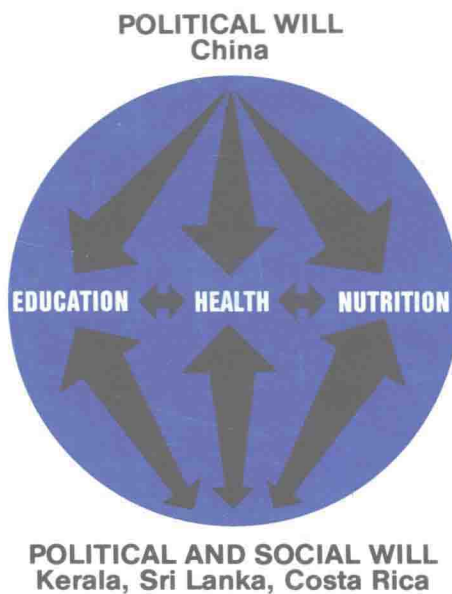


CONFERENCE REPORT
The Rockefeller Foundation

GOOD HEALTH AT LOW COST

Edited by Scott B. Halstead, Julia A. Walsh and Kenneth S. Warren



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Good Health at Low Cost



Proceedings of a Conference held at the
Bellagio Conference Center
Bellagio, Italy

April 29 - May 3, 1985

Sponsored by
The Rockefeller Foundation

Editors:

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Table of Contents

Editors' Preface.....	5
Conferees' Preface.....	7
List of Participants.....	9

PART I. COUNTRY REPORTS

China.....	11
Health Statistics of the People's Republic of China.....	11
By Xu Su-en	
China's Health Care System: Policies, Organization, Inputs and Finance.....	21
By Dean T. Jamison	
The Development of the Health System in China and the Conducive Factors.....	33
By Chen Chun Ming	
Kerala State, India.....	39
Health Statistics in Kerala State, India.....	39
By T. N. Krishnan	
Health Care System in Kerala and Its Impact on Infant Mortality.....	47
By P. G. K. Panikar	
The Impact of Social and Economic Development on Mortality: <i>Comparative Study of Kerala and West Bengal</i>	57
By Moni Nag	
Sri Lanka.....	79
Health Statistics in Sri Lanka, 1921-80.....	79
By Dallas F. S. Fernando	
Health Care Systems of Sri Lanka.....	93
By P.D.A. Perera	
Health and Development in Sri Lanka: An Overview.....	111
By Godfrey Gunatilleke	
Costa Rica.....	125
Infant Mortality Decline in Costa Rica.....	125
By Luis Rosero-Bixby	
Health Changes During a Decade: The Costa Rican Case.....	139
By Lenin Saenz	
Health Improvements in Costa Rica: The Socioeconomic Background.....	147
By Claudio Gonzalez-Vega	

PART II. INTERVENTIONS

Economic Factors	159
Notes on Per Capita Income in the Case Study Areas	159
By S. H. Preston	
Cultural Factors	163
Consideration of Cultural Factors in Child Health	163
By Marilyn K. Nations	
Social and Political Factors	173
The Contribution of Social and Political Factors to Good Health	173
By Patricia L. Rosenfield	
Education and Literacy	181
Education and Literacy as Factors in Health	181
By John C. Caldwell and Pat Caldwell	
Relative Roles of Female Education and Medical Services for Decreasing Infant Mortality in Rural India	187
By Anrudh K. Jain	
Water Supply and Sanitation	191
The Role of Water Supply and Sanitation in Reducing Mortality in China, Costa Rica, Kerala State (India) and Sri Lanka . . .	191
By R. G. Feachem	
Nutrition	199
Trends in Nutrition, Food Supply and Infant Mortality Rates	199
By Reynaldo Martorell and Ramesh Sharma	
Vertical Programs	215
Specific Public Health Measures	215
By W. B. Greenough, III	
Clinical Services	221
The Case for Clinical Services	221
By Stephen C. Joseph	

PART III. DISCUSSION

Remarks By William H. Foege	229
Remarks By Peter Kunstadter	233
Remarks By Sidney S. Lee	239
Remarks By W. Henry Mosley	241
Remarks By Kenneth S. Warren	245

SUMMARY STATEMENT ADOPTED BY CONFEREES	247
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Economic Factors	159
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Trends in Nutrition, Food Supply and Infant Mortality Rates	199
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Vertical Programs	215
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---	------------

Editors' Preface

The impetus for this Conference emerged from the interest of some of us* in developing a global strategy for achieving "Health for All" by targeting for action an essential short list of diseases. This effort to define a prioritized health development strategy analyses the achievements of four remarkable modern societies. As the architects and participants in these events will be the first to admit, none of these societies claims to have achieved "Good Health"; all are still striving for better health. The biggest contribution to improved life expectancy is reduced infant mortality. In many of these societies illness burdens, especially in children, are still high and in others, health gains are unequally distributed. In still others, chronic diseases, accidents and malignancies are emerging as leading health problems posing challenges for the decades ahead. Thus, "Good Health" is not a permanent state, a particular level of statistical achievement, but, a direction and a commitment.

"Low Cost" is also subject to interpretive complexities. As the readers of this volume will discover, no country, certainly not the ones described here, has achieved reductions in mortality or fertility rates without effort. The costs of commitment, planning, management and execution were formidable. In all instances, efforts across varied sectors of the nation contributed additively to successful outcomes. Nonetheless, in absolute dollar expenditures, the health gains of China, Kerala State, Sri Lanka and Costa Rica were achieved at relatively modest cost. Each of the success stories described has evolved, with one exception, in countries with unusually low gross domestic product per capita.

The message is clear. A high level of economic activity is not essential to successful programs for the betterment of human health. Other factors may be more important. It is these factors that are explored in "Good Health at Low Cost."

A great deal of effort has gone into the production of this volume. The editors would like in particular to acknowledge Theodore Lester, who helped organize the Bellagio Conference, and the painstaking editorial efforts of Carol Jimenez and Henry Romney, who brought this book to fruition.

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*Walsh, J.A. and Warren, K.S. Selective primary health care: an interim strategy for disease control in developing countries. N. Engl. J.Med. 301:967-974, 1979.

Conferees' Preface

The Alma Ata Declaration has seemed to many to present impossibly difficult health targets for the poorest countries. Yet a number of poor societies, Kerala State, Sri Lanka, China and Costa Rica for example, have achieved mortality levels close to those of the industrialized countries. The first three did this in spite of annual per capita incomes which are still around only \$300. Each added 15-20 years to its expectation of life at birth in little more than two decades.

This immense improvement in their social situations was largely carried through by their own efforts. It is particularly exciting because there appears to be a common pattern. Central to that pattern was a strong political and popular commitment to extending good health to all, so that the effort had a high profile, involved widespread participation, and had some of the aspects of a crusade. The effort was not dirt cheap but it did not so distort the economies of these countries as to render the attainment of other desired ends impossible.

Other common, and perhaps essential, elements were an equally strong commitment to education for all and for guaranteeing that even the most underprivileged secured an adequate diet. The programs were broadly based and employed all available health technologies, at least those that could be afforded.

A guarantee of a long life to nearly everyone cannot wait the attainment of global affluence. It now appears that it does not have to. There is an available model. However, that model cannot be quietly accepted as a health priority. The community has to feel strongly and even righteously about the desirability of the ends and the high priority in effort that they should be awarded. It is clear that this feeling must have as a fundamental element a strongly held commitment to equity, or at least to a satisfactory minimum level for all, of health services, food and education.

It also appears to be probable that the effort need be sustained at its maximum only during the period of rapid mortality decline. Thereafter, there can be some relaxation in effort and expenditure, while other goals are pursued, without a rise in mortality levels.

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Health Statistics of the People's Republic of China

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Introduction

China is such a large country with such an enormous population and long history that any interpretation of statistical data on the health status of its people and the nation as a whole must be qualified by time, place, and environmental and socioeconomic conditions and changes.

More than three decades ago, China entered into a new era of social development. Prior to that, China's population statistics exhibited the classical combination of a high death rate, a high birth rate, a low rate of natural increase and a short life expectancy that described the human condition throughout history down to the present.

Since liberation, the total population has doubled – a fact that provides the most convincing evidence of the improvement of the people's well-being. The sharp decline in the death rate soon after 1949 brought the natural rate of increase up to 20 per 1,000 and for a few years to more than 30 per 1,000. Decline in the birth rate has now reduced the net annual increase to 12 per 1,000, signifying the entry of the Chinese people into the second stage of the demographic transition.

Today, with socialist construction underway, one billion Chinese people, a fourth of the world population, are secure against famine, flood and epidemic disease.

With the above highlights of health status in view, we present the necessary health statistical data in order to provide a basis for whatever generalizations may be deduced and to facilitate the analysis of causative factors.

Materials and Methods

That health statistics did not exist in China was just a speculation. As early as 300 B.C. the system of household registration was established, and relatively complete population figures were available in the year 2 A.D.

The data presented in this paper are chiefly obtained directly or indirectly from four sources.

1. *Household registration* furnishes data on population, birth, death and migration. Offices at various administrative levels add up the sums and forward them to corresponding bureaus of statistics. The National Statistical Bureau publishes the population statistics in their bulletins, which are readily available.
2. Since the founding of the People's Republic, *national censuses* have been taken – in 1954, 1964 and 1982. The last one is a milestone in the development of demography in that it includes a large number of items, requires a set of carefully designed procedures of implementation, employs computer technology in compilation and calculation, and guarantees the accuracy and precision of the results. Results of the third census are now being published.
3. *Sample surveys* were done in 1982 and 1983, the third one nearing completion. From now on, a sample survey of population changes is to be carried out annually.
4. *Special surveys* on particular topics are being conducted. This type embraces the surveys conducted by various governmental departments and agencies with the aim of

collecting information as required for decision-making in connection with socialist construction.

Health surveys have been conducted in great numbers during the past years and the results have been published in the form of monographs, scientific articles, atlases, etc.

Very recently, a health yearbook was published by the Ministry of Health for 1983, from which the author has gathered materials for this paper.¹

Results

Births and Population Growth

At the end of 1949, the total population was 541,670,000 (not including Taiwan Province) and it reached a little bit over one billion at the third census on July 1, 1982, a net increase of 466,500,000 in 34 years. (Table 1)

Before liberation, the growth of population had been steady but slow. Since 1949 there have been great increases, the first peak covering the 1950-1958 period during which a total of 186,000,000 was reached with an annual figure of 20,600,000 births a year, giving a total of 234,000,000. The third peak covered the period from 1971 to 1975, averaging 23,800,000 births a year and totalling 119,000,000. The second and third peaks covered a period

Table 1

China: Population Growth

<u>Year</u>	<u>Population (x 10,000)</u>	<u>Male (x 10,000)</u>	<u>Female (x 10,000)</u>
1949	54,167	28,145	26,022
1952	57,482	29,833	27,649
1957	64,653	33,469	31,184
1965	72,538	37,128	35,410
1978	95,809	49,129	46,680
1981	99,622	51,081	48,541
1982	100,817	NA	NA

Source: *China Health Yearbook 1983*, p. 164.
NA: Not available

Table 2

China: Birth Rates, Death Rates and Percent of Natural Increase, 1949-82

<u>Year</u>	<u>Birth Rates</u>	<u>Death Rates</u>	<u>% Natural Increase</u>
1949	36.00	20.00	16.00
1952	37.00	17.00	20.00
1957	34.03	10.80	23.23
1965	38.06	9.55	28.51
1978	18.34	6.29	12.05
1981	20.91	6.36	14.55
1982	21.09	6.60	14.49

Source: *China Health Yearbook 1983*, p. 164.