to the five percent of well-to-do Latin Americans who take in 4,100 - 4,700 calories per day) (Tentori 1981). Nutritional deficiencies account for nearly a quarter of infant mortality and are an underlying or associated cause of death for as many as fifty deaths per 1,000 in the population under five years of age. One must keep in mind that there is a synergistic relationship between nutrition, infection, and immune response. If children are not breastfed, they are more vulnerable to gastrointestinal attacks and certain infectious diseases such as measles, that in combination with poor nutrition lead to high mortality. Malnutrition and communicable diseases (pneumonia, bronchitis, diarrhoea and tuberculosis) are the major health problems and causes of death within Latin America, particularly among children, young mothers and the poor (Brockington 1985, Mörner 1985, Alonso 1984). The long-term implications of poor nutrition are severe, since malnutrition interferes with proper physical and intellectual development of the children and eventually with their capacity to lead a fully productive life.

Differences in life expectancy among countries are considerable (Table 1), with life expectancy much higher in the more developed countries (MDC's) than in the less developed countries (LDC's) (Wilkins 1980). Not only does a gap exist between the MDC's and the LDC's, but also among LDC's themselves who differ in economic and social development. The life expectancy of a person depends not only on the country of residence, but also on other things such as gender, region, genetic heritage and personal habits, and the socioeconomic development of the country. An abundance of literature (Tesh 1988; Townsend & Davidson 1982; Townsend 1981; Waitzkin 1981; Navarro 1974, 1976, 1984; Doyal 1979) discusses the important role economic and socio-structural factors play in the distribution of health and well-being. Poverty or economic deprivation and disease have become synonymous for describing conditions of life in the shanty towns of Latin American countries (Navarro 1976).

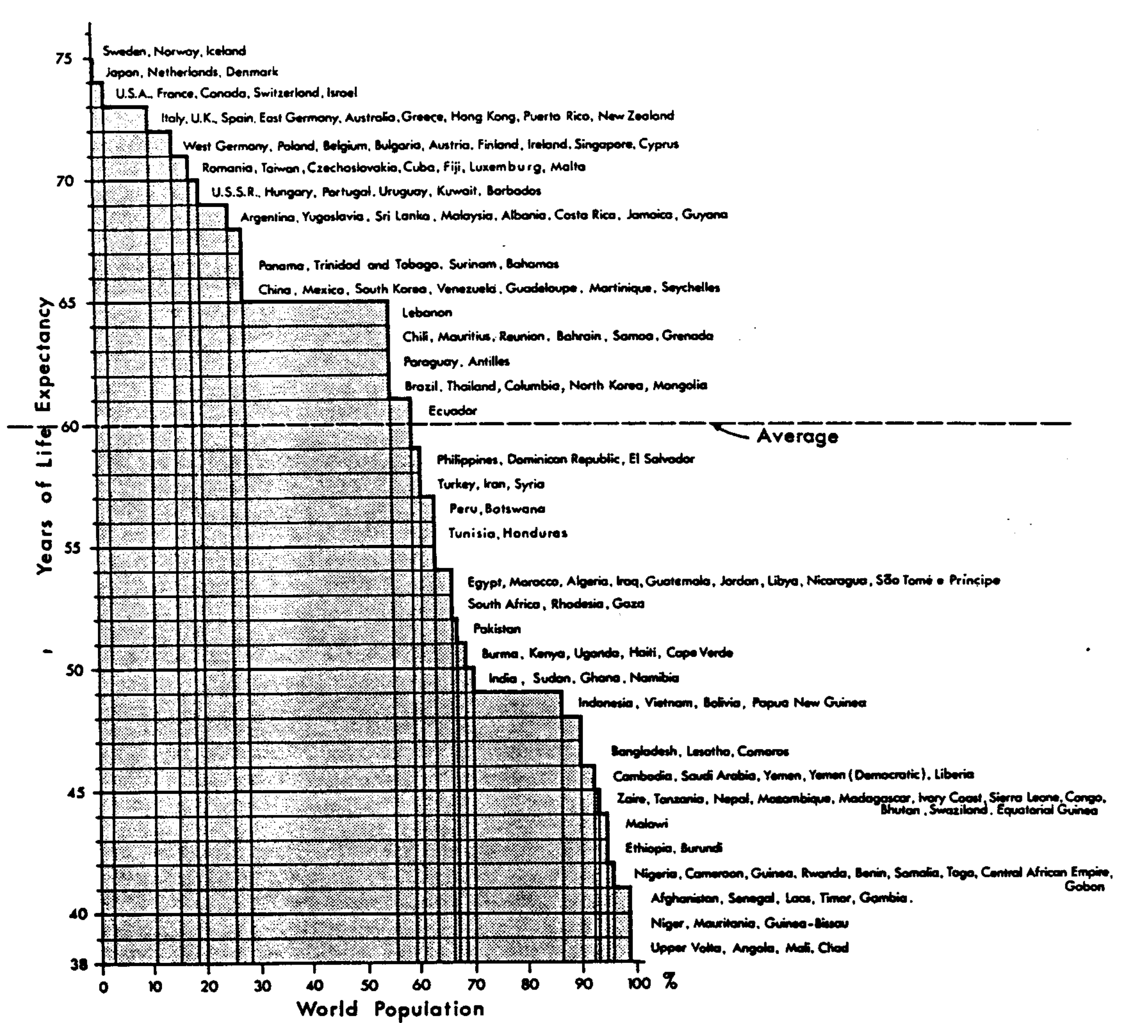
2. Health Care in the Region

The way in which society is structured plays a crucial role in health care inequality (Doyal 1979). Those who dominate within the system, i.e. the political and economic elite, are able to secure more care. They will also strive to maintain this position and deflect any reforms which might radically alter the status quo and threaten their power in society. This power reflects control over capital; it is

Table 1

WORLD PERSPECTIVE ON LIFE EXPECTANCY

Life Expectancy at Birth, Mid-1970s



Note: Horizontal scale shows percentage of world's population living in countries where average life expectancy at birth is equal to, or greater than, number of years shown on vertical scale. Countries listed in order of decreasing population within each single year.

Source: Wilkins (1980), p. 7.

economically based and the aim is to keep it. Obviously, only the few people in power benefit from this and it is in their interests to try to justify and maintain the structure of a society from which they have benefited. This is the structural root cause of inequality.

Health care delivery in Latin America is perceived in essentially Western terms (doctors, nurses, hospitals, and drugs) by the governments and the middle class (including doctors for whom this arrangement is convenient as it serves their interests) and the aim of national governments has been to increase the availability of 'modern' medicine (Gesler 1984, Heggenhougen 1984). The role of governments in providing health care services operates to control health care allocation along with other power groups such as professional medical organizations which control overall health care distribution (Meade, et al, 1988, Joseph & Phillips 1984). But provision of the kind of formal and popular health care systems that are customary in the developed world is problematic and not appropriate in Latin America given the constraints of budget, population size, disease environments and the profound inequalities between the rural and urban population sector (Walsh 1988, Akin, et al 1985, Brockington 1985, Gesler 1984, Walsh & Warren 1980). Considerable numbers of people go without decent health care because of lack of resources, lack of sharing power and an indifferent attitude of people in power toward poor populations. Navarro (1974, pp. 5-27) notes that

the maldistribution of health care resources in Latin American countries is due to the same factors that help keep these areas underdeveloped: the cultural, technological, and economic dependency of the countries and economic and political control of resources by local elites and foreign interests. Unless those conditions change, resource imbalances will continue to exist.

What is required is a wider social and economic strategy to reduce social inequalities, and a restructuring of health care services (Learmonth 1988, Meade, et al 1988, Akin, et al 1985, Bannerman 1983, Good 1977). This involves a change in governmental planning and a redistribution of government resources, as well as a broadening of education to provide better access to knowledge and information. In terms of the health field, a move away from hospitalized care towards prevention, community and primary health care (PHC) is more appropriate to the socioeconomic conditions of Latin America.

B. THE NEED FOR PRIMARY HEALTH CARE (PHC)

1. Components of PHC

The WHO HFA/2000 strategy depends upon PHC. According to WHO (Fry & Hasler 1986, pp. ix - x), PHC:

1) reflects and evolves from economic conditions and socio-cultural and political characteristics of the country and its communities;

2) addresses the main health problems in the community and provides promotive, preventive, and curative services accordingly;

3) includes at least: health education; proper nutrition and promotion of food supply; adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; expanded program of immunization EPI; prevention and control of locally endemic diseases; treatment of common diseases and injuries; provision of essential drugs;

4) involves also aspects of national and community development (agriculture, animal husbandry, food industry, education, housing, communications) and coordinated efforts of all those sectors;

5) requires and promotes community and individual self-reliance and participation in the organization, operation and control of PHC, and that it develops through appropriate education the ability of communities to participate;

6) should be sustained by integrated referral systems;

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, trained to work as a health team and to respond to the expressed health needs of the community.

PHC is seen as essential health care and more low-cost than traditional hospital-based curative care; its focus is on the general well-being of the population, emphasizing equity, acceptability, self-determination, and social justice (McKeown 1989, WHO 1980b). The goal is to make substantial, inexpensive, and rapid improvements in the delivery of curative and preventive health services at the community level in rural areas and to reduce social inequalities. It is seen as being the first level of contact with the national health system and being based on social ahd economic development of the country

(Walsh 1988).[1]

Among the recognized basic human needs is the fundamental right of each individual to health. Today health is seen more than just a social goal; it is also increasingly recognized as a means or even a prerequisite for socioeconomic development. Health and development are now viewed as closely interrelated and health policy and health strategy should be integrated into national development plans (Acuna 1982). The health status of people can be improved as a result of appropriate national efforts and coordinated activities by the health programs and the social, cultural, and economic development sectors.

2. Goals of WHO

To achieve HFA/2000 the WHO strategy included specific goals that ought to be addressed and met by all member

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[1]An alternate model to PHC is Selective Primary Health Care (SPHC) which is concerned with selective provision of PHC to combat specific causes of morbidity and mortality, such as vector control and water and sanitation programs to reduce deaths from typhoid, cholera and other diarrhoeas, and nutrition programs to decrease morbidity and mortality in children (Walsh & Warren 1980).

A concern with SPHC is that this approach to health care does not directly address the social and economic problems of the populations (Gish 1982, Berman 1982). Therefore it may not be a relevant or desirable alternative for most countries, although Warren (1988) argues that until PHC can be made available to all, effective services aimed at the few most important diseases need to be adopted to improve the health of the people.

countries. These goals are (WHO 1987):

- ascertainment of needs and decision-making at the community level
- the necessity of government cooperation at all levels
- a multi-faceted approach that includes education concerning prevailing health problems and the methods of identifying, preventing and controlling them
- promotion of food supply and proper nutrition
- 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
- provision of essential drugs
- better housing
- geographic, financial, cultural, and functional accessibility to health care
- a strong emphasis on paramedical persons and community health workers
- a new international economic order
- detente and disarmament

WHO argues that these goals are essential to achieve adequate health conditions. But HFA is not a goal of the health sector alone, nor can it be achieved by the health sector alone. It is part of the fabric of socioeconomic development of a country (Acuna 1982) and requires 1) changes within the health care sector and 2) changes outside the health care sector.

1) Changes within the health care sector require a shift of health resources to those without access. This involves the expansion of training and use of paraprofessionals. These paraprofessionals usually live in the community they serve. They are familiar with the language and cultural factors in the community and are a necessary component of the PHC program (Bender & Pitkin 1987). They bridge a gap between the

underserved rural population and the formal health system. Other changes within the health care system require targeted interventions such as Expanded Programs on Immunization (EPI) and oral rehydration therapy (ORT) which have been shown to have a direct impact on child and infant survival (Walsh & Warren 1980).

Even greater changes must occur 2) in the outside health sector where both the haves and have-nots must be part of the process. The challenge is to expand the circle of development to encompass the marginal groups, particularly the children, women of child-bearing age, the elderly and the poor. To reach those priority groups, fundamental changes in national priorities must occur. These changes depend on comprehensive social and economic development and involve education for all populations, a better infrastructure (such as an improved road system) and a more equal distribution of wealth and power.

Literacy, education, decent housing, adequate supply of safe water and basic sanitation, and increased food production, are directly related to health conditions, yet they are not provided by the health sector. These conditions require a fundamental change in the socioeconomic development of a country and government cooperation at all levels. This may be difficult to achieve. Some governments may view PHC as a political threat as its concepts promote equity and decentralization of power (Newell 1988). In reality, no government will hurry to divert power unless a fundamental

reorganization of society occurs through revolution.

Indeed, one wonders if many of the WHO goals are not pure rhetoric. For example, the WHO is completely powerless in creating a 'new economic order'. Moreover, most representatives of nations within the UN would undoubtedly not want changes called for within PHC. This issue is not something that can be solved in a few years. It involves the sharing of resources from more developed countries (MDC's) with less developed countries (LDC's) and a more equal distribution of income within the LDC's. But most developing countries' ruling groups consider this issue a non-negotiable one (Ghosh 1984) as it involves a reorganization of the economy. The economy in most LDC's is based on the capitalist agroexport model and the exploitation of cheap labour and land (Schuh 1984, De Janvry 1981). Poor peasants are required to produce cheap foods in order to maintain urban wages at depressed levels. They are also the major source of cheap labour for the dominant rural sector of agroexport production.

3. Global Indicators

To measure the progress of Latin American countries toward meeting the objective of HFA/2000, WHO/PAHO identified twelve specific indicators (WHO 1987, PAHO 1980):

1. Health for all has received endorsement as policy at the highest official level, e.g., in the form of commitment by the governments.

2. Involvement and participation of all communities (including villages, hamlets, etc.) and people in the

planning and organization, operation and control of PHC through representations of political parties and organized groups such as trade unions, farmers' groups, etc.

3. At least 5 percent of the Gross National Product (GNP) is spent on health.

4. A reasonable percentage of the national health expenditure is spent on local health care, i.e., first-level contact, including community health care, health centre care, dispensary care.

5. Health service resources are equitably distributed between the urban and rural areas (e.g., health care facilities, staff, and per capita health expenditures).

6. Developing countries with well-defined strategies for HFA receive sustained support from more affluent countries.

7. Primary health care is available to the whole population with the following: safe water in the house or within 15 minutes walking distance; adequate sanitary facilities in the house or immediate vicinity; immunization against diphtheria, tetanus, whooping cough, measles, poliomyelitis, and tuberculosis; local health care, including availability of at least 20 essential drugs within one hour's walk or travel; trained personnel for attending pregnancy and childbirth and caring for children up to at least one year of age.

8. The nutritional status of children is adequate in that: 90 percent of newborn infants have a birth weight of at least 2,500 g.

9. The infant mortality rate for all subgroups is no more than 30 deaths per 1,000 live births (PAHO 1980).

10. Life expectancy at birth is at least 70 years (PAHO 1980).

11. Adult literacy rate for both men and women exceeds 70 percent.

12. The Gross Domestic Product per head exceeds U.S. $500.

4. Assessment of Indicators

The twelve WHO/PAHO indicators are seen as proxy measures for a host of changes that will take place in a society over time. These changes are consistent with HFA/2000 and will improve health conditions for all people (including the indigenous populations). An improvement in people's health status also indicates that a fundamental change has taken place in that society. But are these twelve indicators really appropriate to demonstrate those changes?

Some of the indicators are too vague to measure the progress towards HFA/2000. Indicator #1 stipulates that governments commit themselves to HFA. But despite governmental commitment, for example in the guise of national health services, inequalities have continued. Service provision priorities are inconsistent with HFA and deployment of resources is unevenly distributed between rural and urban areas. Resources have been purposely directed to the cities. This suggests that concepts of equity and decentralization are not accepted in any sector of some Latin American countries. It suggests that there is an underlying force (elite groups) preventing welfare initiatives. Without the necessary degree of commitment of a country's governing elite groups and political system, PHC is accepted in name but not in reality. This force and its power is an indication of the inability and political unwillingness of governments[4] to combat inequality.

These problems are not only exacerbated by domestic elites but also by the actions of the World Bank and the International Monetary Fund (IMF) which have provided development cooperation funds and technical assistance to the Region. As a requirement for the use of the Fund's resources, the recipient country generally agrees to certain conditions which might require a reallocation of resources to urban areas (Musgrove 1986, Alonso 1984).

Indicators #3 and #4 address the financial aspect of health care. Indicator #3 stipulates that 5 percent of the GNP is spent on health. Why was this number chosen by WHO/PAHO? Why not 10 percent? Was it chosen because most governments only spent 3-5 percent on health and this number does not require a change in the present system? Also, Indicator #4 stipulates that a "reasonable" amount of the national health expenditure be spent on PHC. Again, what constitutes a "reasonable" amount? Money is at the root of most Latin American countries' difficulties in providing for an adequate health service. Severe inflation in the early 1980's has resulted in the reallocation of funds for health and social services to cover problems in the industrial sectors which are located mostly in urban centres (Musgrove 1986, Alonso 1984). The result of this reallocation is a widening gap between the urban/rural sectors. A poor country with a predominantly urban population and with limited resources may need to spend the available resources on the urban sector. Foreign aid can

alleviate some of these monetary problems. PAHO/WHO help mobilize external financial resources from the World Bank, Inter-American Development Bank, European Community, UNICEF, and US-AID. This external aid is only beneficial to the general population if governments are committed to HFA and use the funds to improve the general standard of living for everybody.

Indicator #7 addresses the universal availability of PHC. It ignores factors such as geographical accessibility and cultural beliefs with regard to health and health care. In many Latin American countries many people, especially indigenous people, are physically isolated by rugged terrain and the lack of adequate rural roads (Indians in Guatemala) (AID 1979). In Venezuela, the rural population is dispersed over a large territory. Access to health care facilities is a problem. Transportation networks are important (Tugwell, et al 1984, Annis 1981, Morrill, et al, 1970 Shannon 1969). Without government commitment to provide an adequate transportation system, HFA will not be realized for many poor populations.

Cultural beliefs with regard to health and health care are also important (Bastien 1987). Many Indians adhere to their traditional beliefs regarding health. Community attitudes towards health care are a strong obstacle that cannot be changed readily by the government's efforts. The Indians' health beliefs are that things are fine the way they are or that everything, including illness, is ordained by God and all

one needs is faith in God (Colburn 1981). Indicators could have been used that more appropriately address the health beliefs of indigenous people, integrating traditional beliefs with modern aspects of health care.

Indicator #11 should indicate that the literacy rate for both men and women exceeds 70 percent in urban and rural areas, indicating a more equal distribution of resources. Studies (McKeown 1989, Alonso 1984, Nyrop 1984, Steltzer 1983, Colburn 1981) show that literacy rates are lower in rural areas. A high literacy rate in both urban and rural areas indicates a higher level of economic development.

Indicator #12 ignores the profound inequalities in income that may exist within a country. In spite of its general usefulness, a number of limitations are associated with using GDP as a measure of domestic wealth. First, the GDP does not reveal the distribution of wealth within countries. In many Latin American countries a small percentage of the population controls a large share of the wealth, while most of the people are poor. A wide gap exists between the incomes of the majority of the population (40 percent) and those of the small elite class (20 percent) that controls the economy and, generally, the governments (Stoddard, et al 1989). What the GDP is not showing is that income distribution is unequal between sectors of populations (indigenous and European) and between urban and rural populations.

There is also a problem of standardization of such measures as the GDP is given in U.S. dollars. This measure ignores the relative cost of living in Latin American countries. Official exchange rates often do not accurately reflect the actual comparative value of goods in two different countries. The relative cost of living in these countries is usually less than in MDC's and housing and food usually cost just a fraction of that in MDC's. A GDP of 1,202 US dollars goes a lot further in Guatemala than it would in the United States of America or in Venezuela.

Against this backdrop, the progress of five selected countries of Latin America toward HFA/2000 will be evaluated. These countries were chosen because of their socioeconomic differences rather than their representativeness for Latin America as a whole. They represent a range of ideological models, from free-market capitalism (Venezuela, Costa Rica, Guatemala) to populous revolutionary government (Nicaragua) to socialist states (Cuba). They are also somewhat diverse in their geographic features (a theme which is discussed in greater detail in the text).

CHAPTER THREE

HEALTH AND WELL-BEING IN SELECTED COUNTRIES OF THE REGION

A. AN OVERVIEW OF VARIOUS SOCIOECONOMIC AND DEMOGRAPHIC INDICATORS

Attainment of the targets set by the WHO/PAHO indicators will be evaluated for five countries in the Latin American Region: Venezuela, Costa Rica, Guatemala, Nicaragua, and Cuba (Figure 4). These countries were selected because they are different in geographic, economic, demographic, social and political structures. Basic characteristics of these countries are compared in the beginning of this chapter.

Table 2 lists the Gross Domestic Product (GDP) per capita for each of the five countries. Venezuela has a GDP per capita about three times greater than that of Nicaragua which has the lowest GDP. This in turn reflects the economic development of both countries, with Venezuela being the most economically developed of the five countries.

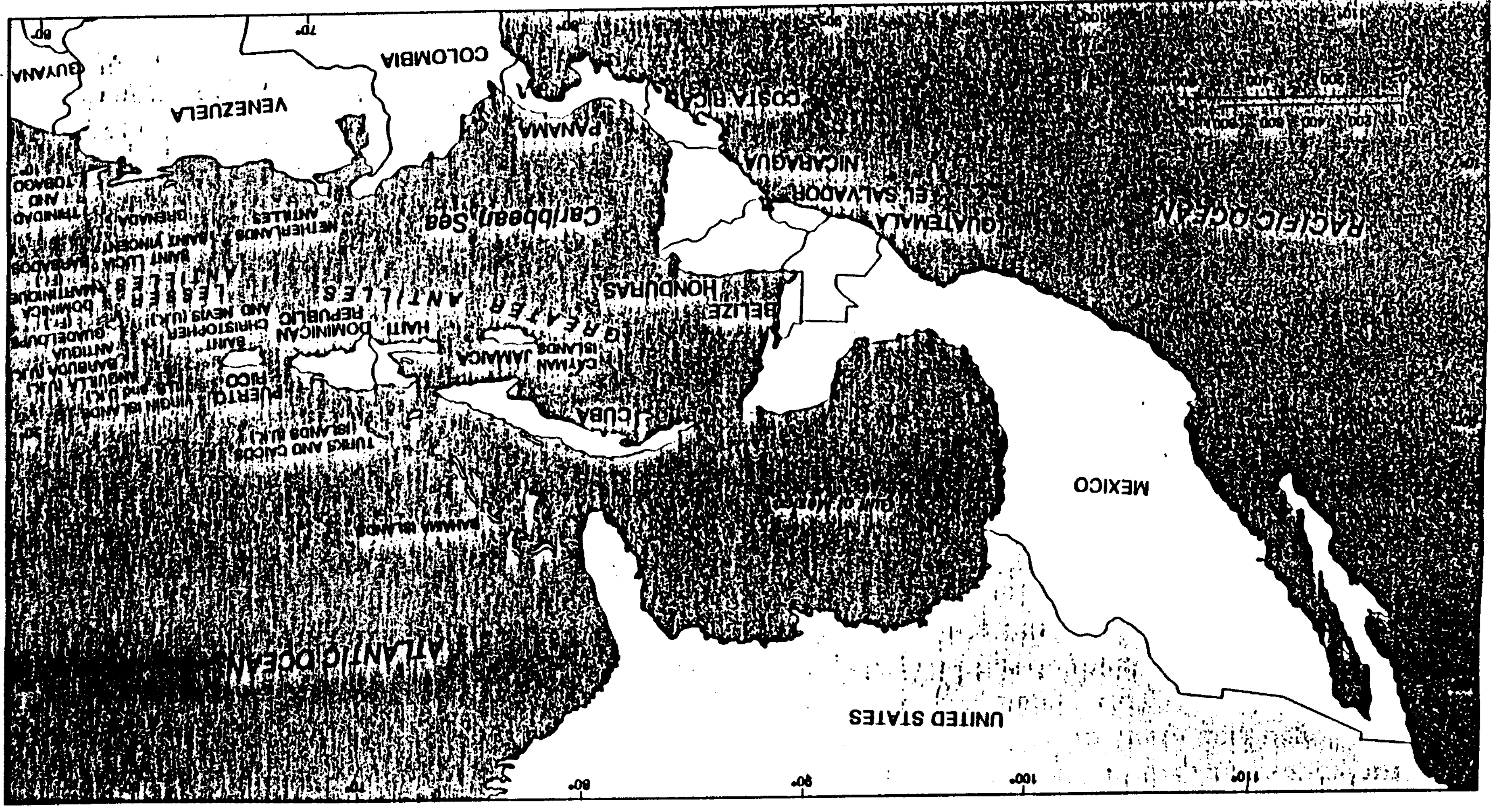
Table 2: Gross Domestic Product (GDP) Per Capita (given in 1982 US dollars)

Country	Year	GDP Per Capita
[a]Costa Rica	1984	1,565
[b]Cuba	1985	1,410
[c]Guatemala	1984	1,202
[a]Nicaragua	1984	874
[a]Venezuela	1984	2,340

Source: [a]Musgrove (1986), p. 153.
[b]James, et al (1986), p. 159.
[c]PAHO (1986), p. 232

Figure 4

LATIN AMERICA



Source: James et al (1986), p. 6.

In Table 3, the ethnic composition of each country is represented. It shows that Guatemala has a high percentage of an indigenous population compared to the rest of the countries. Costa Rica and Cuba have a population of predominantly European ancestry, whereas the inhabitants of Nicaragua and Venezuela are predominantly mestizos (persons of mixed European and indigenous ancestry).

Table 3: Population Composition

Country	Indigenous Unmixed (%)	Unmixed European (%)	Mestizos (%)	Blacks (%)
Costa Rica	<1	80	17	2
Cuba	/	66	21	12
Guatemala	50	5	42	/
Nicaragua	5	10	75	10 (mulatto)
Venezuela	2	20	69	9

Source: James, et al (1986).

In Table 4, the selected social characteristics of each country are represented. The selected demographic and social indicators for Cuba indicate a population resembling those of developed countries, with a predominantly older (65+) urban population, a low birth and crude death rate and a high literacy rate. Guatemala, on the other hand, has a predominantly young (under 15 years of age) and rural population, one of the highest birth and crude death rates and the lowest adult literacy rate.

Table 4: Selected Demographic and Social Indicators

Country	[b]Population (1985) Total (1000)	Under 15 (1000)	65+ (%)	Rural (%)	Birth Rate (per 1000) 1980-1985	Crude Death Rate (per 1000) 1980-1985
Costa Rica	2,595	36.7	3.8	54.1	30.5	4.2
Cuba	10,038	26.4	7.9	28.2	16.9	6.4
Guatemala	8,270	43.1	3.0	58.6	38.4	9.3
Nicaragua	3,258	46.7	2.5	40.6	44.2	9.7
Venezuela	18,297	41.0	2.9	14.3	35.2	5.6

Table 4 (Continued):

Country	[b]Rate of Natural Increase 1980-1985	[a]Annual % of Increase 1980-1985	[a]Adult Literacy Rate Year	Total (%)
Costa Rica	4.2	2.7	1985	93.0
Cuba	10.4	1.1	1985	96.0
Guatemala	29.1	3.5	1985	51.1
Nicaragua	34.5	3.4	1985	87.0
Venezuela	29.6	2.7	1985	86.0

Source: [a]James, <u>et al</u> (1986);
[b]PAHO (1986), p. 231.

Note: No data available re male/female adult literacy rate.
Some figures used in analysis appear in appendix.

This brief analysis indicates that marked socioeconomic and demographic differences exist between all five countries. An indepth analysis of each country will be presented in the remainder of this chapter.

B. VENEZUELA

Venezuela (Figure 5) has a unique position among the countries of Latin America. Its population is small in relation to the total national territory, and its material resources are substantial (James, et al 1986, Martz & Myers 1986).

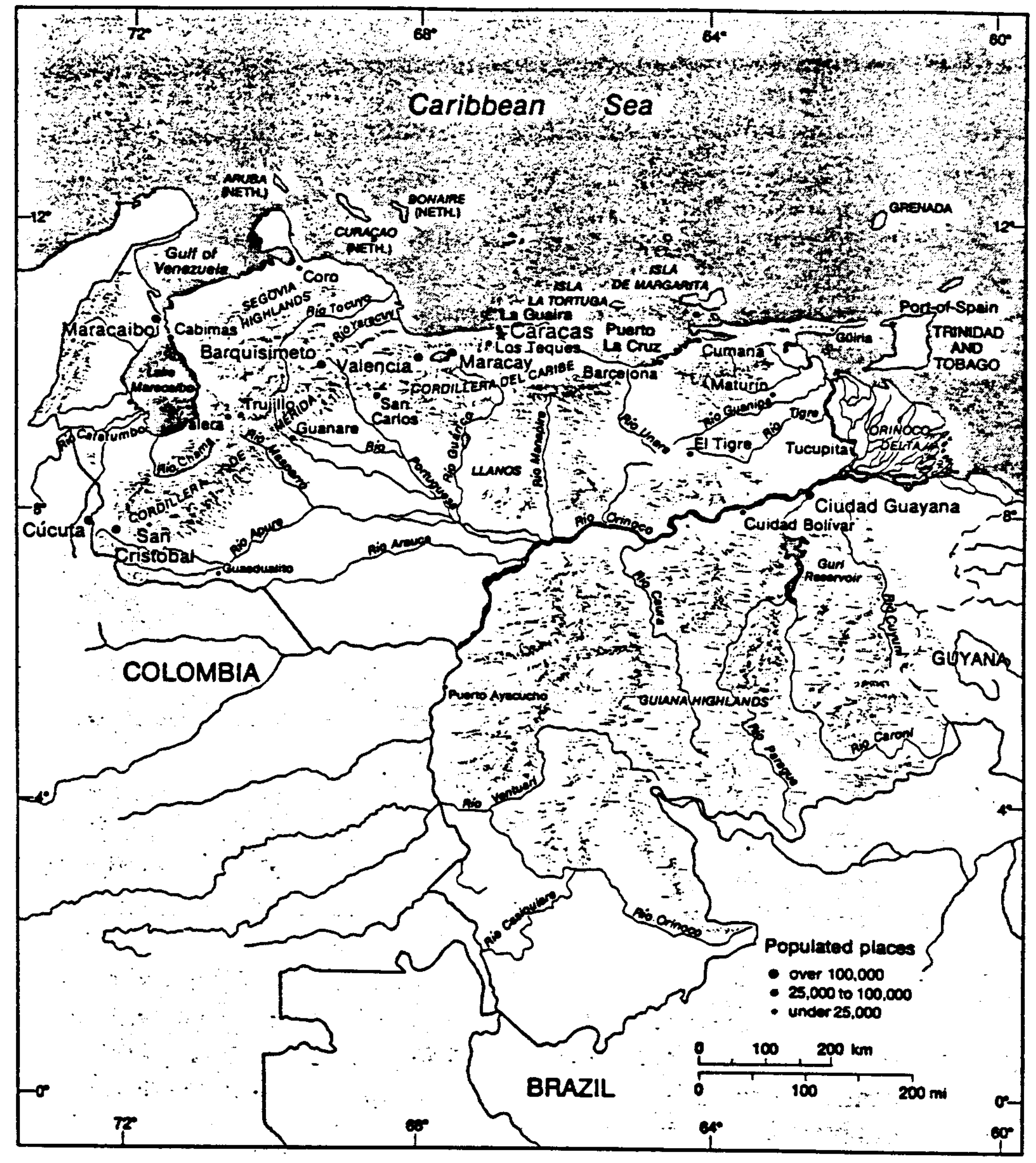
It is one of the world's greatest oil producing and exporting nations, and enjoys the wealth and prosperity derived from rich deposits of petroleum. It is also the "richest" of the five countries, measured by the GDP per capita (Table 2). But the national income is unevenly shared and great disparity between the rich and the poor exists (James, et al 1986, Martz & Myers 1986).

A small percentage of the population (about 20 percent), controls a large share of the wealth, while about 40 percent of the population live in poverty (Stoddard, et al 1989). The income of the country's top 5 percent is about three times the amount of the bottom 20 percent (Kidron & Segal 1987).

1. Population

Venezuela, with eighteen million inhabitants, is the largest of the five countries. The population figures include 20 percent of unmixed European ancestry, 2 percent of unmixed Indian ancestry, 9 percent blacks, and 69 percent mestizos (persons of mixed European and Indian ancestry) (Table 3). The population distribution is predominantly urban (approximately

Figure 5 MAP OF VENEZUELA



Source: James & Minkel (1986), p. 276.

86 percent). The rest of the population is unevenly distributed over the national territory. Europeans and Mestizos are concentrated in the larger towns and cities in the north; native Indians live in the more remote areas such as the Guiana highlands south of the Orinoco River, while blacks live along the coast. The economy is based on oil and the wealth from this resource has produced regional inequalities in Venezuela. The wealth is concentrated in the north-central region where the major oil fields and cities (Maracaibo and Caracas) are located. Lack of economic development and uneven land distribution force many people from rural areas to migrate to these major cities in search for a better life.

Venezuela, like many other developing countries, presents great contrasts between large urban concentrations of population and rural populations living in small villages or isolated ranches (Figure 5). Although urbanization has been rapid in Venezuela, the rural population is still very scattered and it is difficult to provide it with services, including basic medical care.

2. Health Conditions

Venezuela's modern health movement began in the late 1960's, when it was officially recognized that trained physicians could not reach the remote and dispersed population. Health problems in the country included a number of communicable diseases (tuberculosis, typhoid and dysentery),

and high infant and preschool mortality in both urban and rural areas. The Ministry of Health and Social Security (MSAS) was formed in 1936. It developed specialized campaigns in rural areas for control of certain diseases (malaria, yaws, leprosy) and specific programs in urban areas around tuberculosis, venereal diseases and child health programmes (Gonzalez 1975). This curative medical care work was expanded gradually, but mostly in cities where most of the technology and resources were concentrated. In the rural areas, small health centres (staffed with one physician), known as medicatures rurales, were built in towns of 5,000 inhabitants. The number of medicaturas rurales increased from 71 in 1937 to 188 in 1945. The increase was slow due to lack of government finances and insufficient resources. By 1950, there were 384 centres, staffed by 418 doctors. The medicatures rurales served an estimated population of 2.2 million, of whom only 80,000 lived in the towns near the doctors. Over one million people lived in villages where there were no medicatures rurales (Gonzalez 1975, Djukanovic & Mach 1975). Health conditions of these people were poor: one in every three registered deaths (most occurring in children aged less than two years) was ascribed to diarrhoea, dysentery, or acute respiratory diseases. Other cases of death included tetanus and maternal conditions (pregnancy, childbirth) (Gonzalez, 1975).

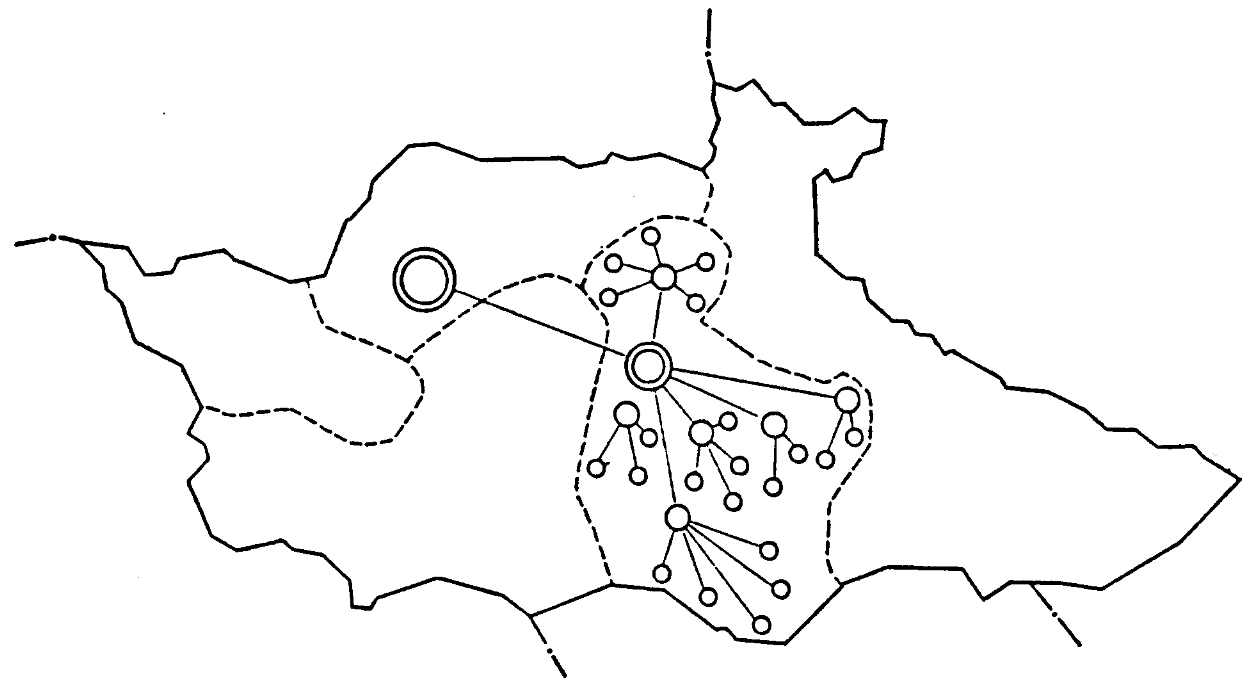
The provision of services to meet the elementary general health needs of remote and dispersed populations proved to be a

difficult task. It was recognized by the Ministry of Health and Social Security that a better system was required to bring health and health care closer to the people. This led to the introduction of Simplified Medicine in the rural environment in 1962.

3. Simplified Medicine Programme (SMP)

In the Region of Territorio Federal Amazonas, with a surface area of 175,750 km (20 percent of the whole country), the population of about 12,000 inhabitants, mainly jungle indigenous people and nomads, lived in extreme poverty and isolation. The government introduced a programme called "Simplified Medicine" (SMP) to bring health care services to the area. The area was divided into health regions with each regional unit organized as a network comprising four levels: (1) the regional centre, (2) the district health centre, (3) the medicatura rural and (4) the dispensary (dispensario rural) (see Figure 6). The programme represented a more balanced type of development by promoting a decentralized pattern of health care services in order to narrow social, sectorial, and regional disparities. The 'simplified medicine' concept was introduced in the most peripheral level, the traditional dispensaries (rural health posts) located in small villages with a population of usually not more than 1,000. SMP's specific goals were to deliver basic health care through auxiliary health care workers (Gonzalez 1975, Djukanovic &

SCHEME OF A HEALTH DISTRICT
WITHIN A HEALTH REGION IN VENEZUELA



Symbol	Type	Number
◎	Regional Headquarters	
◎	Health Centre	1
○	Medicatura Rural	6
○	Rural Dispensaries	21

Source: Newell (1975), p. 176

Mach 1975).

The health worker is concerned with the general health of the community and must be available on a permanent basis to deliver simple services. The worker is usually a native or resident of the village, with at least four years of primary schooling. Health care training consists of a four-month course held in district centres. Workers are trained to recognize and treat common diseases or conditions (diarrhoea, pneumonia, malnutrition). They are also taught to provide first aid in emergencies and how to treat minor trauma. Workers are responsible for health promotion, maternal and child health, environmental sanitation, and health protection. Auxiliaries participate in the detection of malaria cases by taking blood slides. They follow-up patients undergoing treatment for tuberculosis, perform tuberculosis tests, and help in locating contacts and referring them to the appropriate centre. They record births and deaths, stimulate community development by working with teachers and agricultural extensionists, and they take a health census of each family in the area (Gonzalez 1975, Djukanovic & Mach 1975).

Supervision is carried out by the doctor in charge of the medicatura rural to which the dispensary is attached, and by regional supervisors of simplified medicine. They are based in the regional health office and devote their whole time to the supervision of dispensaries.

By 1973 the SMP was operating in 12 of 23 major states or territories of the country (Gonzalez 1975). It is financed

from the budget of the regional health services. Services are provided free of charge to individuals. Local communities help to meet some of the expenses such as maintenance and minor repairs of buildings (Gonzalez 1975, Djukanovic & Mach 1975).

Health policies have been directed toward making health services available to the entire population (PAHO 1986). In 1983, MSAS established 426 rural medical stations, 2,443 rural dispensaries, and 548 urban outpatient clinics (PAHO 1986, p. 223). Of the 17,425 physicians and 46,028 nurses and auxiliaries, 88 percent were employed in hospitals and only 10 percent in community care (PAHO 1986, p. 223).

4. Achievements

Although it predates the HFA initiative, the SMP represents a step forward in providing PHC to rural communities. SMP promotes the overall development of rural areas and has been implemented side by side with other health related programmes such as the Rural Housing Programme and the Rural Water Supply Programme (WHO 1990). An estimated population of some 280,000 people were covered by the SMP in the late 1970's, so that an average of some 890 people were served by each dispensary (Gonzalez 1975, Djukanovic & Mach 1975). This increase in health care provision has contributed to a reduction of certain problems such as tetanus, which has disappeared in some rural areas, as well as an increase in the proportion of pregnant women receiving antenatal services (PAHO

1986). EPI and ORT programmes which are provided by SMP have had a direct impact on child and infant survival (WHO 1986). Infant mortality has been significantly reduced to 39 per 1,000 live births throughout Venezuela. Life expectancy increased to 67.8 (PAHO 1986) to come close to the goal of the WHO/PAHO global indicator.

It was expected that by 1980 the SMP would be operating in all the regional health services (Gonzalez 1975). Community medicine was introduced to medical school curricula which brought students into contact with rural dispensaries. Students now spend some weeks in villages and work with the auxiliaries. Family planning programmes are part of the SMP. Health instructions are incorporated into the educational system (PAHO 1986).

SMP was successful in providing health care services but was not successful in community development which is limited to the supply of free labour for maintenance and minor repairs of buildings (PAHO 1986). Community involvement in health or in social development programmes require profound economic reforms in the local communities so that they can become less dependent on subsidies from central sources (Reilly 1989). These reforms also need to be complemented by a better distribution of revenues so that government income is not so largely consumed within metropolitan areas. The gains of the SMP will be ineffective if elements of equal or greater importance than health care such as socioeconomic reforms for the improvement

of the overall status of the population are lacking. These include more land reforms, changes in land tenure system, improved housing, and increased agricultural output and tax reforms to further reduce the inequalities that are still apparent between the urban and rural sector of the population.

Because these reforms entail specific consequences for both economic and political structures, they have been resisted by hegemonic economic and political groups. The reforms call for state intervention into peripheral rural areas with a focus specific to rural problems. These problems are based on the relation of functional dualism (de Janvry 1981), an exploitive relationship where land-poor or landless peasants who cannot meet their own needs have to seek part-time or seasonal work on large plantations or haciendas. This system ensures cheap labour for the agroexport market needed to maintain a comparative advantage in the international community markets and to produce inexpensive foodstuffs for the urban sector. But if land reforms, which are usually aimed at reducing urban-rural and regional disparities and improving peasants' access to basic foods and services (Rondinelli & Evans 1983, de Janvry, Rondinelli & Rundle 1978, Waterston 1974) are allowed to the point of significantly affecting rural structures, this would undermine the basic source of cheap rural labour for the agroexport production. These reforms would also end the commercial exploitation of peasants by large rural landowners and commercial intermediaries, especially the state itself (de

Janvry 1981, Fals Borda 1971).

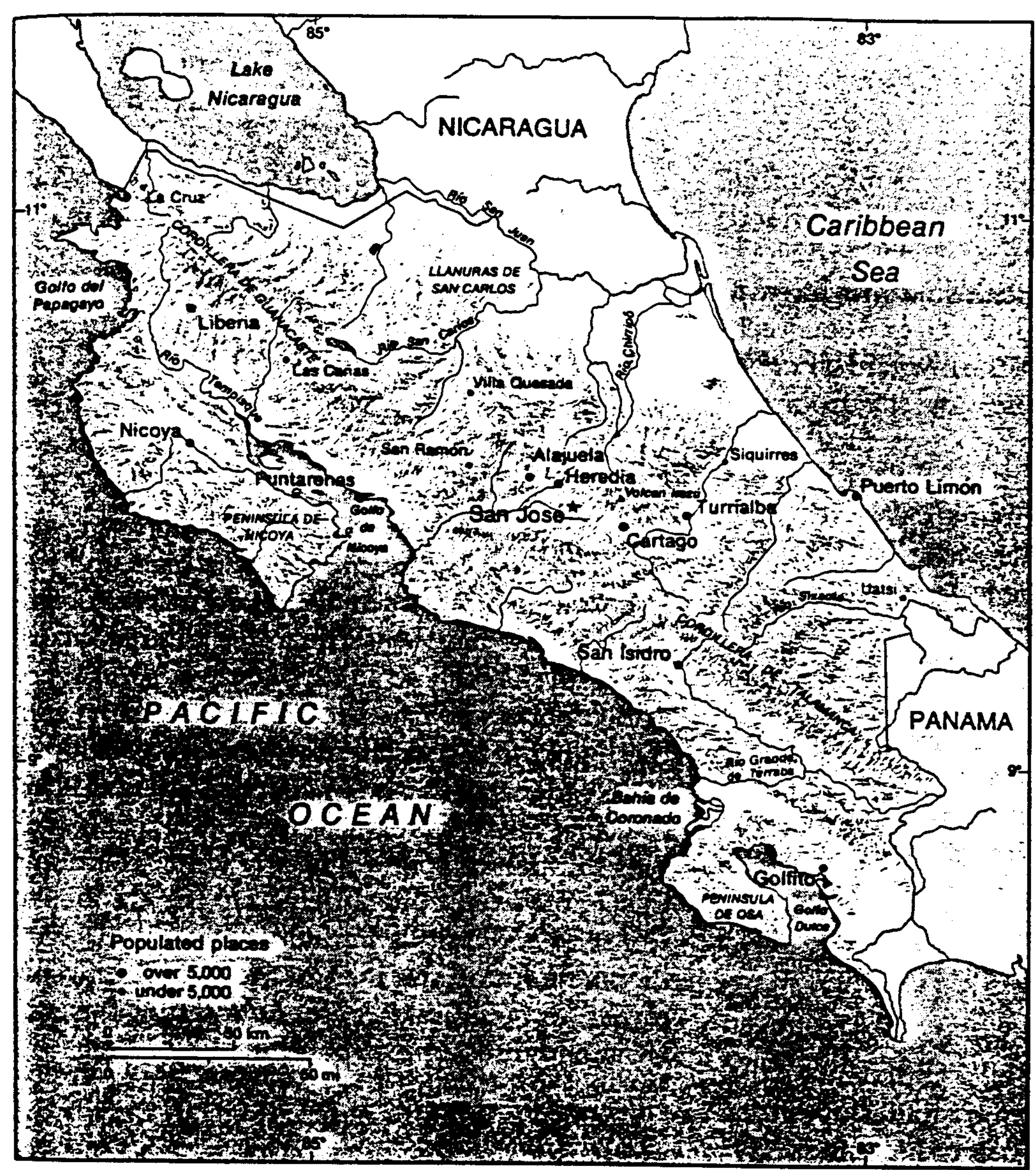
C. COSTA RICA

1. Population

Costa Rica (Figure 7) is the smallest in geographic territory of the five countries chosen for this study. The physical features of Costa Rica are not complex. The area of concentrated settlement that forms the nucleus of the country is in the highlands, where a small interment basin with deep volcanic soils offers land of relatively gentle slope in the midst of the tierra templada (which is the land above an altitude of about 2,100 feet rising to about 6,000 feet). It is also known as the temperate country. The densely populated core area, including the basin and the lower slopes of the bordering mountains, measures only about 15 by 40 miles (James & Minkel 1986). Its population of approximately 2.6 million people (PAHO 1986) is predominantly Spanish speaking (Table 3) and is concentrated in the core area of the highlands where also 90 percent of the nation's industry is located. It has a well-developed social and economic infrastructure. The country has a highly developed system of education and more than 90 percent of the population is literate (PAHO 1986). Its birth rate of 31 per thousand (1984) and exceptionally low death rate of four per thousand (Table 4) (PAHO 1986), are the lowest of the five countries.

Figure 7

MAP OF COSTA RICA



Source: James & Minkel (1986), p. 125

But there is also internal variety. In the Province of Guanacaste on the Pacific Coast, nearly half of the people are mestizo in origin, racially indistinguishable from the people of Nicaragua. In this area, there are many large properties, a small landed aristocracy, and tenant workers who live in relative poverty. On the Caribbean side, more than half of the people are blacks, mostly of Jamaican origin (James, et al 1986).

The great majority of Costa Rican farmers own and operate their own farms because there is no significant landed aristocracy and hegemonic political groups to dominate the social life and collect a disproportionate share of benefits from the economy. The traditional large estate (hacienda) with tenant workers is not common and, although the average size of farm unit is rising, this is due to the operation of modern cost factors favouring larger enterprises and not to the existence of colonial or post-colonial land grants (Enconienda system). The very small holdings are less common also. Family labour is more important than hired help (Blakemore & Smith 1971). There has also been considerable agricultural expansion where farm settlers have moved from overpopulated core areas to empty lands. This kind of outward movement has been generally lacking in Latin America until recently.

2. Health Programs

During the 1970's Costa Rica's major health problems were

high infant morbidity and mortality caused in part by poverty and ignorance and in part by a lack of well-defined national health policy guidelines (Jaramilla 1987). This situation began to change as a result of new health strategies and socioeconomic improvements.

In the 1970's the government of Jose 'Pepe' Figueres[2] made health services the top priority of government policy to eradicate extreme poverty. This involved the implementation of two programmes: The first of these, the Rural Community Health Program (RCHP), was established, which covers 60 percent of the total rural population, targeted on communities with less than 500 inhabitants. The goal of this programme is to provide health care services to rural populations (Ministry of Health, Costa Rica 1982). Local community health committees are responsible for the maintenance of their health post, which is staffed by a full-time auxiliary nurse and a rural health assistant. The health assistant is chosen by a local committee.

A health assistant receives 16 weeks of training and is paid by the state. The worker may be male or female, and he or she is responsible for approximately 2,000 people, or 400 homes, and visits each home at least once every two months. A health assistant's responsibilities include: updating census

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[2]Figueres had been in power before, e.g. in 1948, and had been responsible for the institutionalizing of many reforms at that time (Bender & Pitkin 1987).

data, giving vaccinations, treating malaria and intestinal parasites, teaching health education, promoting family planning, referring serious cases to secondary and tertiary level of care, and participating in community organization. Family files are kept, including growth charts, vaccination records, records of contraceptive use and socioeconomic surveys (Bergvall 1979).

The health assistant receives a one-day refresher course each month. He or she is supervised regularly by a nurse who accompanies him or her to evaluate skills. While the health assistant is responsible for the home visits, the full-time auxiliary nurse remains at the health post where her duties are similar to those of the health assistant.

The second program undertaken to extend coverage of health services was targeted on marginal urban areas. On the fringes of metropolitan San Jose (the capital) about 16,000 dilapidated huts housed tenants who lacked employment, adequate food and decent sanitary facilities. These slum-dwellers were exposed to illness. Measures were required that not only protect health but also remedy social problems (regarding education, jobs, housing, etc.). In response to these problems, a Community Health Program (CHP) was launched in 1976. The program depends on community health aides, specially trained auxiliaries who make home visits to extend basic health services, promote community organizations, participation and development, as well as to ensure coordination of program

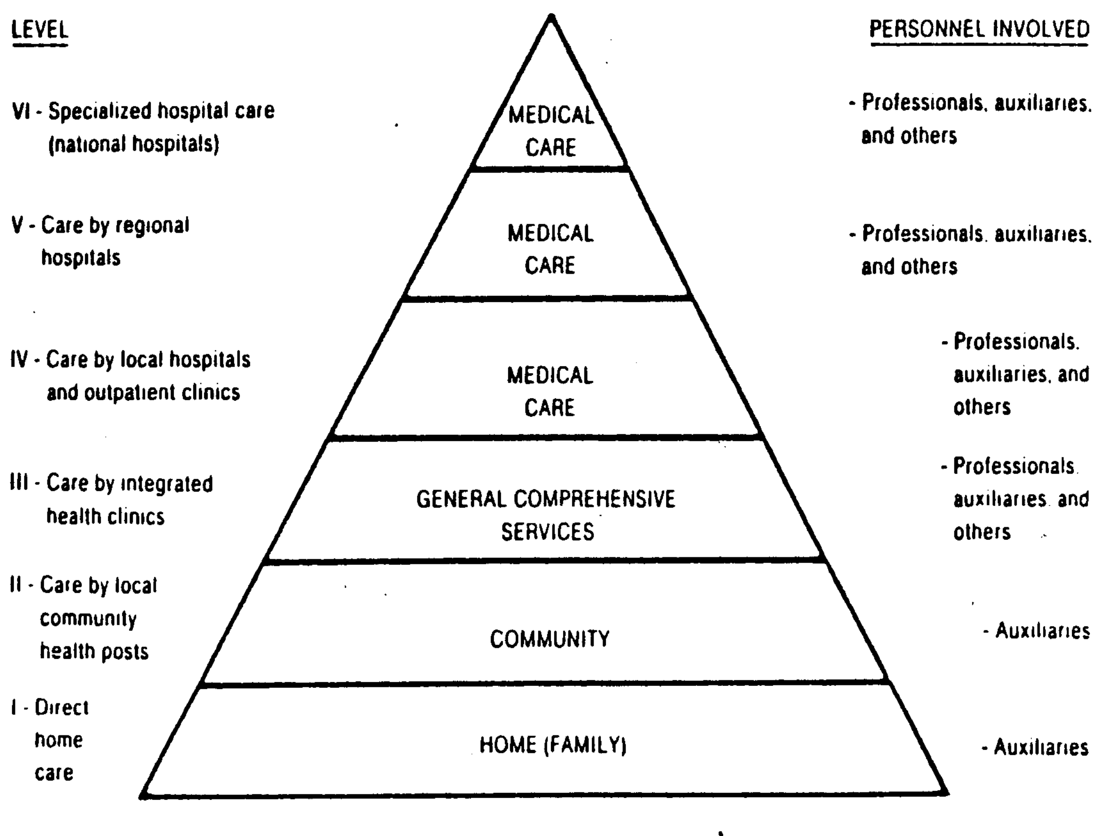
activities with other areas of development. Duties are similar to those of the rural health assistant (vaccinations, prenatal and postnatal care, health education, monitoring growth of children, caring for the elderly and disabled, surveying sanitary facilities, taking blood pressure, referrals, etc.). There are now 247 such community health areas established (including 54 health centres) which cover approximately 70 percent of poor urban dwellers (Jaramillo, et al 1984, Jaramillo 1987). Supervision is provided by nurses and physicians who are in charge of the health centres.

Health services are provided by two systems (which are integrated to share resources and programs), the Ministry of Health and the Corja Costarricense de Seguro Social (CCSS). The Ministry of Health is responsible for the rural and community health programs, the CCSS for the organization and administration of medical care in hospitals. Through these two systems, approximately 95 percent of the population receives medical care (PAHO 1986). The two systems are coordinated by a National Health Council which administers 80 percent of the total health budget. 20 percent is administered by the Ministry of Health.

The integration of the two systems is patterned on a pyramidal model of services (Figure 8) that starts at the base with simple measures taken in the home and community--measures that become gradually more complex at each successively higher level and that are supported by ongoing advisory services and

Figure 8

The health care pyramid in Costa Rica.



Source: Jaramillo (1987), p. 144

systems of supervision and support. As part of the implementation of this service delivery system, steps are being taken to strengthen the intermediate regional levels of health care; the overall health policy decisions will be kept at the central level but authority will be delegated to the regional headquarters for executive actions (Jaramillo 1987).

This service delivery system shows a well balanced type of socioeconomic development with a decentralized pattern of health care services where resources, operations, and programs are integrated.

Help to build up the health care system was provided by PAHO, UNICEF, US-AID, and CARE through grants, technical assistance and clinical teams to establish the two health programs (Rural Community Health Program [RCHP] and the Community Health Program [CHP] that targets marginal urban areas) and to build health posts and train health workers. By 1977, Costa Rica assumed financial responsibility for the two programs. National health expenditure as a percentage of the GDP increased from 3% in 1970 (Bender & Pitkin 1987, p. 520) to 5.7% in 1982. Unfortunately, the economic crisis that affected the Region during the same time called for austerity measures. This resulted in a decrease in all expenditures after 1982, particularly in health, education and social welfare. In light of the present economic realities, some people believe that the present level of health service delivery cannot be maintained (Bender & Pitkin, 1987).

3. Achievements

Costa Rica dramatically improved the health status of its poor population. The 1970's saw a reduction in infant mortality from 61.5 per 1,000 live births in 1970 to 19.3 per 1,000 live births (a 68.9 percent decrease) in 1985 (PAHO 1986), and a reduction in mortality of children one to four years of age from 5.1 per 1,000 in 1970 to 1.1 per 1,000 in 1980 (78.4 percent decrease) (Bender & Pitkin 1987, p. 521). Life expectancy at birth increased from 68.1 years (1963-1973) (Ibid., p. 521) to 73.0 years in 1985 (PAHO 1986). Significant achievements in the reduction of child and infant mortality were made through the use of immunization (EPI), growth charts and oral rehydration therapy (ORT). One must keep in mind the synergistic relationship of nutrition, infection, and immune response to appreciate how the success of any one program contributed to the success of the others. In a matter of four years (1974-1977) the RCHP had increased surveillance of children from 900 to 125,000 children, and the number of pregnant women enrolled in pre-natal clinics had risen from 350 to 10,000 (Bender & Pitkin 1987).

The reason behind Costa Rica's success is that the country has no army and therefore incurs no military expenditures. Local funds and external loans are spent in the health field, with the result that many of the previously existing health problems were resolved.

Costa Rica is also lacking an Enconienda system (a system of tribute where large tracks of land were granted to Spanish settlers) that is common to Latin American countries. Elsewhere, this system resulted in a landed aristocracy (large landholders) that enslaved the rural labour force and ultimately lead to their systematic exploitation for the benefit of other classes and social groups. In Costa Rica, as a consequence, relative disparities between the best off and the worst off are not as great as they are in other Latin American countries.

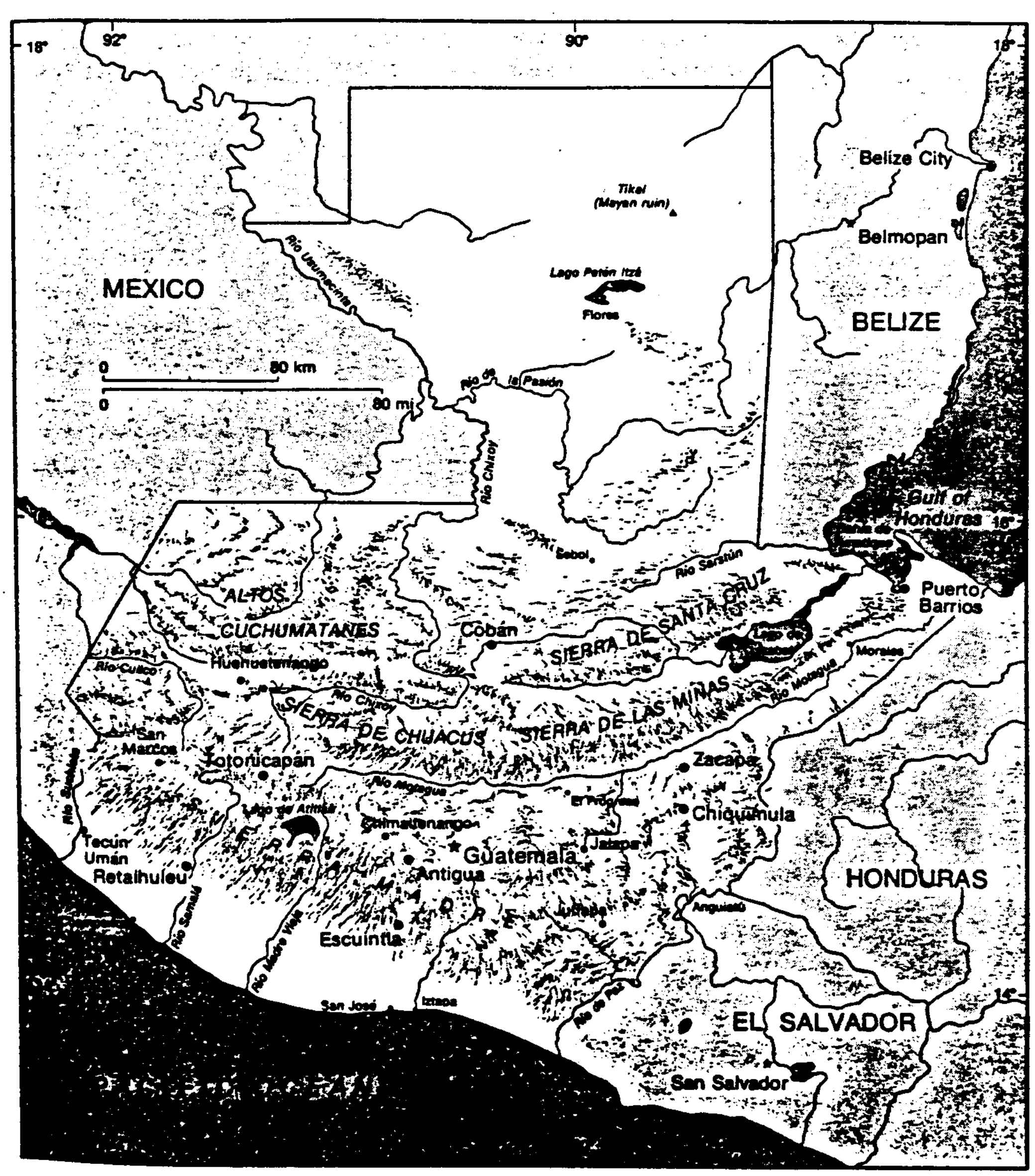
D. GUATEMALA

1. Population

Guatemala is largely a rural society with a population of 8.2 million (PAHO 1986). Approximately 60 percent of its working-age population engaged in agricultural activity. There are two distinct cultural groups: the indigenous Indian population and the ladinos. The Indian population, descended from the Mayas, comprises 50 percent of the total population (Table 3). Most of the Indians live in the relatively isolated highlands north and west of the capital, Guatemala City (Figure 9). Many still do not speak or understand the official Spanish language. They live in communities that have been traditionally isolated from the rest of the Guatemalans. They work small plots which do not provide all the food they need

Figure 9

MAP OF GUATEMALA



Source: James & Minkel (1986), p. 65

and they rely on temporary employment as farm labourers on the large coffee and banana plantations (AID 1979).

The second cultural group is known as the ladino. It includes all people who are of Indian ancestry but who no longer live as Indians, i.e., the Indians who speak Spanish, wear shoes, and non-traditional dress, abandon the religious practices of the Indian community, and perhaps move away from the native community. It also includes the 42 percent of the people who are mestizos, and 5 percent of the total population that is of unmixed Spanish ancestry (Alonso 1984).

2. Urban-Rural Inequalities

Rural Guatemala, where approximately two-thirds of the population lives, is marked by profound inequalities. In the 1970's more than 40 percent of the rural labour force was landless, 50 percent nearly landless (90 percent of people who either did not have any land at all or had too little to meet their basic needs). Income of the rural poor in the early 1980's was less than US $80 per capita annually for 60 percent of the population (Alonso 1984). Because of poor living conditions, lack of resources, land tenure, and underemployment and unemployment in the countryside, Guatemala has experienced a massive urban expansion in the last decade.

Wealthy people live in Guatemala City, where all amenities are located. There are wide differences in wealth among city dwellers as many peasants migrating from the country to the city live in shanty towns on the outskirts of Guatemala City.

These migrants consider themselves more fortunate than their rural counterparts. They have a higher literacy rate and school attendance, longer life expectancy, and better schools, sanitation, and public services than those who live in the countryside (Nyrop 1984).

Guatemala has an extremely high illiteracy rate (Table 5). About one-half of all adults cannot read or write a paragraph in Spanish. Sixty percent of women are illiterate. In rural areas, literacy rates are approximately one-half those of cities; 70 percent of urban dwellers are classified as literate in contrast to 30 percent of the rural population. Indians are at the bottom of the scale (Table 5). They face triple disadvantage: they are rural, poor and non-speakers of Spanish.

Table 5: Guatemala: Illiteracy Among the Rural Population (age: 7 years and above)

Origin of Population	% Literate	% Illiterate
Spanish	37	63
Indigenous	18	82
Total	28	72

Source: Guatemala, Economic and Social Position and Prospects, 1978, p. 20.

Only one-third of rural school-age children attended primary school in 1970, compared to three-quarters of urban children. Of these, only 5 percent completed primary school (50 percent of urban school children did) (Alonso 1984).

3. Health Conditions

Among Guatemalan's principal health problems are a high mortality rate (particularly among infants and children), an elevated incidence of infectious diseases, and extensive malnutrition among the poorest segments of the population. High fertility and high population growth rates (Table 3) worsen the situation of the poor and exacerbate the socioeconomic problems of the country. Although the death rate fell from 35 per 1,000 in the early twentieth century to some 12-15 per 1,000 in the late 1970's, the benefits of this drop have been by no means equally spread throughout the population. In the late 1970's and early 1980's, life expectancy at birth averaged approximately 60 years. Indians, however, could expect to live 10 to 15 years less than ladinos; rural Guatemalans about 15 years less than ladino city dwellers. Indeed, among rural Indians and rural ladinos, life expectancy was virtually equal (Nyrop 1984).

High infant and childhood mortality account for the bulk of the deaths. Some 35 percent of all infants die before the age of five. Deaths of children 1-4 years of age account for 55 percent of all mortality. One study found that more than 81 of pre-adult mortality took place within the first three years of life (Colburn 1981). In the 1970's officials estimated infant morality at 66 per 1,000 live births. Infant deaths are often not reported, so the actual figure could be much higher

(estimated at approximately 80-90 per 1,000 births) (Colburn 1981). Rural rates far outstrip those of the cities: they range from 100 to a high of 160 per 1,000 live births. Indian infant mortality rates average perhaps 1.7 times those of ladinos. One study of a Highland Indian Community found an infant mortality rate of 200 per 1,000 live births (Nyrop 1984). Enteritis and other diarrhoeal diseases, influenza and respiratory ailments and measles were the principal direct causes of death. They together accounted for more than 40 percent of all deaths (Nyrop 1984). Poor sanitation and nutrition were implicated in the high rates of respiratory and intestinal tract infections. Provision of basic services to the poor half of the population was severely deficient. In the mid-1970's, roughly 40 percent of the population had access to potable water. But the disparity between rural and urban Guatemalans was dramatic: 87 percent among urban dwellers, and only 14 percent among those in the countryside had access to potable water. Sewerage in rural areas was virtually non-existent (Nyrop 1984).

The health status of the population is also determined by nutritional standards. These standards were less than adequate for the population. About 35 percent of the rural population is malnourished. About 20 percent of the total rural population consume about 80 percent of the recommended calorie intake of 2,850; about 10 percent consume less than 70 percent of the minimum nutritional balance and the remaining 5 percent

consume less than 60 percent of the recommended diet (Alonso, 1984).

Poor prenatal nutrition results in low birth weight, a critical component in infant mortality. In the early 1970's, when less than 7 percent of U.S. infants weighed less than 2.5 kg at birth, more than 40 percent of those in a Guatemalan countryside did (Nyrop 1984).

In the 1970's and early 1980's, approximately 80 percent of all children under five years of age suffered from some degree of malnutrition; 30 percent were severely malnourished. Early mortality was highest where bottle feeding was most common. Where breast feeding was the norm, mortality rose later, during weaning, when inadequate supplements to maternal milk led to lowered immunity, coupled with increased exposure to intestinal ailments (Alonso, 1984).

Health resources are unevenly distributed. An estimated 2 nurses, 7.6 technicians, and 21.5 hospital beds per 1,000 people were available in the early 1980's. Most resources, however, are concentrated in the environs of Guatemala City, the capital. Housing about 20 percent of the total population, the city has 80 percent of the country's doctors and more than 40 percent of the dentists, nurses, and laboratory technicians (Colburn 1981).

Similar distortions are apparent in publicly funded spending on health care, In the late 1970's, budgets of the Ministry of Public Health and Social Welfare showed per capita

expenditure in the capital's city department to be nearly three times the level of the rest of the country. Of the annual budget of between 12-15 percent of government total expenditures, $7.10 was spent in the capital, $2.40 in the rest of the country (Viau & Boostrom 1978). Costly public hospitals in the city largely explain this differential. Public health priorities were geared toward curative medicine, which accounted for about 80 percent of spending; only 20 percent was spent on preventive services. Access to health care was extremely limited, especially for the rural poor (Steltzer 1983).

4. Primary Health Care Approach

In 1971, the Ministry of Public Health and Social Assistance realized that it was unable to meet the health care needs of both urban and particularly rural people. As a result, it was clear that a new approach to health care was needed. A series of studies were undertaken to determine rural health problems. Then a four-level health care delivery plan evolved (Table 6). At Level 1, two new levels of auxiliary personnel (health promoters or promotores) and rural health technicians were trained and utilized. The rationale for the creation of these new levels of auxiliary personnel was to meet the lack of trained personnel in general, and to have personnel trained specifically in public preventive health care. These paraprofessionals attend most basic health needs. They treat

common diseases or conditions (diarrhoea, pneumonia, malnutrition and minor trauma). They are responsible for health promotion, maternal and child health, environmental sanitation and health protection. They also refer patients to more sophisticated medical services, if required. Level 2 involved the establishment of health posts. The health posts are staffed with rural health technicians and promoters. Levels 3 and 4 provide sophisticated degrees of medical services (hospital care and specialized service) (Colburn 1981).

The implementation of the paraprofessional and auxiliary concept had been hampered and restrained by Guatemala's physician-dominated health care community. In the early 1980's, the health training program was eventually implemented into the Ministry of Health Services.

Table 6: Health Care in Guatemala

Level Involved			Personnel
IV -	Care by national hospitals	Medical Care	- professionals, auxiliaries, and others
III -	Care by regional hospitals	Medical Care	- professionals, auxiliaries, and others
II -	Care by community health posts	Community	- auxiliaries (health promoters and health technicians)
I -	Home care	Home	- auxiliaries (health promoters and health technicians)

Source: Colburn 1981, pp. 6-7.

5. Achievements

Promoters have been accepted by the rural communities they serve and they have at a relatively low cost extended the coverage of the Ministry of Health. But achievements have been very modest. Infant mortality remains high. It has been reduced marginally from 66 per 1,000 live births in the 1970's (Nyrop 1984) to 62.4 per 1,000 live births (PAHO 1986). But as many infant deaths (particularly in rural areas) are often not reported, the actual infant mortality rate is much higher, in the range of 80 to 160 per 1,000 live births (Nyrop 1984).

Social development has lagged, and the gap between the Indians and ladinos in terms of per capita income, health and education has not been reduced to any significant extent over the last decade, in large part because of the very limited role played by the public sector in the nation's development.

The standard of living in rural areas has been only minimally improved and gross inequalities remain. 90 percent of urban people are served with safe water, whereas only 26 percent in rural areas have access to safe water; 53 percent of urban dwellers have access to sanitary facilities as compared to only 28 percent in the rural areas (PAHO 1986). These percentages suggest that the dichotomy between urban and rural areas still exists and that Guatemala is failing to meet its rural population's basic needs.

Life expectancy of the indigenous population and for the

rural population in general are the same: 45 years (Colburn 1981). This contrasts markedly with the life expectancy of the urban population--61 years (PAHO 1986).

The modest achievements that have been demonstrated through the use of para-professionals should not be ignored. Potable water projects and improvements in sanitary facilities were made in villages. Health care was provided to many areas for the first time in many villager's lives. This new access gives villagers at least a limited knowledge of preventive health care. But without profound economic reforms in the local communities and comprehensive agrarian reform programs that so far have been resisted by the powerful rural oligarchy, the extremely uneven income distribution will remain and the goal of achieving health for all its population will remain unattainable for Guatemala.

These economic reforms have not been implemented because they entail specific consequences for both economic and political structures. Guatemala's economy is based on the dependent capitalist agroexport model that requires a cheap rural labour force. Allowing economic land reforms to succeed would result in a loss of this cheap rural labour for agroexport production and for production of inexpensive foodstuffs for the urban sectors. These reforms would also end the commercial exploitation of the peasants for the benefit of other classes and social groups (including the state, affluent and influential agrarian groups, and the local rural elite) (de

Janvry 1981).

E. NICARAGUA

Nicaragua offers a unique opportunity to analyze the effect of changes in political economy on the health delivery system. In 1979 the country underwent a revolution in which the right wing Somoza regime was replaced by the left wing Sandinista government--a dramatic transformation of administration and political power (Donahue 1986).

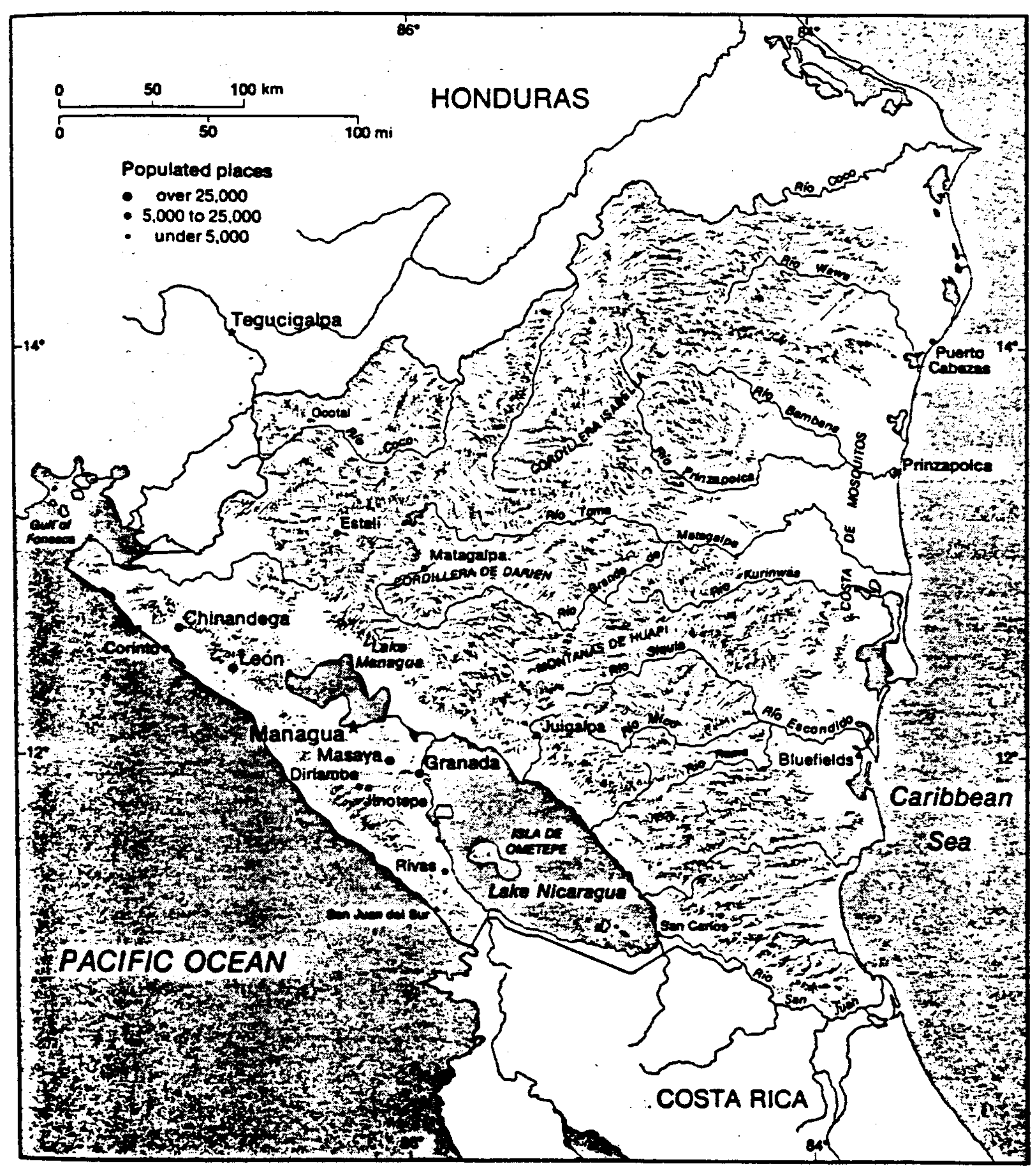
1. Population

Nicaragua is the largest Central American nation (in territory size, Figure 10). The population was estimated to be 3.5 million (Mathey 1990). The population is comprised of 5 percent Indians, who live in the remote parts of the country; 75 percent mestizos; 10 percent people of unmixed European ancestry; and 10 percent blacks, who live along the Caribbean coast (James, et al 1986). The country is sparsely occupied and most settlements are concentrated in the lowlands.

The land in Nicaragua is comprised of four surface regions. The greater part of the country is a triangular wedge of highlands that continues southward from Honduras. To the east is the Miskito coast, a wide belt of swampy lowland. The most important part of the country in terms of development is the third region, the Nicaraguan lowland which is the most

Figure 10

MAP OF NICARAGUA



Source: James & Minkel (1986), p. 111

populated area. The fourth region is a narrow northward extension of the highlands of Costa Rica which separates Lake Nicaragua from the Pacific (James & Minkel 1986).

2. Health Conditions

Under the Somoza regime, health services were dismal. Only 10 percent of the population benefited from 90 percent of the health resources available (Donahue 1986). The Ministry of Health was responsible for providing health services to the entire population. In 1974, 16 percent of the country's budget was spent on the health sector. Of this, 81 percent went to operating expenses. Nearly 75 percent of the budget was spent in Managua, the capital, which accounted for only 25 percent of the entire population of that time (Donahue 1986, p. 10). The effects of these allocation policies left the vast majority of Nicaraguans, especially those in rural areas, to make do with what meagre resources were available.

Some 70 percent of children under 5 years of age suffered from malnutrition. As a result of poor nutrition and lack of maternal-child care programs, infant mortality rates reached 149 per 1,000 live births in 1979. Deaths of children age four and under accounted for 32.3 percent of all deaths in 1975. Enteritis was the major cause of general and infant mortality in the country (Donahue 1986). The average life expectancy at birth was 55.2 years (Halperin, et al 1982). Poliomyelitis was a major health problem. While polio was not a major cause of

death, it did leave infected people handicapped, and in continued need of medical attention.

In 1978, potable water services reached only 41.4 percent of the urban population and 10.9 percent of the rural people. 29.4 percent of the urban population had access to sanitary facilities. In the rural areas these facilities hardly existed.

3. Health Programs

With the fall of the Somoza regime, the Sandinista government began to transform the Nicaraguan society. A new national health system, Sistema Unico de Salud or SNUS, was created in 1979, and placed under the Ministry of Health (MINSA). It was responsible for the health of all the population, including vaccination campaigns, building of hospitals, and the establishment of health centres. In the early 1980's, a process of decentralization of the SNUS was initiated through the creation of 9 health regions. These regions permitted a more adequate distribution of resources and better planning, implementation and supervision of programs. Each health region was subdivided into health areas of between 15,000 and 80,000 inhabitants, and contained a health centre and several health posts (Bender & Pitkin 1987). Mass immunizations have been organized. During 1981, immunization, malaria prophylaxis and sanitary campaigns were launched. Oral rehydration units (ORU) were established at health centres and

health posts. Through these campaigns, health volunteers (brigadistas) were mobilized, and many community health councils were formed throughout the country. A massive national literacy campaign and the formation of education centres have expanded opportunities for health education.

In 1981, the government prepared a 5-year PHC plan with the help of UNICEF and WHO. This plan lead to the formation of a committee for 'integral primary case' which included representation from the Ministries of Health, Education, and Agrarian Reform, Urban Development and Housing, and the Institutes of Water and Sewage and Security and Social Well-being (Donahue 1986). These committees demonstrated a political commitment to PHC as health was recognized as a right of the people and an obligation of the state.

At the same time a land reform program was initiated by the Sandinistas. More than 2 million acres have been redistributed to about 68,000 peasants (McGeary, 1990). The Sandinista government also attempted to transfer people from subsistence farming into a new economic system of surplus production. This economic transformation has not progressed far as it requires the creation of many new jobs and a heavy investment of capital.

4. Achievements

Most of the activity of the Nicaraguan health system has occurred in the extension of programs, such as popular

campaigns, while the actual planning and decision-making remain at the national level.

Health campaigns have been successful. Data reveal a reduction of some diseases since 1977. Malaria has been reduced by 39 percent, polio eradicated, measles and whooping cough and tetanus are almost extinct (Strelnick 1984). The country has achieved a high literacy rate (Table 4).

Other statistics reveal a still uneven distribution of resources. For example, access of the population to safe water is 98 percent for the urban people but only 9 percent for rural inhabitants. Sanitary facilities are available for 73 percent of the urban population but only 16 percent of the rural people (PAHO 1986). Infant mortality is the highest of all five countries with 76.0 per 1,000 and life expectancy remains low at 59.8.

These statistics reveal a difficulty in overcoming the legacy of the Somosa regime and indicate a continuing disparity between urban/rural populations. The restructuring of Nicaragua's health system is still underway as different interest groups attempt to influence the direction of change (Donahue 1986). Within the Ministry of Health (MINSA) itself there are interests which could direct the health care system more to urban and professional demands by training large numbers of physicians. This might eventually lead to a national health system dominated by the medical profession.

It should not be forgotten that throughout the 1980's Nicar-

agua had to endure an aggressive and hostile U.S. foreign policy, which sought to undermine the government of the Sandinista party. Since 1985, Washington has strangled Nicaragua's trade with an embargo. It has cut off Nicaragua's credit at the World Bank and the International Monetary Fund (IMF) (McGeary, March 1990, Eschbach 1990). This economic boycott has contributed to shortages of medical supplies, pharmaceuticals, paper used in popular education, and normal day-to-day administrative operations. These events strained the economy and further impoverished the people who are faced with constant food shortages and a lack of basic necessities, a high inflation rate and a drop in the GNP which is already the lowest of the five countries (Table 2). The undeclared war of the United States against Nicaragua and its support of a counterrevolution by the Contras had created some 120,600 internal refugees by May 1984 (Donahue 1986, p. 93) and absorbed $66 million dollars in relief and relocation costs (Ibid.).

By mid-1984, the damages inflicted upon the health infrastructure by the Contras amounted to $1 million dollars (Ibid., p. 94). Twenty health centres have been closed near the Honduran border. At the same time, increased Contra activity in the country created a demand for emergency and surgical care (Garfield & Taboada 1984). Hospitals and health care centres have been destroyed. Health and education workers have been special targets for Contra assassination (Siegel

1985). Civilian deaths due to Contra activity have been high. Garfield (1985, p. 127) estimates that war fatalities among civilians and combatants reached 10.0 per 10,000 and that more people were dying from the war than had died from communicable diseases before the revolution.

All these events have had an adverse effect on the health of the population. Few resources are available to meet the health needs of the rural people--these are required for defence. Brigadistas are recruited into the armed services and health facilities must treat the victims of war, thereby making a bad situation worse. Because of the war, Nicaragua experienced a major setback in providing HFA to all its citizens.

Any achievements made in health care since 1979 are evidence of the political will to improve the health and well-being of the Nicaraguan people. Yet, the ultimate success of revolution in health will depend on how the state is able to confront the internal pressures to professionalize the health care system and the external pressures to destabilize it.

F. CUBA

To offer a point of contrast to the four countries already analyzed, an analysis of health and health care in Latin America must include Cuba because it is the only country in the region with a well established socialist government.

Cuba is a socialist country in the Caribbean with an

estimated population of about 10.1 million people (PAHO 1986). The 44,000 square miles of territory extend for 785 miles in an east-west direction, with a width that varies from 25 to 120 miles (Figure 11). At least half of the area is level enough for agriculture. Only about one-fourth of Cuba is mountainous. The most rugged area is at the southeastern end.

The population is composed of 66 percent of European ancestry, 12 percent blacks and 21 percent mestizos. The remainder include Chinese, Filipinos, and other Asians. Havana, the capital, has a population of about 2 million people (James & Minkel 1986).

1. Health Care in Cuba

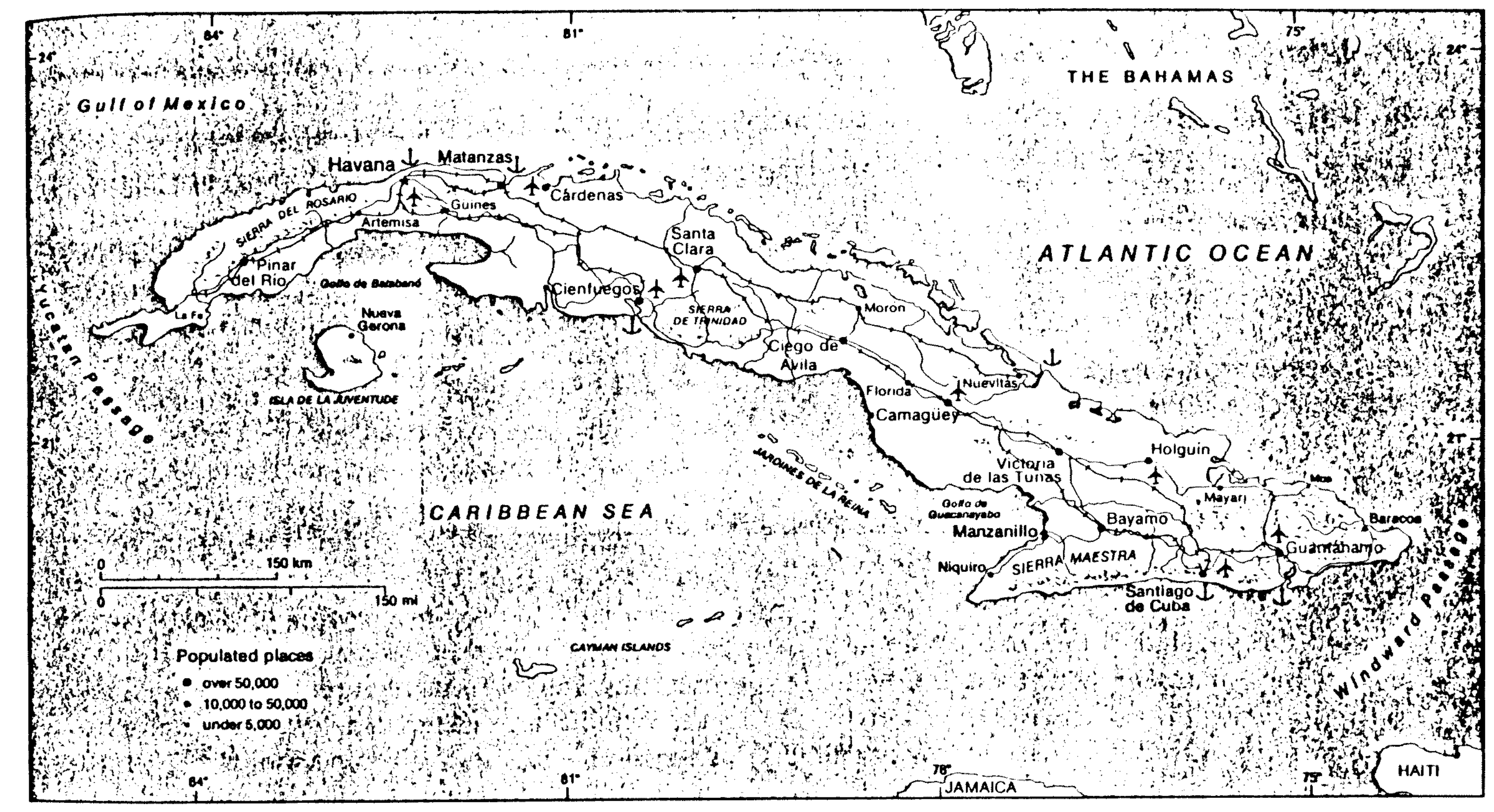
In Cuba, health care is a basic human right and the responsibility of the state; health services are free for everyone. Cuban leaders consider health indicators to be measures of government efficiency, and as a result, health care has assumed a prominent place in Cuban government policies despite the present world economic crisis (Feinsilver 1989).

Before the 1959 revolution, Cuba was typical of underdeveloped countries in that life expectancy at birth was low (58 years in 1959), infant mortality was high (70 deaths per 1,000 live births), mortality from infectious diseases was very high (94.4 per 1,000 people), and diarrhoeal diseases were a major cause of death (Tesh 1988, Djukanovic & Mach 1975).

The new government immediately put great emphasis on

Figure 11

MAP OF CUBA



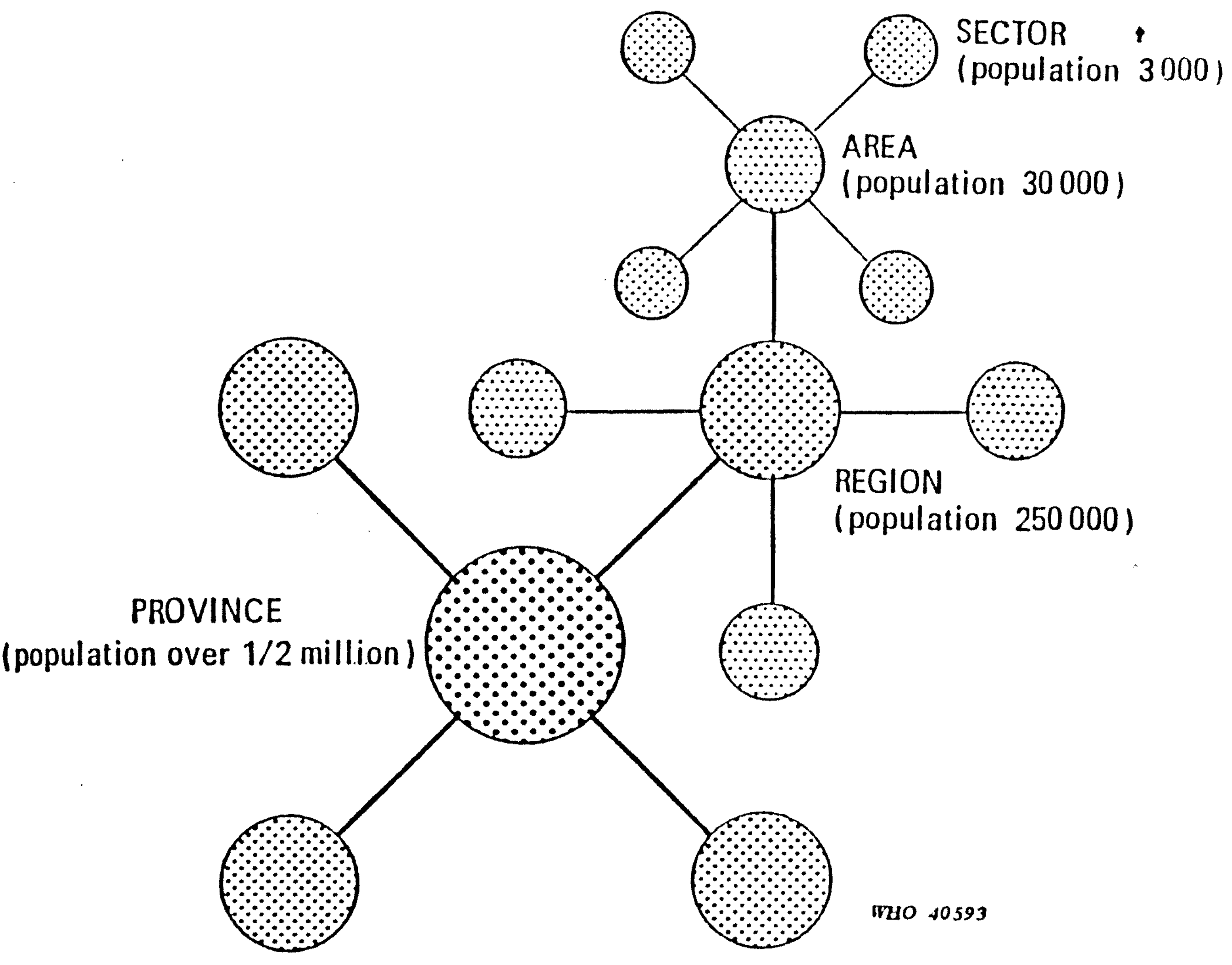
Source: James & Minkel (1986), p. 163

improving health (Radical Community Medicine 1982). From the outset, it was considered necessary to integrate all the formerly separate components of the health care system into a single organization able to give direction, set standards, and control all health activities. The Ministry of Public Health was formed in 1970, and given the responsibility for all public health services. At the same time, measures were adopted to bring health services to the whole population. This was done through regionalization of health services, centralizing policies and decentralizing implementation strategies, with the purpose of making the organization most flexible and efficient. This regionalization of health services indicates a more equal distribution of resources between urban and rural areas.

Each of Cuba's seven provinces contains a central organization which supervises and controls state and government policy with regard to health care of the population. The next level below the province is called the 'health region' of which there are 43. Medical officers are in charge of all health services in each region. The regions are divided into areas with a polyclinic in urban areas, and a hospital with 30-100 beds in rural areas. Each area is further subdivided into sectors, each of which serve some 3,000 people (Figures 12 & 13). Each sector provides a rural hospital with 10-30 beds (Djukenovic & Mach 1975).

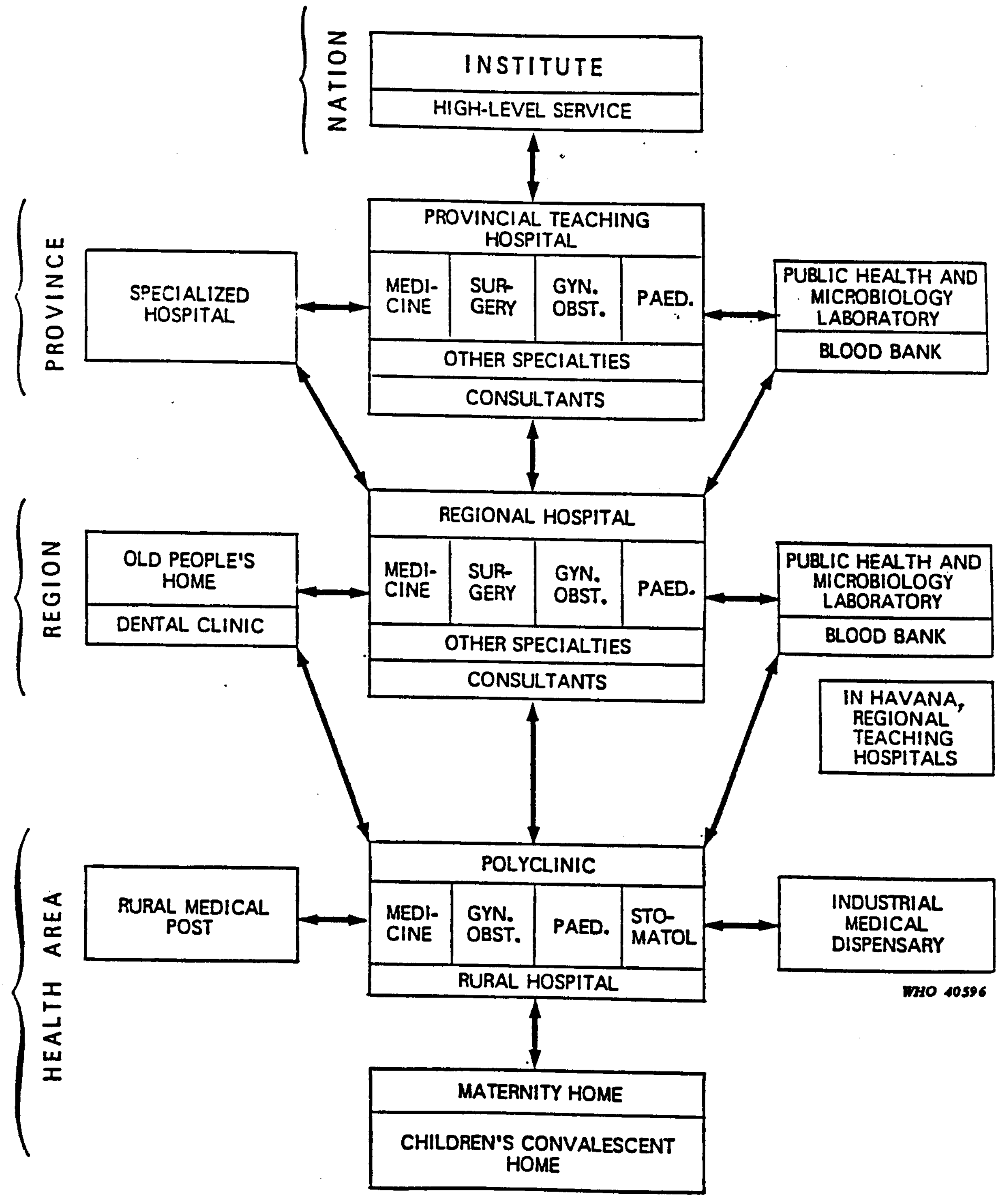
Special attention has been paid to maternal and child health programs, communicable diseases, environmental

Figure 12



Source: Newell (1975), p. 17

Figure 13



Source: Newell (1975), p. 24

sanitation, food hygiene, occupational health, dentistry, health education and malaria eradication. Immunization schedules and gastroenteritis and tuberculosis programs have been established for the whole population (Fernandez 1975, Djukanovic & Mach 1975). Local women health promoters from the communities attend to primary health needs of areas with less than 2,000 inhabitants. 4,000 women health promoters and 400 women assistant nurses are employed and trained in treating common diseases and conditions (pneumonia, diarrhoea, malnutrition). They cover those sectors of the population which have no ready access to conventional health services (WHO 1980a). Reasons for each health activity are explained to the general population. Training courses for different types of health staff have been organized. Medical doctors, nurses, nursing assistants (auxiliaries) and medical technicians (for clinical laboratory work, statistics, microbiology and for the maintenance of equipment and buildings) make up the health teams. The number of health staff has increased rapidly over time because of expanding training programmes (Feinsilver 1989).

Each member of every health team is schooled in community health care and as a health educator. Small rural villages are supplied with schools and medical services. The new government also tore down thousands of slum dwellings, and moved people to new housing with all necessary services (water supply, severage, electricity). The price of essential foods was

drastically reduced to guarantee that everyone could afford basic nutrition. The government initiated country-wide literacy campaigns, and also wiped out unemployment. In early 1981, health promotion campaigns against obesity, sedentariness and smoking began (Tesh 1988).

2. Achievements

Cuba has transformed itself into a world-class health care provider, able to meet the population's basic health needs. By 1982, Cuba's infant mortality rate of 17 per 1,000 lives births was only one greater than the average rate for all developed countries (Table 7). By 1984, Cuba's infant mortality rate was 15 per 1,000 live births, only 3.5 deaths per thousand higher than the U.S. 1982 rate (Feinsilver 1989) and one of the fifteen lowest in the world.

Unlike other developing countries, Cuba has established a health care system that is based on physicians rather than paramedics (Tables 8 & 9). By the end of 1986, Cuba had 25,567 doctors, or one doctor for every 399 inhabitants. Projecting the growth of the general population and the physician-to-population ratio for the year 2000, Cuba will have approximately one physician for every 196 inhabitants (Ibid.).

In an effort to "revolutionize" primary care, the Cuban government established the family doctor program in 1984. This program called for twenty thousand doctors and twenty thousand nurses to provide entry-level primary care on each city block

Table 7

Selected Health Statistics (1982)

Selected 1982 Health Statistics for Cuba, the United States, the Soviet Union, and Averages for Latin America, Developed Countries, and Less Developed Countries

Area	*Health Expenditure per capita (in 1982 dollars)*	*Population per Physician*	*Population per Hospital Bed*	*Infant Mortality per 1000 Live Births*	*Life Expectancy at Birth (years)*	*Daily Calories as % of Nutritional Requirements*[b]	*Daily Protein Supply per Capita*[b] *(grams)*	*Population with Safe Water*[c] *(%)*
Cuba	65	580	170	17	74	126	75	62
United States	589	500	170	11	74	138	106	99
USSR	178	250	80	36	70	133	100	—
Latin America (average)	30	1155	338	61[a]	65	111	67	71
Developed Countries (average)	445	387	102	16	73	133	100	94
LDCs (average)	14	2044	570	90	59	104	58	51

Source: Ruth Leger Sivard, *World Military and Social Expenditures 1985* (Washington, D.C.: World Priorities, 1985), p. 39.

[a]Data for most developing countries (except Cuba) understate infant mortality due to inadequate registration systems.

[b]These data are national averages and do not reflect distribution patterns. In Cuba distribution is equal for the rationed basic food supply but not for unrationed foods bought in the parallel (free) market.

[c]Data are for any year available between 1975 and 1983.

Source: Feinsilver (1989), pp. 6-7

Table 8 *Ratios of Doctors, Nurses, and Nursing Personnel per 10,000 Population, 1979 and 1984*

	Doctors		Nurses		Nursing Personnel	
Place	*1979*	*1984*	*1979*	*1984*	*1979*	*1984*
Cuba	14.8	19.1	14.6	26.5	13.4	9.0
Latin America	9.1	11.2	4.0	4.1	10.9	7.8
Caribbean[a]	5.0	7.1	18.3	22.1	8.2	7.8
North America	19.5	21.2	51.3	81.8	61.3	52.3
PAHO Region[b]	13.9	15.7	23.7	35.3	31.8	26.4

Source: Pan American Health Organization, *Health Conditions in the Americas, 1981–1984* (Washington, D.C.: PAHO, 1986), 150, 153, 154.

Note: All figures represent ratios per 10,000 population.

[a]Non–Latin American Caribbean.

[b]The Pan American Health Organization Region includes all of North, Central, and South America and the Caribbean.

Table 9 *Ratios of Nurses and Nursing Personnel per 100 Doctors, 1979, 1984, and 1987*

Place	*1979*	*1984*	*1987*
Cuba	190.2	186.0	206.1
Latin America	204.6	128.8	—
Caribbean[a]	516.3	405.5	—
North America	578.8	631.8	—
PAHO Region[b]	450.8	439.6	—

Sources: Calculated from Pan American Health Organization, *Health Conditions in the Americas, 1981–1984* (Washington, D.C.: PAHO, 1986), 150, 153, 154; and República de Cuba, Ministerio de Salud Pública, *Informe Anual 1987* (Havana: MINSAP, 1988), 61.

[a]Non–Latin American Caribbean.

[b]The Pan American Health Organization Region includes North, Central, and South America and the Caribbean.

Source: Feinsilver (1989), pp. 8-9

and in the mountainous rural areas by the year 2000. Family doctors are trained in social and comprehensive general medicine and thus can focus on both cure and prevention, including health education. Most family doctors and nurses live in the communities in which they work and so can provide immediate and continuous care.

Health services cover the entire population. The structure of the services is shown in Figure 13. Health care coverage is 100 percent. Doctors in rural hospitals and polyclinics are in constant contact with units at higher levels. Further training and improvement is available to all health personnel in the country. Close contact with the community is achieved. Preventive, curative and rehabilitation services are well planned and integrated and show excellent results in terms of mortality and morbidity data (Table 10). Government commitment, complete literacy, a high proportion of doctors and other health professional staff, good transport facilities, mass mobilization and full participation of the people have helped to make the Cuban health services successful.

While the Cuban model of primary health care may not have been consciously adopted by the WHO in its HFA/2000 resolution, the guidelines are strongly reminiscent of the Cuban health system. A notable exception concerns the use of paramedical personnel rather than doctors in primary care. Not surprisingly, Cuba has often been compared favourably with the HFA model and has already achieved the goal of HFA (Feinsilver

1989).

Cuba's experience in the health field derives from the transformation of its socioeconomic political structure in the period following the revolution in 1959. Its economy has been rebuilt along Marxist lines, with a centrally planned control of production and distribution of goods. The priorities given to, and the changes made in, health services at that time were political decisions based on the needs of the population as seen by the political leadership. Health, education and means of communication continue to have the highest socioeconomic development priority in Cuba and receive a considerable portion of the government's budget. In short, the Cuban administration under Castro demonstrated a commitment to improving the health status of all Cubans.

These reformist strategies can only be achieved in other Latin American countries through revolution to overcome the opposition of powerful interests based in peripheral capitalist structures. As long as the basic structure of peripheral capitalism remains unchallenged, reformist strategies cannot affect the root causes of inequalities and rural poverty (Fals Borda 1971).

G. SUMMARY

Basic characteristics of health and well-being have been examined. In the next chapter, a detailed evaluation of progress will be presented.

CHAPTER FOUR

EVALUATION OF PROGRESS TOWARD HFA/2000

WHO/PAHO indicators of well-being (Table 9) indicate differences in the success of achieving HFA for the five selected countries. Costa Rica and Cuba have been successful in eradicating extreme poverty and inequalities between the urban and rural sectors by making health and health services the top priority of their governments, which translates into reduced disparities between rich and poor population sectors. Both countries are within reach of the goal of HFA/2000. Nicaragua experienced a dramatic civil strife that destabilized all aspects of development including health and health care. Venezuela has improved infant mortality and life expectancy and the availability of potable water, although inequalities remain between the regions of the country and the urban and rural sectors. Guatemala appears to be the furthest from reaching the goal of HFA. Marked inequalities between its two distinct cultures (the Indians and the ladinos) and between the urban/rural sectors remain. The low level of health care in the rural sector is related to the overwhelming poverty of the rural populace. In this society, fundamental changes in national priorities have not occurred, i.e., a redistribution of resources and sharing of power. Changes are resisted by a powerful elite that is controlling the government.

From the limited and sometimes biased data and literature reviewed here, the PHC approach in the five Latin American countries will be evaluated with respect to progress made toward fulfillment of the twelve WHO/PAHO indicators and to see how well these Latin American countries are doing with regard to HFA/2000. In Table 10 the raw data concerning WHO/PAHO indicators of well-being are presented. The results of this review are summarized in Table 11.

LATIN AMERICA

Table 10: Indicators of Well-Being (1980-1985)

<u>WHO/PAHO Indicator</u>	<u>#3</u>	<u>#4</u>
Country	5% GNP spent on health (%)	% of national health expenditure spent on PHC
Costa Rica	[b]5.7	[b]1.9
Cuba	-	-
Guatemala	[b]3.7	[b]17.3
Nicaragua	[c]4.3	[d]13.9
Venezuela	[b]3.0	-

Table 10 (Continued):

WHO/PAHO Indicator #7

Country	[b]% of population with safe water in home or within 15 minutes walking distance				[b]% of population covered with sanitary facilities		
	Year	Total	Urban	Rural	Total	Urban	Rural
Costa Rica	1983	88	93	86	76	100	40
Cuba	1982	61.2	-	-	31	-	-
Guatemala	1983	51.0	90	26	36	53	28
Nicaragua	1983	56.0	98	9	28	73	16
Venezuela	1983	83.0	88	65	45	57	6

Table 10 (Continued):

WHO/PAHO Indicator #7

Country	[b]% of infants fully immunized (diphtheria, whooping cough, tetanus (DPT), measles, polio, tuberculosis [Data for 1984])				
	Year	Total	Measles	Polio	Tuberculosis
Costa Rica	1984	82.0	83.0	81.0	-
Cuba	1984	88.0	80.0	99.0	91.0
Guatemala	1984	54.0	27.0	53.0	37.0
Nicaragua	1984	32.0	30.0	73.0	24.0
Venezuela	1984	27.0	25.0	59.0	23.0

Table 10 (Continued):

WHO/PAHO Indicator

Country	#8 [b]% of newborn with birth weight of at least 2500 g (1980-1984) Total	#9 [a]Infant mortality per 1000 (1985)	#10 [b]Life expectancy at birth Total	M	F
Costa Rica	9.6	19.3	73.0	70.5	75.7
Cuba	7.9	16.8	73.4	71.8	75.2
Guatemala	10.0	62.4	60.7	59.7	61.8
Nicaragua	15.4	76.0	59.8	58.7	61.0
Venezuela	9.1	39.0	67.8	65.1	70.6

Table 10 (Continued):

WHO/PAHO Indicator

Country	#11 [a]Adult literacy rate Total (%)	#12 GDP per capita (in U.S. dollars)
Costa Rica	93.0	[e]1,565
Cuba	96.0	[a]1,410
Guatemala	51.1	[b]1,202
Nicaragua	87.0	[e]874
Venezuela	86.0	[e]2,340

Source: [a]James, et al (1986)
[b]PAHO (1986), pp. 233, 234, 236
[c]Bender & Pitkin (1987), p. 523
[d]Latin American Health Handbook (1984)
[e]Musgrove (1986), p. 153

Note: No data available re urban-rural distribution.
For more detailed accounts see appendix.

LATIN AMERICA

Table 11: Criteria Met by Countries With Regard to Global Indicators

WHO/PAHO

Global Indicators	1	2	3	4	5	
Countries	Government Commitment (Health care)	Community Involvement and public participation PHC	GNP (5%) spent on health	Reasonable % of National health expenditure spent on PHC	Equally distributed resources	
					Economic	Health care
Costa Rica	Yes	Yes	Yes	Yes	Yes	Yes
Cuba	Yes	Yes	Yes	Yes	Yes	Yes
Guatemala	Yes	Very Little	No	No	No	No
Nicaragua	Yes	Yes	Close	No	Yes	Yes
Venezuela	Yes	Very Little	No	-	No	No

Table 11 (Continued):

WHO/PAHO

Global Indicators	6	7			8
Countries	External Aid	PHC Availability			Nutrition birth wt. 2500g (90%)
		Water (100%)	Sanitary (100%)	EPI (100%)	
Costa Rica	Yes	Close	Close	Close	No
Cuba	Yes	Yes	No	Close	No
Guatemala	Yes	No	No	No	No
Nicaragua	Yes	No	No	No	No
Venezuela	Yes	Close	No	No	No

Table 11 (Continued):

WHO/PAHO

Global Indicators	9	10	11	12
Countries	Infant mortality (30 per 1,000 live births)	Life expectancy > 70 years	Adult literacy > 70	GDP per capita > US $500
Costa Rica	Yes	Yes	Yes	Yes
Cuba	Yes	Yes	Yes	Yes
Guatemala	No	No	No	No
Nicaragua	No	No	Yes	Yes
Venezuela	Close	Close	Yes	No

A. WHO/PAHO INDICATORS

#1. Government Commitment With Regard to Health Care

All five countries have established national health policies concerning PHC. The government of Venezuela recognized in the early 1960's that it was unable to meet the health care needs of all its populations and implemented a health care programme based on the PHC context into its national health care system.

The government of Costa Rica initiated social reforms in the early 1970's. Several laws were passed in 1973-74 which provided the political commitment as well as the financial resources for the rural and community health programs. In

1973, Costa Rica formed a Rural Community Health Program (RCHP) to help eradicate extreme poverty. Health services were made the top priority of government policy. Another program, the Community Health Program (CHP) was launched in 1976. Its aim was to reduce poverty among the marginated urban population.

Guatemala adopted a new health care policy in 1971 in which para-professionals were used as health care providers for isolated and rural areas.

Nicaragua underwent revolutionary and ideological change in 1979 and adopted a new decentralized health care system which permitted a more adequate distribution of resources and better planning, implementation, and supervision of the program. In 1981, the government prepared a five-year PHC plan that was to be implemented into its health care system.

In Cuba health care is seen as a basic human right and the responsibility of the state. Cuban government leaders consider health indicators to be measures of government efficiency, and as a result, health care assumed a prominent place in Cuban government policies following the 1959 revolution. Measures were adopted to achieve complete geographical and population covering in the whole country. This was done through regionalization of health services.

Except for Nicaragua, these health care policies were in place before the Alma-Ata declaration. The author assumes that this particular indicator was chosen because it was already in place.

#2. Community Involvement and Public Participation in PHC

i) *Community Involvement*

All countries were able to mobilize their populations for health activities although the degree of community involvement varies between countries. Venezuela's SMP depends largely on rural health assistants. Community participation and involvement is not well developed and has been limited to providing free labour for the building and maintenance of community health posts. A genuine community involvement in health or in any social development program requires profound economic reforms in the local communities so that they can become less dependent on subsidies from central sources. These reforms may need to be complemented by a better distribution of revenues so that the government income is not so largely consumed within metropolitan areas.

The Community Health Program in Costa Rica achieved significant success in promoting community development, participation and organization. Local community health committees are organized (Bender & Pitkin 1987, Jaramillo 1987). They are involved in choosing health assistants in their area. The high level of living standards in this country confirms a more balanced sharing of available resources (land, income, health care).

Guatemala achieved some degree of community involvement through its health promoter program. The promoters helped establish village improvement committees and used local resources to improve village life (e:g., committees are organized to collect funds and labour to build simple facilities). But progress will be ineffective if elements of equal or greater importance than health care for the improvement of the overall status of Guatemalans are lacking.

Important to the Nicaraguan model of health care is popular participation. Its programs rely heavily on community organization and participation, e.g., mass immunization campaigns that have been very successful in the early 1980's. Through these campaigns health volunteers (brigadistas) were mobilized, and many community health councils were formed throughout the country.

Unlike other developing countries, Cuba established a health care system that is based on physicians rather than paramedics. Although it is centrally organized it also involves population participation and mass mobilization. The whole population is enrolled in the fight against disease. A massive participation of women in social work has made a great contribution in this respect. At the local level, whether the rural hospital or the polyclinic, people's health commissions are active. In the rural areas, a member of the National Association of Small Farmers also participates. The commission meets regularly and a variety of problems are discussed (school

children's vaccination or the hygiene of local milk production) (Djukanovic & Mach 1975).

The Committees for the Defence of the Revolution are responsible for public health tasks such as immunization of the whole population, removal of animals from near houses and the elimination of rubbish to avoid the proliferation of flies and other disease carriers. The free availability of all mass media, including radio, press, and television, makes it easy to approach the people.

Cuba and Nicaragua both utilized strategies that could be planned nationally and reach large numbers of people. In both countries, the generally neglected and fragmented health systems necessitated revolutionary change in order to affect the highly controlled distribution of health resources. Costa Rica and Guatemala, with a high proportion of population in rural areas, made achievements through a commitment at the national level with more of a dependence on the local level (communities) to carry out programs. Costa Rica extended basic services to unserved areas through extension of existing systems. The mere size of Venezuela with an unevenly distributed population presents more of a challenge to extending basic services.

ii) *Public Participation*

In countries such as Venezuela and Guatemala, where regional inequalities exist and the economy and the political

system is influenced by a powerful elite (wealthy business people and land owners) who are resisting social and economic change, the majority of the population is not able to participate in the planning and control of PHC through representation of political parties and organized groups such as farmers' groups, etc. (Martz & Myers 1986, Herman 1986, Alonso 1984, Nyrop 1984, Blakemore & Smith 1971).

In Costa Rica, disparities between rich and poor are not as great as in other Latin American countries. Resources are more equally distributed between rural and urban areas. Between 1962 and the early 1980's, under the Costa Rican agrarian reform program 5,000 families received land and 25,000 other families received titles for the land they occupied. The country has one of the highest literacy rates in the Region (93%) (James, et al 1986). The results of this equity are seen in the high level of wealth and health care provided to all the people.

In Nicaragua, PHC relies heavily on community organization and participation (health campaigns, literacy campaigns). But continued civil strife has placed a heavy burden on the population and on the health care model. In spite of these problems, people continue to participate in providing health care to the people. Mobile health teams have been organized to service those villages where health posts have been closed down by the Contras (Garfield & Taboada 1984).

In Cuba, the State assumes responsibility for all its

citizens. But people are represented and able to participate in PHC strategies through local commissions. These commissions meet regularly to discuss a great diversity of problems (health, agricultural, community issues) (Djukanovic & Mach 1975).

#3. & #4. Health Care Expenditure

Health care expenditure varies from country to country. The most complete estimates of what governments in the Region spend on health care were calculated by the Interamerican Development Bank (IDB), 1981. These are presented in Table 12.

Table 12: Central Government Expenditure per Person on Health, Excluding Social Security (given in 1982 US dollars)

Country	1970	1978	1979	1980	1981	1982	1983	1984
[a]Costa Rica	13.61	20.88	19.33	29.16	18.09	16.76	15.80	24.34
[b]Cuba	-	-	-	-	-	65.00	-	-
[a]Guatemala	-	14.50	-	22.47	15.71	18.34	8.89	9.38
[a]Nicaragua	10.13	27.27	-	39.59	44.99	38.01	39.55	-
[a]Venezuela	34.93	48.93	-	32.31	40.05	38.22	31.32	-

Source: [a]Musgrove (1986), p. 155; [b]Feinsilver (1989), p. 6.

Cuba's health care expenditure is outstanding considering its limited resources, but recent data on central government health expenditure are incomplete.

A severe economic recession in the Region in the early 1980's resulted in reduced health care spending, except for Nicaragua. It is the only country that increased its health care spending at that time in spite of limited resources.

During the economic crisis, Venezuela went deep into debt and the economy was stagnant. Unemployment increased, and health care spending was reduced.

On average, governments apportion only 3-5 percent of their budgets on health (Table 13). In Nicaragua, the 1981 health budget represented 16 percent of the national budget, but 51.8 percent was absorbed by hospitalization costs and only 13.9 percent went to PHC (Latin American Handbook, 1984). In Guatemala, public health priorities were also geared to curative medicine, which accounted for 80 percent of spending. Expensive public hospitals in Guatemala City were major recipients of funds; only 20 percent of the budget was spent on preventive services (Nyrop 1984, Colburn 1981, Viau & Boostrom 1978).

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Table 13: Health Expenditure

Country	Year	GDP Per Capita (US $)	% of GDP Spent on Health	% of Health Expenditure Spent on PHC	Central Government Expenditure Per Person on Health (US $)
Costa Rica	1983	[a]1270	[a]5.7	[a]1.9	[b]15.80
	1984	[b]1565	-	-	[b]24.34
Cuba	1982	-	-	-	[c]65.00
	1985	[a]1410	-	-	-
Guatemala	1984	[a]1202	[a]3.7	[a]17.3	[b]9.38
Nicaragua	1983	[b]917	[d]4.3	[d]13.9	[b]39.55
	1984	[b]874	-	-	-
Venezuela	1983	[b]2447	-	-	[b]31.32
	1984	[b]2340	[a]3.0	-	-

Source: [a]PAHO (1986), p. 232
[b]Musgrove (1986), pp. 153, 155
[c]Feinsilver (1989), p. 6
[d]Latin American Handbook (1984)

#5. Health Care Resource Distribution

Perhaps an obvious factor in determining how a government will respond to the health needs of its population is its command over resources. Because the resources are limited in most countries of the Region, governments will look at different ways of meeting the health needs of its populations.

In Nicaragua, Guatemala and Venezuela, volunteer workforces are used in building up the countries' health

programs. Health services are free for the population. But health service resources are distributed unequally. Some of the most glaring inequities in access to health care have been reduced in Guatemala, Venezuela, and Nicaragua as governments have implemented health policies to bring basic services to the rural populations. Specially trained paramedics and primary care rural health units are the backbone of the improved services.

Indicators of availability of health services show substantial differences from country to country (Table 14).

Table 14: Health Personnel per 10,000 Population; Latin American Countries, Most Recent Data

Country	Year	Physicians	Nurses	Auxiliaries
[a]Costa Rica	1975	6.6	5.5	21.9
[b]Cuba	1984	19.1	26.5	9.0
[a]Guatemala	1976	1.2	1.1	5.6
[a]Nicaragua	1979	3.6	3.7	15.7
[a]Venezuela	-	-	-	-

Sources: [a]Alonso (1984) p. 85.
[b]Feinsilver (1989) pp. 8-9.

In Cuba the number of physicians and nurses per 10,000 inhabitants is considerably higher than in the rest of the Region. Costa Rica has the highest number of auxiliaries.

Data on health care coverage are incomplete and those which are available show differences between countries (Table 15). Costa Rica achieved a very high population health care

coverage through its health care system because of social changes and political commitments to its people. Data for Guatemala suggests a lack of social reforms and a continuing isolation of the poor rural Indian population from the rest of the country. Data for Cuba are not available, but the high health status of its population suggests that health care coverage and health care delivery is universal.

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Table 15: Health Care Coverage

Country	Year	Population Covered by Health Care (%)	Attended by Trained Personnel (%)
	Total	Total	Total
Costa Rica	1982	94.8	93.0
Cuba	1984	-	98.0
Guatemala	1984	59.0	-
Nicaragua	-	-	-
Venezuela	1982	-	82.1

Source: PAHO(1986), p. 235

Note: Data for urban/rural areas were not available.
Data for infants cared for by trained personnel not available.

Health Indicators (#7: Sanitation; #9: Infant Mortality; #10: Life Expectancy)

An examination of the most basic health indicators reveals marked differences in health standards among the countries as well as within individual countries.

Venezuela has achieved some success in reducing health inequalities through various programs (housing, sanitation, water, social) as available health data reveal. Infant mortality has been reduced to a level of 39 per 1,000 live births and life expectancy has increased to 67.8 years and is close to the PAHO goal of 70 years per person. Achievements have been made in education and availability of PHC services to the population.

Cuba and Costa Rica have attained high levels of life expectancy (73.4 years and 73.0 years respectively) and very low infant mortality (Cuba: 16.8 per 1,000; Costa Rica: 19.3 per 1,000) (Table 10). Most preventable deaths caused by infections or by a combination of infectious diseases and malnutrition have been eliminated. Access to potable water and sanitary facilities is within the reach of the WHO/PAHO indicator in Costa Rica (potable water: 88%, sanitary facilities: 76%). In Guatemala and Nicaragua, life expectancy levels are lower (at 60.7 and 59.8 years) and infant mortality rates are substantially higher (62.4 for Guatemala and 76.0 for Nicaragua) than the other countries studied. But there are different reasons for this. In Guatemala, the predominantly

Indian population living in rural areas has remained isolated from the rest of the Guatemalans culturally and economically. Resources of any kind (health care, land, jobs) are poorly distributed. The health conditions of these people remain poor. The principal cause of death is gastroenteritis, which at present can be easily controlled with adequate nutrition, basic health care, and essential sanitation (PHC) (Nyrop 1984), mainly afflicting young children The WHO/PAHO goals are being pursued but have not yet been reached. Data regarding availability of potable water and sanitary facilities demonstrate continuing inequalities between urban and rural sectors.

In Nicaragua political and military conditions have adversely affected the popular health care model. Many health posts have been closed by the Contras. More people are dying from the war than died from communicable diseases before the revolution (Siegel 1985). There is little doubt that the continued military activities have reversed the health achievements of the last decade as fewer resources for the health needs of the people are available.

Health differentials are also substantial within countries (between rural and urban areas). These differentials are probably narrower in the countries that have made progress upgrading social services (Costa Rica and Cuba). But even in Costa Rica, with life expectancy levels approaching those found in developed countries, infant mortality levels are much higher

in the rural areas where relatively fewer social and medical services can be found and nutritional and educational levels are lower (Alonso 1984). The situation is still grim in some rural areas in Guatemala.

#11. Education

Cuba, Costa Rica and Nicaragua have achieved high levels in education (96%, 93% and 87% respectively) (Table 10). This was achieved through massive literacy campaigns and the establishment of education centres in these countries. In Venezuela, a 1980 education law made school attendance obligatory for all children of eligible age (Ellner 1986, p. 297). 85% of the total population is classified literate.

But consistent urban-rural differentials in illiteracy rates are found in all countries. Illiteracy rates tend to be twice as high in rural as in urban areas (Alonso 1984). In Guatemala, 70 percent of the urban populace was classified as literate, only 30 percent of the rural. Part of the large differential was attributed to the concentration of Indian population in the rural areas. Many of the Indian populations are marginalized from the dominant national culture. Information available from Guatemala also shows sex differentials in illiteracy rates; male illiteracy rates at 46 percent are lower than female at 61.4 percent (Alonso 1984). Great disparities in the rates reflect the relative isolation of Indian women, perhaps due to cultural factors.

#12. GDP Per Capita

All five countries achieved the WHO/PAHO indicator goal of a per capita income of US $500 or above. But the indicator does not pay attention to the distribution of the income among the rural/urban sector and among the poor/rich inhabitants.

In Venezuela, the average per capita income in the 1960's was US $800 (Blakemore & Smith 1971), but more than 80 percent of the population received less than $200 per annum. Such inequalities probably still exist today as resources continue to be unequally distributed in the country. The wealth of oil produced extreme regional inequalities with the wealth concentrated in the urban areas of the North. Despite more than 20 years of agrarian reform, Venezuela's rural population has declined to about 14 percent of the total labour force. Not more than 20 percent of the country's land area is under cultivation or in pasture.

The implications of highly inequitable distribution of land tenure structures for the social and economic development of the countries, and for the pattern of income distribution, are considerable (Damiba 1989).

Many people are kept in poverty, unable to meet their basic needs (nutrition, housing, education). What is required is a fundamental reorganization of society that allows sharing of power by the people.

In Costa Rica, government policies have been aimed toward

identifying pockets of extreme rural poverty, then correcting the situation by local land distribution or colonization projects. Hence, most of the farmers own and operate their own farms. Rural development regions were created to give the peasants financial and technical support they need to become self-reliant. Some expropriation of privately owned lands with compensation was also undertaken. Because of this system, and other factors such as a rising level of education, early family planning and good public health conditions, Costa Rica appears to have the most equitable pattern of rural income distribution.

In Guatemala, the situation remains explosive because of an extremely uneven income distribution. Income in the early 1980's was less than US $80 per person annually for 60 percent of the rural population (Alonso 1984). Ninety percent either did not have any land at all or had too little to meet their basic needs. Agrarian reforms have been largely unsuccessful because they have been resisted by the powerful rural oligarchy.

In Nicaragua, and Cuba, income inequalities have been sharply reduced since the revolutions in 1979 and 1959. Comprehensive agrarian reforms distributed large amounts of land to the impoverished population. The level of living conditions was improved in Cuba. However, in Nicaragua poverty levels have hardly changed very significantly because of an undeclared war of the United States against Nicaragua that

resulted in a U.S. economic boycott against Nicaragua.

B. SUMMARY

HFA/2000 has been achieved by two of the five selected countries: Cuba and Costa Rica. In both countries, selected health data indicate a high level of health and health care. The success in bringing health to all populations has been achieved not only through health care programs but through a fundamental change in social and economic programs. In both countries, governments realized that they have responsibility for the health of their people. The change resulted in more equally distributed resources.

Nicaragua's society also underwent a fundamental change after its 1979 revolution. But an undeclared war with the U.S.A. and internal political strife has led to a major setback in providing HFA.

In Venezuela and Guatemala government efforts to meet the HFA goals have been limited. A powerful elite that is in control of the economy and the governments is resisting all change. Without such change, HFA/2000 will not be realized for its people.

The twelve WHO/PAHO indicators are not appropriate to guide these countries toward meeting the goals of HFA. Four of the five countries (Venezuela, Costa Rica, Cuba, and Guatemala) already had health programs established prior to the Alma-Ata

declaration, addressing the health problems that the indicators are also addressing. The WHO/PAHO indicators are basically concerned with preventive health care, but do not address the wider social changes that are required to improve the living conditions of marginalized people. These changes include a more equal distribution of resources (accessibility to land, income, housing). These socioeconomic factors are necessary to significantly influence the health and well-being of every individual.

CHAPTER FIVE

CONCLUSION

The Alma-Ata Conference specified a full list of health and multisectorial improvements for reaching the goal HFA/2000. This list included specific medical and public health interventions such as endemic disease control, maternal and child health, treatment of common diseases and injuries, plus other related interventions such as water supplies and sanitation, promotion of food supply and proper nutrition. Its emphasis is on equity, acceptability, self-determination, and social justice.

In the Alma-Ata declaration, health is considered comprehensively. It is not just a matter of lack of disease but rather the social outcome of national development and program expressed in terms of improved quality of life. Attainment of the HFA goal calls for far-reaching social and economic changes as well as reorientation of health care.

This evaluation of five Latin American countries has revealed that progress toward the goal HFA/2000 has been made by some of the countries discussed. One important factor is the use of paramedical health workers (Guatemala, Venezuela, Costa Rica, Nicaragua) in helping to bring the formal health system and previously unserved populations together, to encourage community participation and help communities become more self-reliant. But is it possible to have a workable

community organization and primary health care in a situation where the land tenure system is manifestly unjust (Guatemala, Venezuela)? The answer must be that it is not possible.

Equity of access to the determinants of health is an important feature in these countries. This equity is achieved through political commitment to bring about improvements in health. In some countries, as in Costa Rica, this will originated from the people themselves and was largely the result of the impact of education leading to awareness of basic human rights. In other countries, notably Cuba and Nicaragua, the political will is centrally directed on behalf of the people. Health and politics are indeed related.

PHC networks can be said to have been distributed by all five countries, and in general there has been perceptible improvement of the health status of populations, although there remain great disparities from country to country and within countries.

There was, throughout the 1960's and 1970's, evidence of an emerging concern to satisfy 'essential human needs' through programs in nutrition, health, education and housing. All efforts to specifically improve health must be appreciated as the resources available for these efforts are generally small (an average of 3-5 percent of the national budget).

In Costa Rica and in Cuba, the effectiveness of the strategy and its impact are demonstrated by the high levels of health and health coverage attained, reaching the goals of

HFA/2000 in the context of the Alma-Ata Conference.

The starting points for Costa Rica and Cuba were national commitments to change. In Costa Rica, social change was achieved without a revolution. Cuba achieved its goal through dramatic revolutionary change which involved a shift in resource distribution and a national political commitment resulting in a model health care system and health for its population in the Region. An overall change in political ideology helped mobilize efforts for primary health care, as well as facilitate the reorientation of resources, but there is sometimes a trade-off involved, that is, some loss of individual freedom for a gain in individual health.

In Nicaragua, revolutionary change brought about changes in resource distribution and improvements in health, although these improvements are still a long way from the goal of health for all.

Venezuela made a commitment to reduce health inequalities between the urban and rural sectors, but there was very little redistribution of wealth through a variety of social programs and efforts at land reform and housing reforms were not as successful.

In Guatemala, social development has lagged and the gap between the two cultures, ladino and indigenous Indians, in terms of per capita income, health and education, has not been reduced to any significant extent over the past 20 years, in large part because of the very limited role played by the

public sector in the nation's development. Any positive changes in health status have not been equitably distributed between the urban and rural sector.

These health problems continue to exist largely because of inadequate reorganization and reorientation of the health system; a highly skewed land tenure structure and distribution of resources; a very limited role played by the public sector in the nation's development, and demographic changes.

In a developing country seeking rapid progress in health, an essential requirement and the starting point is the political and social will to bring about improvement. Countries also need to achieve some equality of access to the resources that determine health. Economic development is essential for sustained improvement in health and a more even distribution of resources.

Unless the system is changed to create greater equality, full effectiveness of the strategy for primary health care and 'health for all' is inhibited. This change is not easy, politically or otherwise, since many of those who hold power are the same ones who are apt to lose the most. But political courage, social stability, and a considerable infusion of foreign economic aid all appear crucial for the emergence of more just and equitable societies that will eventually lead to a healthful life for all.

APPENDIX

Selected demographic and social indicators.

Country or other political unit	Population (1985)				Birth rate (per 1 000 population 1980-1985)	Crude death rate (per 1 000 population) 1980-1985	Rate of natural increase 1980-1985	Adult literacy rate			
	Total (1 000)	Under 15 (%)	65 + (%)	Rural (%)				Year	Total (%)	Male (%)	Female (%)
Anguilla	7	28.0[a]	11.0[a]	...	25.0[a]	7.1[a]	...	1984	90.4	...	...
Antigua and Barbuda	80	32.0[b]	6.0[b]	67.4[b]	15.1[c]	...	...	1984	90.0	...	...
Argentina	30 457	31.0	8.5	15.4	24.6	8.7	15.8	1980	94.2	...	...
Bahamas	224	37.7[b]	4.2[b]	24.7[b]	23.8[c]	5.5[a]	...	1976	93.0	...	...
Barbados	264	27.6	9.1	57.8	19.9	8.6	11.3	1983	96.4	...	...
Belize	158	46.1[c]	5.0[b]	50.0[b]	39.2[a]	4.2[c]	...	1983	93.0	...	
Bermuda	77	22.7[b]	8.3[b]	-[d]	16.9[e]	7.0[e]	...	1984	97.4	...	
Bolivia	6 340	43.7	3.2	56.3	44.0	15.9	28.2	1983	66.1	75.6	51.4
Brazil	134 625	36.4	4.3	27.3	30.6	8.4	22.2	1980	74.0	75.6	72.2
British Virgin Islands	13	34.0[b]	6.0[b]	...	20.3[a]	5.1[c]	...		...	...	...
Canada	25 517	22.5	9.6	25.0	16.2	7.1	9.1	1983	96.0	...	...
Cayman Islands	18	...	...	...	21.4[d]	...	...		...	...	...
Chile	12 026	31.2	5.7	16.6	24.8	7.7	17.0	1983	98.0	...	...
Colombia	28 442	37.2	3.8	32.6	31.0	7.7	23.3	1981	78.0	...	...
Costa Rica	2 595	36.7	3.8	54.1	30.5	4.2	4.2	1982	92.5	...	...
Cuba	10 038	26.4	7.9	28.2	16.9	6.4	10.4	1982	97.8	...	...
Dominica	77	47.2	7.7	...	23.4[e]	5.1[c]	...	1983	59.5	...	...
Dominican Republic	6 156	40.7	3.0	44.3	33.1	8.0	25.1	1982	72.4	...	...
Ecuador	9 333	44.2	3.4	52.3	40.6	8.9	31.7	1982	85.6	...	...
El Salvador	5 474	44.6	3.4	57.0	40.2	8.1	32.1	1982	69.8	65.5[e]	58.9[e]
Grenada	112	47.0[e]	6.0[e]	...	26.3[c]	7.3[c]	...	1982	85.0	...	...
Guatemala	8 270	43.1	3.0	58.6	38.4	9.3	29.1	1983	57.0	...	...
Guyana	943	36.9	3.9	67.6	28.5	5.9	22.6	1982	86.0	...	...
Haiti	6 565	43.6	3.4	72.0	41.3	14.2	27.2	1982	37.0	...	...
Honduras	4 342	46.9	2.9	60.1	43.9	10.1	33.8	1974	56.9	...	...
Jamaica	2 296	36.8	5.9	46.2	28.3	6.7	21.6	1982	75.7	...	...
Mexico	78 524	42.2	3.5	30.0	33.9	7.1	26.8	1983	87.2	...	...
Montserrat	13	30.5[a]	12.7[a]	90.0	22.6[c]	10.4[c]	...	1984	76.3	...	...
Netherlands Antilles	263	28.9[e]	6.7[e]	...	17.5[e]	5.3[e]	...	1979	98.4	...	...
Nicaragua	3 258	46.7	2.5	40.6	44.2	9.7	34.5		...	...	...
Panama	2 169	37.6	4.4	48.1	28.0	5.4	22.6	1980	88.1	87.6	88.4
Paraguay	3 656	41.7	3.6	58.5	36.0	7.2	28.8	1975	81.0	...	...
Peru	19 658	40.5	3.6	32.6	36.7	10.7	26.0	1983	82.6	87.2	78.1
St Christopher and Nevis	52	44.8[a]	11.0[a]	...	21.0[e]	9.2[c]	...	1985	87.0	...	...
Saint Lucia	127	50.0[e]	5.3[c]	60.0[b]	31.1[c]	6.2[c]	...	1985	85.0	...	...
St Vincent and the Grenadines	128	44.0[e]	6.0[b]	73.7[b]	32.3[c]	6.9[e]	...	1980	76.2	...	...
Suriname	352	42.5	4.5	54.3	29.5	6.1	23.3	1980	86.9	69.6	64.1
Trinidad and Tobago	1 117	31.7	5.8	77.4	24.6	6.2	18.3	1983	95.0	...	...
Turks and Caicos Islands	8	41.4[b]	6.4[b]	...	25.5[a]	3.9[e]	...		...	...	...
United States of America	235 606	21.9	11.5	25.8	16.0	9.3	6.7	1979	99.4	...	...
Uruguay	2 987	26.9	10.7	15.0	19.5	10.2	9.3	1984	94.0	93.4	94.3
Venezuela	18 297	41.0	2.9	14.3	35.2	5.6	29.6	1982	87.2	89.7	85.2

Note on sources. Total 1985 population: Estimates prepared by PAHO in early 1985 based on official historical data series. Per cent population under 15, per cent 65 years and over, per cent rural, birth rate, crude death rate, rate of natural increase: United Nations. *World Population Prospects Estimates and Projections as Assessed in 1982*. New York 1985, except for figures which carry a footnote, which are from country summaries. Adult literacy: Data from country summaries. Countries have approved the estimates contained in the table.

[a] Data for 1982. [b] Data for 1980. [c] Data for 1983. [d] Data for 1984. [e] Data for 1981.

Source: Pan American Health Organization (1986), p. 231

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Health expenditure.

Country or other political unit	Year	GDP per capita (US$)	Percentage of GDP spent on health	Percentage of health expenditure devoted to primary health care
Anguilla		...	...	...
Antigua and Barbuda	1983	299	6.2	...
Argentina	1984	2 366	...	...
Bahamas	1980	6 646[b]	5.9	7.9
Barbados	1984	3 381[c]	4.1	13.0
Belize	1983	970	3.0	...
Bermuda	1983	13 500	18.7	16.4
Bolivia	1985	135	6.0	...
Brazil	1981	1 639	5.5	...
British Virgin Islands	1981	2 456[b]	5.5	27.0[c]
Canada	1984	12 983	8.4[b]	...
Cayman Islands		...	...	...
Chile	1983	1 355[b]	6.0	55.9[c]
Colombia	1980	806[b]	5.4	...
Costa Rica	1983	1 270	5.7	1.9
Cuba		...	...	...
Dominica	1978	460	4.3	...
Dominican Republic	1980	1 260	3.7[c]	...
Ecuador	1982	1 385	6.0	...
El Salvador	1983	752[b]	2.1	100.0
Grenada	1982	679	...	...
Guatemala	1984	1 202[c]	3.7	17.3[d]
Guyana	1982	1 559	5.0	...
Haiti	1984	300[c]	3.0	9.0
Honduras	1983	633	7.0	...
Jamaica	1983	2 983[b]	3.6	...
Mexico	1983	1 524	1.6	...
Montserrat	1982	3 565	...	...
Netherlands Antilles	1981	1 300[a]	8.5	...
Nicaragua		...	...	...
Panama	1983	961	10.1	...
Paraguay	1982	902	4.9[e]	...
Peru	1984	605[b]	4.5[c]	8.1
St. Christopher and Nevis	1982	3 064[a]	...	...
Saint Lucia	1981	965[d]	4.0	...
St. Vincent and the Grenadines	1982	544	5.3[e]	...
Suriname	1983	3 382	...	...
Trinidad and Tobago	1980	6 691[b]	1.6	...
Turks and Caicos Islands		...	...	...
United States of America	1983	13 918	10.9	...
Uruguay	1980	2 183	...	...
Venezuela	1984	4 714[b]	3.0	...

[a] 1979. [b] 1982. [c] 1983. [d] 1985. [e] 1984.

ANNEX

Percentage of population with safe water in the home or within 15 minutes' walking distance and adequate sanitary facilities in the home or immediate vicinity.

Country or other political unit	Year	Safe water supply % population covered			Sanitary facilities % population covered		
		Total	Urban	Rural	Total	Urban	Rural
Anguilla		...	...	...	75	...	...
Antigua and Barbuda	1983	95	...	...	100	...	...
Argentina	1983	67	72	19	84	93	37
Bahamas	1983	59	59	...	64	64	...
Barbados	1983	52	100	20	100	40	...
Belize	1983	67	100	38	67	67	63
Bermuda	1984	100	100	...	100	...	...
Bolivia	1983	43	78	12	24	41	9
Brazil	1983	75	...	52	24	33	1
British Virgin Islands	1983	90	...	...	85	...	...
Canada	1982	97	...	...	60	...	...
Cayman Islands	1984	66	...	...	84[a]	...	...
Chile	1983	85	100	18	83	100	10
Colombia	1983	91	100	76	68	96	14
Costa Rica	1983	88	93	86	76	100	40
Cuba	1982	61.2	...	...	31	...	...
Dominica	1980	77	...	...	86	...	...
Dominican Republic	1983	62	85	33	27	41	10
Ecuador	1983	59	98	21	45	64	26
El Salvador	1983	55	71	43	41	52	34
Grenada	1983	85	...	...	...	...	...
Guatemala	1983	51	90	26	36	53	28
Guyana	1983	80	100	61	90	54	81
Haiti	1983	33	73	25	19	54	12
Honduras	1983	69	91	55	44	44	40
Jamaica	1983	73	99	93	90	92	90
Mexico	1983	74	90	40	56	93	12
Montserrat	1980	53.1	...	...	...	...	...
Netherlands Antilles	1984	81.8	...	...	100	...	...
Nicaragua	1983	56	98	9	28	73	16
Panama	1983	62	97	26	66	61	71
Paraguay	1983	25	46	10	84	92	95
Peru	1983	52	73	18	35	57	2
St. Christopher and Nevis	1983	75	...	...	96[b]	...	...
Saint Lucia	1979	70	...	...	62	...	...
St. Vincent and the Grenadines	1981	75	...	...	88	...	...
Suriname	1983	89	91	87	100	100	96
Trinidad and Tobago	1983	87	97	77	99	100	98
Turks and Caicos Islands	1984	39	...	...	...	...	...
United States of America	1984	100	100	...	98.2[c]	...	...
Uruguay	1983	83	95	27	59	59	59
Venezuela	1983	83	88	65	45	57	6

[a] 1979. [b] 1985. [c] 1980.

Source: Pan American Health Organization (1986), pp. 232-233

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Percentage of infants fully immunized against diphtheria, whooping cough, and tetanus (DPT), measles, poliomyelitis, and tuberculosis.

Country or other political unit	Year	DPT Total	DPT Urban	DPT Rural	Measles Total	Measles Urban	Measles Rural	Poliomyelitis Total	Poliomyelitis Urban	Poliomyelitis Rural	Tuberculosis Total	Tuberculosis Urban	Tuberculosis Rural
Anguilla	1984	69.0	...	...	72.0	...	...	73.0	...	...	75.0	...	...
Antigua and Barbuda	1984	94.0	...	...	73.0	...	...	92.0	...	...	...	...	...
Argentina	1984	66.0	...	...	90.0	...	...	64.0	...	...	72.0	...	...
Bahamas	1984	62.0	...	...	62.0	...	...	62.0	...	...	...	...	...
Barbados	1984	83.0	...	...	84.0	...	...	77.0	...	...	...	...	...
Belize	1984	54.0	...	...	44.0	...	...	54.0	...	...	82.0	...	...
Bermuda	1984	40.0	...	...	42.0	...	...	41.0	...	...	...	...	...
Bolivia	1984	24.0	...	...	17.0	...	...	56.0	...	...	24.0	...	...
Brazil	1984	67.0	...	...	80.0	...	...	99.0	...	...	79.0	...	...
British Virgin Islands	1984	85.0	...	...	89.0	...	...	85.0	...	...	...	...	...
Canada	1983	80.0	...	...	...[a]	...	...	80.0	...	...	...[b]	...	...
Cayman Islands	1984	90.0	...	...	75.0	...	...	90.0	...	...	64.0	...	...
Chile	1984	84.0	...	...	77.0	...	...	86.0	...	...	87.0	...	...
Colombia	1984	60.0	...	...	52.0	...	...	60.0	...	...	67.0	...	...
Costa Rica	1984	82.0	...	...	83.0	...	...	81.0	...	...	...	...	...
Cuba	1984	88.0	...	...	80.0	...	...	99.0	...	...	91.0	...	...
Dominica	1984	84.0	...	...	85.0	...	...	82.0	...	...	84.0	...	...
Dominican Republic	1984	20.0	...	...	19.0	...	...	99.0	...	...	43.0	...	...
Ecuador	1984	36.0	...	...	40.0	...	...	36.0	...	...	79.0	...	...
El Salvador	1984	44.0	...	...	41.0	...	...	44.0	...	...	21.0	...	...
Grenada	1984	76.0	...	...	31.0	...	...	73.0	...	...	...	...	...
Guatemala	1984	54.0	...	...	27.0	...	...	53.0	...	...	37.0	...	...
Guyana	1984	43.0	...	...	33.0	...	...	41.0	...	...	49.0	...	...
Haiti	1984	12.0	...	...	13.0	...	...	12.0	...	...	58.0	...	...
Honduras	1984	48.0	...	...	51.0	...	...	84.0	...	...	47.0	...	...
Jamaica	1984	57.0	...	...	60.0	...	...	56.0	...	...	48.0	...	...
Mexico	1984	26.0	...	...	30.0	...	...	91.0	...	...	24.0	...	...
Montserrat	1984	84.0	...	...	82.6	...	...	82.0	...	...	81.0	...	...
Netherlands Antilles	1982	85.8	...	...	30.0	...	...	85.6	...	...	...	...	...
Nicaragua	1984	32.0	...	...	30.0	...	...	73.0	...	...	24.0	...	...
Panama	1984	70.0	...	...	72.0	...	...	70.0	...	...	79.0	...	...
Paraguay	1984	58.0	...	...	53.0	...	...	59.0	...	...	70.0	...	...
Peru	1984	26.0	...	...	32.0	...	...	26.0	...	...	59.0	...	...
St. Christopher and Nevis	1984	97.0	...	...	85.0	...	...	97.0	...	...	...	...	...
Saint Lucia	1984	83.0	...	...	60.0	...	...	84.0	...	...	80.0	...	...
St. Vincent and the Grenadines	1984	86.0	...	...	92.0	...	...	90.0	...	...	32.0	...	...
Suriname	1984	80.0	...	...	83.0	...	...	79.0	...	...	...	...	...
Trinidad and Tobago	1984	65.0	...	...	10.0	...	...	66.0	...	...	...	...	...
Turks and Caicos Islands	1984	60.0	...	...	44.0	...	...	70.0	...	...	99.0	...	...
United States of America	1983	37.4	...	...	71[a]	...	...	24.0	...	...	...[c]	...	...
Uruguay	1984	57.0	...	...	17.0	...	...	83.0	...	...	...	...	...
Venezuela	1984	27.0	...	...	25.0	...	...	59.0	...	...	23.0	...	...

[a] Immunization is done at 12-15 months. [b] Immunization is done only in [illegible] tuberculosis areas. [c] BCG vaccine is not used in the USA.

Coverage of health care.

Country or other political unit	Year	Population covered by health care (%) Total	Urban	Rural	Infants cared for (%) Total	Urban	Rural	Pregnant women attended by trained personnel (%): During pregnancy Total	Urban	Rural	During childbirth Total	Urban	Rural
Anguilla	1985				9[illegible]	...	...	90	...	...	100	...	...
Antigua and Barbuda	1985	100			100[e]	...	...	...	...	...	82.9[a]	...	...
Argentina					...	...	...	...	...	...	...	...	...
Bahamas	1984	100			...	...	...	99	...	...	99	...	...
Barbados	1983	100			78[e]	...	...	98[e]	...	...	98[e]	...	...
Belize	1984	75			90	...	...	81.1	...	...	83	...	...
Bermuda	1984				90	...	...	90	...	...	90	...	...
Bolivia						...	...	...	...	...	...	...	...
Brazil	1985					...	...	75	...	...	73	...	...
British Virgin Islands	1985	100			90	...	...		...	...	...	...	...
Canada	1984	...				...	...	...	...	...	99	...	...
Cayman Islands						...	...	...	...	...	...	...	...
Chile	1983	94.7			89.9	...	...	91	...	...	95.3	...	...
Colombia	1984	87.6			...	...	...	65[e]	...	...	51[e]	...	...
Costa Rica	1982	94.8[e]			...	...	...	54.4	...	...	93	...	...
Cuba	1984					...	...	...	...	...	98[a]	...	...
Dominica	1983	100[e]	...	...	93	...	...	96	...	...	96	...	...
Dominican Republic	1983	...			...	...	...	...	...	...	98	...	...
Ecuador	1983	...			54[a]	...	...	46[a]	...	...	26.4	...	...
El Salvador	1984	...			45	...	...	25.5	...	...	34[a]	...	...
Grenada	1983	...			66	...	...	...	...	...	81	...	...
Guatemala	1984	50			...	...	...	...	...	...	...	...	...
Guyana	1983	86.8[e]			96	...	...	90.5[e]	...	...	92.5[e]	...	...
Haiti	1983	...			...	...	...	44.6	...	...	20	...	...
Honduras	1983				72	...	...	...	...	...	50	...	...
Jamaica	1983				90	...	...	72	...	...	89	...	...
Mexico	1984	50[a]			...	...	...	...	...	...	...	...	...
Montserrat	1985	100			95[e]	...	...	100	...	...	96.4[e]	...	...
Netherlands Antilles		...			...	...	...	...	...	...	...	...	...
Nicaragua					...	...	...	...	...	...	...	...	...
Panama	1983	...			40.4	...	...	65.5	...	...	53.3	...	...
Paraguay	1983	...			70.6	...	...	65.4[e]	...	...	21.9	...	...
Peru	1983				...	...	...	46.2	...	...	44.3[e]	...	...
St. Christopher and Nevis	1984	96			40[e]	...	...	...	...	...	49.5[e]	...	...
Saint Lucia	1985	100			81[c]	...	...	95[e]	...	...	98[e]	...	...
St. Vincent and the Grenadines	1985	80			82[e]	...	...	60[e]	...	...	73[e]	...	...
Suriname	1985	100			...	...	...	...	...	...	80[e]	...	...
Trinidad and Tobago	1983	...			...	...	...	90	...	...	90	...	...
Turks and Caicos Islands					...	...	...	...	...	...	...	...	...
United States of America	1984	100			...	...	...	...	...	...	99[a]	...	...
Uruguay					...	...	...	...	...	...	...	...	...
Venezuela	1982				...	...	...	...	...	...	82.1	...	...

[a] 1981. [b] 1984. [c] 1985. [d] 1982. [e] 1983.

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ANNEX

Source: Pan American Health Organization (1986), pp. 234-235

Country or other political unit	Year	% Newborns with birth weight of at least 2500 g			% Children with corresponding weight for age			Infant mortality rate			Life expectancy at birth[d]		
		Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Male	Female
Anguilla	1984	3.8	...	..	...	...	..	26.7[b]	...	...	.	62.2	76.9
Antigua and Barbuda	1982	8.2	...	...	74.5	...	...	11.1[a]	...	...	70.0[a]	...	...
Argentina	1983	...	...	...	...	...	...	35.3	...	...	69.7	66.4	73.1
Bahamas	1980-84	4.8	...	...	..	...	..	20.3	...	...	69.3[c]	...	...
Barbados	1983	...	...	..	.	...	..	24.5	...	...	71.6	68.9	73.1
Belize	1984	..	...	..	94.0	...	..	24.1[a]	...	...	70.0[e]	...	...
Bermuda	1984	6.8	...	...	90.0	...	...	11.6[a]	...	...	73.0[e]	...	...
Bolivia	1981	10.0	...	...	...	...	...	124.4[d]	...	...	50.7	48.6	53.0
Brazil	1980-85	...	...	...	...	...	...	71.4	...	...	63.4	60.9	66.0
British Virgin Islands	1982	...	...	...	...	...	...	45.1	...	...	70.0[f]	...	...
Canada	1982	5.8	...	...	..	...	...	8.5[e]	...	...	74.9	71.2	78.8
Cayman Islands	1981	...	...	...	...	...	...	14.0	...	...	...	...	...
Chile	1984	6.8[a]	...	...	82.3	...	..	21.8	...	...	67.0	63.8	70.4
Colombia	1977-81	3.4	...	..	80.6	...	...	52.0[f]	...	...	63.6[e]	61.4[e]	66.0[e]
Costa Rica	1983	9.6	...	...	65.8[b]	...	...	18.6	...	...	73.0	70.5	75.7
Cuba	1984	7.9	...	..	8.5	...	...	15.0	...	...	73.4[d]	71.8	75.2
Dominica	1983	10.5[a]	...	...	...	...	...	13.9	...	...	...	68.0	74.0
Dominican Republic	1980-85	...	...	...	...	...	...	63.5	...	...	62.6	60.7	64.6
Ecuador	1980-85	...	...	...	...	...	...	77.2	...	...	62.6	60.6	64.7
El Salvador	1982	8.7	...	..	34.2[a]	...	...	42.2	...	...	64.8	62.6	67.1
Grenada	1974-75	12.2	...	...	...	...	...	21.0[c]	...	...	...	64.0[h]	67.0[h]
Guatemala	1980	10.0	...	...	...	...	...	79.9[a]	...	...	60.7	59.7	61.8
Guyana	1984	19.5[h]	...	..	51.1	...	...	40.5	...	...	68.2	65.8	70.8
Haiti	1978	17.0	...	...	26.8	...	...	124.0[b]	...	...	52.7	51.2	54.4
Honduras	1981	9.2	...	...	23.5[a]	...	..	81.5[d]	...	...	59.9	58.2	61.7
Jamaica	1982	10.0	...	...	27.0	...	...	26.5	...	...	70.3	68.1	72.6
Mexico	1983	15.0[g]	...	...	..	...	...	35.2	...	...	65.7	63.5	68.1
Montserrat	1985	7.8[a]	...	...	92.0	...	...	26.4[a]	...	...	...	...	...
Netherlands Antilles	1983	...	...	...	...	...	...	15.8	...	...	72.8[c]	...	...
Nicaragua	1984	15.4	...	...	...	...	...	75.2[a]	...	...	59.8	58.7	61.0
Panama	1982	8.2	...	...	...	...	...	20.0[a]	...	...	71.0	69.2	72.9
Paraguay	1981	6.5	...	..	68.0[h]	...	...	45.0[d]	...	...	65.1[d]	62.8[d]	67.5[d]
Peru	1982	9.0	...	..	...	...	...	127.0[f]	...	...	58.6	56.8	60.5
St. Christopher and Nevis	1983	9.4	...	...	100.0[h]	...	...	41.2	...	...	65.0[e]	...	...
Saint Lucia	1985	9.7	...	...	...	...	...	26.1[a]	...	...	70.0	...	...
St. Vincent and the Grenadines	1982	10.0	...	...	...	...	...	32.5[a]	...	...	68.5[c]	...	...
Suriname	1985	13.0[c]	...	...	84.0	...	...	33.8[d]	...	...	64.4	67.0	71.9
Trinidad and Tobago	1980-85	...	...	...	...	...	...	29.9	...	...	70.1	67.8	72.6
Turks and Caicos Islands	1982	...	...	...	...	...	...	25.0	...	...	...	...	...
United States of America	1982	6.8	...	...	...	...	...	10.9[a]	...	...	74.0	69.4	78.0
Uruguay	1977	8.3	...	...	...	...	...	33.2[b]	...	...	70.3	67.1	73.7
Venezuela	1983	9.1	..	..	.	..	..	38.6[d]	...	...	67.8	65.1	70.6

[a] 1983 [b] 1982 [c] 1980 [d] 1980-1985 [e] 1981 [f] 1984 [g] 1978 [h] 1985

Source: Pan American Health Organization (1986), p. 236

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