The Historical Development of the Health System of Third World Countries

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Health is an expression of the prevailing socio-economic and political conditions in the respective society.

In a society in which various interest groups are diametrically opposed, poverty as a condition, arises as a result of the unequal division of the products produced by activity in the society. Health is not a personal condition bestowed on the individual but rather the condition of a person in social, cultural, psychic and physical respects.

The cause of most of the diseases in the Third World and in industrial culture are man-made social conditions. They are the result of the prevailing socio-economic relationship of a society. The micro-organisms that may cause diseases are naturally part of our nature, but to suffer under the infection of these micro-organisms is a cultural factor. It is cultural because our reaction to micro-organisms and our methods of prevention have failed.

The primary aim of a health policy of a society should be to create adequate conditions for the human being to get sufficient food, clean water, better housing, appropriate work and working conditions, intellectual and cultural freedom of an individual. An important step to improve the life quality is the increase in the income and the productivity of the people. The health policy is the foundation of all other sectors of the state policy in that given society. But in the western world and naturally in the neo-colonial world the health policy is considered as a process that deals with the state sickness, in other words, its focus is the curative medicine. Curative medicine is an economic branch privately conducted and its main aim is profit, like all other productive branches of a capitalistic economic system. That branch produces means of treatment of diseases and their research works concentrate also mainly on the technical methods to overcome or relieve the diseases. The social character of diseases is not considered important because that may demand the reorganization of the production activity of the society. Preventive medicine is primarily a social method whose activity is aimed at creating conditions which make the development of a disease or health damage superfluous and includes, naturally, its treatment. It demands that the production activity of that society should have to be carried in harmony with its nature, it demands the correction of the social and economic inequality which worsens the life quality of the people. It demands the democratization of the society so that the individual may use his energy to the benefit of all.

The development of capital accumulation which England needed to change its productive means from manufacture to machine production was mainly absorbed through the slave trade triangle. An egg develops into a hen if energy is supplied to it, but energy cannot change every sybstance to a hen. The determining force in the development of the eggs is an internal force but without external supplement the manifestation of internal factor cannot happen. So the industrial revolution of England didn't develop without the external supplement — the development aid squeezed from the Third World.

The diseases which the Europeans didn't have sufficient resistence to, caused them a lot of health damages in the colonial countries. The trade companies of England came to claim that many of their British overseas employers show a significantly higher mortality rate than their colleagues in England. The yearly rate of the British soldiers in Jamaica was 15%, 10 times more than those stationed in England. In the Gold Coast, it was 67% which gave the name 'Grave of the white man'.

When Joseph Chamberlain became the minister for the colony in 1895, he forced an active colonial policy aimed at increasing the productivity of the colony. He came to realize that health damages of their colonial pioneers might limit his ambitions.

The development of bacteriology and parasitology showed a high promise to eradicate the tropical diseases. In 1899, the school for tropical medicine was founded in London and Liverpool. In 1885 the East India Company was given responsibility for the health administration in India. At the beginning of colonization the health service of the colonies was carried out by the British trade companies who engaged a few doctors for the interest of their white employers. At the turn of the century the health service was carried on more or less by the colonial state, but nevertheless public health service remained for many years significantly low.

In 1903 the East African Medical Department was ordered to take care of the health of the European population primarily and secondly for the African and Asian labor forces needed for the colonia interests. In 1903 the whole European medical staff in Kenya and Uganda was 26 doctors, 6 nurses and 7 pharmaceutical chemists. The health service for Europeans was facilitated because they settled in geographically better areas (like the Kenian Highlands). They concentrated in towns, economic, military and administrative centres. Most of the public health expenditure was then spent on the hospitals, which were located in the white settler areas. The settled white population had clean water supply, canalization, electricity and better housing conditions. Only where the labor forces of the colonised people were considered important, minimal health service was given.

As the construction of the Ugandian train line became economically important, Indian labor force was imported and was given better health service than the Africans although the Indians in India didn't receive bettere colonial health service.

Instead of taking adequate measures to prevent epidemic diseases, the colonial administration considered the racial segregation as an adequate step. The Africans, Indians and Europeans were each limited to geographically defined areas. The town segregation shows clearly the material advantages given to the white population: water, electricity, roads, canalization and social establishments. The Europeans called their area « hygienic quarter ». The colonial administration compelled the African population through different methods to give up their food pro-

duction system and introduced the export oriented food production. The white settlers occupied the fertile land; many African people served now either as land and mine workers or in the colonial administration. The urbanization process developed, but nevertheless the Africans in the towns were not allowed to make use of the colonial health establishments. Ironically the Europeans considered the high rate of sickness among the Africans to be due to the unhygienic African living habits.

In 1897 Ronald Ross discovered that the Anopheles mosquito is the carrier of malaria disease, in 1903 Castellani and Bruce discovered that the Tse Tse is the carrierd of sleeping sickness. For the African population the carriers of malaria and sleeping sickness were not only already known, but preventive methods were developed and conducted. Instead of further development of the already existing preventive measures the colonial administration tried to solve the struggle against such diseases with the help of its laboratory results, which naturally gave impulse to their pharmaceutical industries to launch research work for profit greediness. There were different opinions concerning the appropriate strategies for the struggle against such diseases among the colonial doctors and colonial administrators, which was the reflexion of the struggle betweeen the colonial scientific ideology of the laboratory medicine, carried out in the tropical school of England and the practical oriented colonial doctors, who recognised the importance of preventive medicine. Where as the school of tropical diseases received fund for their research works, Mr. Ross didn't succeed in getting minimum financial help for his public health compaign. For sure both doctor groups were serving, the colonial British interest but their approach to the interest of the colonized people were different.

In the 30's the colonial doctors and the administrators confessed that the clinical treatment of such infectious diseases like malaria and sleeping sickness was not the appropriate method and was only a loss of energy and money. Dr. J. L. Gilks, the director of the health administration in Kenya, came to this conclusion in 1929: it is generally recognized that malaria is a social disease and that the endemic areas are characterized with low living standards. Between 1928-1938 there were many reports emphasizing the relationship between poverty and bad health conditions which were the result of the colonial destruction of the traditional society with its traditional production system and social relationships. It became clearer that the infectious diseases which were till then predominant in the industrialising cultures, became more and more the health hazard of Third World people, whose treatments could only be effectively carried out if the social structure of the society is changed, but social change was prevented by the colonial system. The main characteristics of colonialism is to undermine the primary human right, the right of a society to fulfil its own needs through its social activities.

In 20th century the British colonial administration launched coercive resettlements of the African population who was considered to be endangered by the Tse Tse fly. The people were taken away from their traditional villages, their lands and from their communities. In short, the right to feed themselves was taken away from the people. Ironically this intention which was considered as a necessary preventive step, turned out to be a concentration camp for cheap labor force for the colonial investment capital. The missionary service played an important role for the popularisation of the western medicine among the African people. Most of the missionary hospitals and dispensaries are built in the country side,

far away from the colonial administration centres. The missionary service was considered by the colonial administration as an important social factor for their colonial interest. The colonial administration was considered by the African population as a repressive system which provokes resistance and just on this point was the focus of the missionary activities, the psychological and moral disarming of the Africans.

In short, the colonial administration had the whip and the missionaries had the sweetness of morality. Both are the methods which a repressive system applies. The colonial development and welfare declaration which was considered by the British colonialism as an important step for the well being of the colonized people in the British colonial empire, must be considered in the context of the social and political development in England between the two world wars. England was characterized by high unemployment and serious social riots. The government considered the colonial people as the saver of the motherland in the critical situation, as we have always done. When the severe famine happened in England in the years 1876-1879 in which 6 million people died from hunger, the country received from India almost 4 millions tons of grain.

The colonial development act of 1929 was formulated by the previous minister for the colony, Mr. Lord Passfield, as follows: « the important factor for the act is to reduce our unemployment and increase our export ». This was only possible through the increase of the colonial raw material supply and the stimulation of the colonial market to absorb British export goods. Therefore the British administration increased its welfare activities in the colony and limited health oriented projects were established.

After the 2nd World War the industrial capitalistic states were characterized by the intensive engagement of the states in the economic activities in order to rebuild after the damages of the war. The so-called colonial development and welfare act is now modified to the so-called development aid policy. Here in the colony the colonial state had intensified its economic engagement and organised infra-structure improvement projects in order to increase the export capacity which their industries badly needed.

This economic infra-structure laid down by colonialism served the starting point of the new born governments in Africa after the 2nd World War.

The unhealthy condition of our people is the result of colonially developed economic structures. A true independent state of the Third World must therefore gain the right of its society to fulfil primarily its material, spiritual and cultural needs.

Frantz Fanon defined the new born bourgoisie of the Third World as follows: « This bourgoisie is not characterized by its economic power but by its privileged position as intermedia in the process of capital accumulation. The university and trade elite who control the power of the new born states, are few in number and are concentrated in the capital, whose engagements are in trade, agricultural enterprises and in free profession. It is a bourgoisie without an industrial and financial boss. The national bourgoisie of the Third World is not engaged in production, discovery, construction and work, she is only interested in an intermediary role. This national bourgoisie has the psychology of a small business man, not that of an industrial captain.

The transfer of the western medical professionalism and health care structures damages the improvement of the health situation in the Third World. The so

called medical modernization programmes carried out with the help of industrial countries, concentrates mainly on the development of hospitals with high technological and capital input in the big towns. This medical service is costly and consumes a large portion of the state health expenditure. Only 20% of the Third World people are reached by the western medicine. The focus of the health system in the industrial culture is the high technified hospital. The substantial weapon with which they fight against the diseases is not to keep the balance of the relation between woman/man and their natural environment, in which the state of healthy and unhealthy develops, but their weapon is the understanding of the pathophysiology of the diseases and consequently their methods of treatments are pharmaceutical, immunological or surgical means. This health system is planned in such a way that only centralized institutions like hospitals can effectively carry it out. But the truth is that most killer diseases of the children in the Third World cannot be effectively treated by western medical treatment methods. These treatment methods can be shortly summarized as: prevention of death without improvement of the life quality.

In 1972 there were 2.2 million doctors world wide, of whom 120,000 were working in foreign countries, mostly in the industrial countries. Most of these doctors came from the Third World countries. The emigration of Latin American doctors to the USA costs their countries yearly 200 million US dollars, equivalent to the amount of medical development aid given by the USA to the Latin American countries during the decade of the 60's. The brain drainage (6400 engineers, 2211 doctors, 2625 scientists) of the Third World to the USA was in 1970, 3.66 billion US dollars more than the USA non military aid at the same period. A Chilian economist came to the result that each dollar spent in the Third World on the highly specialized hospital service kills hundreds of lives. If that amount was spent on clear drinking water and on food production, hundreds of lives could be saved.

Although the colonial and neo-colonial states concentrated on the management of the so-called tropical diseases, the epidemiological studies show clearly that the main cause of diseases is the living conditions in which the people live. The diseases of poverty like infections of respiratory system, gastro-intestinal tract and diarrhoea,undernourishment, measles, anemia, whooping cough and tetanus are the predominant diseases. If we exelude malaria, 70-80% of these diseases are responsible for the high infant death rate in the Third World.

In 1976 I experienced in Hargeisa/Somalia in a medical ward, that 18 female patients out of 22 were hospitalized due to iron deficiency anemia. Somalia is one of the countries with the highest infant death rate (145 deaths out of 1000 born infants). Between 1972-1980 Somalia has spent per capita 2 US dollars for education and health service and 7 US dollars for military expenses (62% of the GNP and 23,3% of the whole state expenditure).

Most of these diseases can be managed through improvement of nutrition hygiene, vaccination, clean drinking water, energy supply, better housing and health education.

But the present institutions are undemocratic to fulfil these socials demands.

One of the solutions is the decentralization of the health service and institutions accompanied by the development of self relying economic structures in order to regain the elementary right of each society to produce all its elementary needs before it gets economic contacts with the outside world.

The centre of this strategy is the motivation and development of the initiative

of the people. The health institutes have to create the conditions which improve the life quality of the people, instead of managing the outbreak of diseases.

The primary health care is primarily developed in the People's Republic of China, which became famous under the name of « bare-foot doctors », its main instrument is the development of the people's initiative to carry out preventive medicine. The 8 necessary points of primary health care are:

1) balanced diet: 2/3 of the children of the Third World are undernourished. The community health service secures that the people must get a sufficient balanced diet;

2) water and sanitary facilities: 80% of the diseases of the whole world depends on the lack of clean water supply and adequate sanitary facilities; both must be supplied;

3) maternity and child care: more than half a million mothers die during delivery and 10% of the infants die before they reach the age of 1 year. Proper education for midwives, better child care and family planning are necessary;

4) vaccination and adequate treatment of children's diseases: 5 million children die each year from diarrhoea: another 5 million children die each year from children's diseases;

5) medical drugs: in many of Third World countries more than 50% of the state's health expenditure is spent for medical drugs, which are imported mostly from the industrial countries. 240 medical drugs are necessary; in West Germany there are more than 70.000 medical drugs on the market. The necessary drugs must be cheap enough for everybody and shoud be necessarily produced in each country;

6) adequate treatment of the patients: 33% of the World population suffer from the hookworm, yearly 1 billion people suffer from acute diarrhoea, 200 million people suffer from schistosomiasis, 500 million people suffer from trachome and 160 million suffer from malaria etc. The community health workers should be in a position to understand the causes of the diseases and be able to launch preventive methods and treatments of these common diseases in his community;

7) health education: prevention of diseases depends, among other factors, on the social habits of each society. The primary health service should educate the people concerning the cause and prevention of these diseases originating from the traditional habits;

8) traditional medicine; 60-80% of the deliveries in the Third World are carried out by the traditional midwives. The midwives should be given appropriate education and traditional medicine must be given consideration.

Primary health care principally prohibits foreign intervention in its essence. It is a national affair, logistical help can be accepted.

The Somali government propagates primary health care, but that system cannot give the minimal prerequisite needed for the success of such a programme.

The primary health care programme is conducted mostly by the World Health Organization. Its activities concentrate on immunization and educational programmes. Such programmes are important, but they are not the substantial roots of the primary health care. As I have already mentioned, primary health care begins with the satisfaction of the elementary human demands: food, clean water and adequate housing. The amount of the health expenditure out of the whole state expenditure was reduced from 1970-1982 from 6% to 3,5%. The health invest-

ment during the development plan of 1982-1986 is considered to be only 2.1% of the whole state investment volume. In 1983 the state expenditure for health was 130 milion So. Shilin, while the expenses for defence was 1324.8 million So. Shilin, 10 times more than the health expenditure! The expenditure for police and interior was 204.5 millions So. Shilin. Somalia has more guns than bread. This statistics clearly shows the priority of the Somali state: defend yourself from the hungry people.