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THE IMPORTANCE OF HEALTH IN DEVELOPMENT: A CARIBBEAN PERSPECTIVE

The possible effect that health can have on development depends very much on the fashionable review of the determinants of development — that is, primarily of economic development. As I understand it, the view which held sway in the 30s and 40s was that development's essential requirement was physical capital accumulation. Attention to disease and promotion of health might even be anti-developmental, in the sense that investment in health would lead to a reduction in the death rate, an increase in population, and a reduction in per capita income. Readers will, of course, recognise the Malthusian flavour here. However, this has changed, and expenditure on education and health which contribute to human well-being are now accepted as being properly an investment which contributes to the productive capacity of the economy, and may be more important, or at least as important as the physical capital which was once believed to hold the key to economic growth. We have now re-discovered the thesis put forward about 300 years ago by William Petty and later recognised by Chadwick and John Stuart Mill on the primacy of human capital as a development input. Incidentally, Petty was a physician! William Demas in his presentation to the Board of Governors of the Caribbean Development Bank in 1987 followed this line of reasoning, and made an eloquent case for investment in men, women and children for development. It is no longer felt that expenditure in the social sectors has to be considered as consumption because it represents a reduction of the surplus available for investment.

One of the difficulties in exploring any impact of health on development lies in the choice of method to reflect health or health status. If we focus on a particular disease, then there is no shortage of evidence of the effect that the presence or absence of disease or illness can have on development. Biblical history speaks of the plague which contributed eventually to the departure of the Israelites from Egypt; the Black Death transformed Europe; the

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impact of malaria and malaria eradication on economic development has been reported repeatedly.

There is good evidence of increased productivity when individuals with a specific health problem are cured. One such example of this came to my notice in an invaluable manuscript written by Dr George Giglioli from Guyana — one of the Caribbean's greatest scientists. He treated the bauxite-miners at McKenzie for hookworm in September 1923, and in February received a memorandum from the mine manager which said:

> ...."I do think that to a great extent the elimination of this disease has had something to do with our increased output and our reduction of costs For the five months previous to September 1923, the increase in tonnage (of bauxite) per man per day was nil, whereas during the five months following September 1923 our increase in tonnage has amounted to 1 3/4 tons per man per day "

This kind of effect was well known to Dr Eric Williams who, in an address to the University of the West Indies Economics Society in 1963, was justifying expenditures in the social sector and said:

> ".... as if when you remove hookworm in Caroni or in the sugar areas you are not taking a positive step towards the increase of production in that area "

This increase in productivity in controlled groups cannot easily be demonstrated on a national scale, and, in addition, enhanced output is only one of the possible ways in which specific disease control may contribute to economic development. Other mechanisms include increasing work hours and decreasing absenteeism, altering migration patterns, and producing budgetary savings, as occurred in the case of smallpox eradication.

Those of us who work in health have generally been more aware of the impact of development on health than of health on development, and two major concerns stand out. Firstly, there is the possibility of a negative or positive effect on health status of development as measured by economic indicators. Secondly, there is concern about the appropriateness or inappropriateness of health as a social indicator which will complement the use of economic indicators in assessing development.

In very general terms there is a relationship between wealth and health, both within nations and between nations. In the late 40s and 50s when major attention was paid to increasing material production, the prevailing view held that, in general, social benefits would naturally follow economic development. In the decade of the 70s this view came under increasing scrutiny, as it became evident that economic development did not always go hand in hand with increased social well-being, and there were well documented exam-

ples of countries with aggregate indicators which showed handsome economic growth, but whose poorest populations were still socially marginalised. The pattern of development which graded itself on economic performance would take several generations before "all the boats rose with the tide", and this was a time frame which was unacceptable, particularly to the newly independent nations.

There are several indicators used to reflect general health status, but the best two are infant mortality and life expectancy at birth. Infant mortality is particularly good because not only does it tell us how many children die, but it also indirectly indicates the numbers of those who may survive but will lead a marginal existence, and will never develop to their full potential. Infant mortality is also a crude but good indicator of the general effectiveness of the health services.

The relationship between income as a measure of development and life expectancy at birth is an interesting one. In the poorer countries there is a much steeper relationship than in the richer countries — in the poorer countries an increase in income leads to a greater increase in life expectancy. But there are countries which are aberrations — their life expectancy is greater than would be expected for their level of economic development. Among the important reasons for these aberrations is the attention paid to education and particularly education of women. A similar conclusion is reached when infant mortality rate is used. George Cumper analysed the relationship between infant mortality rate and various possible determinants of health levels, and found that GNP/capita was correlated with infant mortality rate, but he also established that GNP/capita, hospital beds, physicians and other health professionals per 1,000 population when taken together accounted for 71 per cent of the variance in infant mortality rate. Another mechanism by which economic development may affect health is by the development of technology. The various vaccines and drugs produced as a result of economic development will not only affect health status positively, but will alter the relationship between income and health status.

On the negative side, there are forms or consequences of development which adversely affect health. Among these one can list urbanisation, dietary practices and ecological disturbances. As the trend away from rural development becomes universal, urban growth becomes the norm: the lack of space and physical infrastructure, the environmental pollution, psychological stress and maladaptation all contribute to poor health status in the city slums. Dietary practices change with economic development and bring in their train their own diseases like diabetes and hypertension. To the

extent that health represents a state of delicate balance between human beings and their environment, any ecological change is likely to affect health. The negative health effect of some large developmental projects has been well documented: the spread of schistosomiasis with the construction of large dams is only one such example. One of the findings of the large study by Weisbrod in St Lucia was that expansion of banana cultivation led to an increase in prevalence of schistosomiasis.

Because of the appreciation that economic measures were not adequate indicators of development as reflecting Dr Williams' "face of Man," considerable attention was paid to developing social indicators to complement the economic indicators. The standard measure of GNP per capita clearly said nothing about distribution of income in a country, and said less about the welfare of persons which is at the heart of development. The most widely used of these social indicators took account of health. For example, the Physical Quality of Life Index was based on infant mortality, life expectancy at birth and literacy. I have never been really convinced of the advantage of the aggregate as opposed to the individual indicators. The movement for the use of social indicators does not merely represent some jealous attempt to dethrone GNP as a good measure of development. There is the suspicion that various inputs and policies are consciously or unconsciously adjusted to show maximum effect on the type of indicator used. Thus, if we were to give health and other social indicators pride of place, we might see implementation of the types of development programes which would have change in health status as their primary objective.

This concern for health and development issues was important in the 70's but it achieved even more urgency and relevance in the 80's with the advent of the global economic crisis. This is not the place to detail the sequence of events, but, in brief, the oil shocks of 1973 and 1979 and the slowing of economic growth in the industrialised countries with frank recession in the early 1980s resulted in reduced demand for developing country exports. The recovery of the developed countries has not been associated with the expected increased demand for the developing country primary products. This has been associated with massive borrowing by the developing countries, creation of a large debt, a reduction in domestic investment and consumption and now utilisation of most of their foreign exchange earnings to repay the debt. Dr Williams in his classic treatise *Capitalism and Slavery* proposed that the industrial growth of Europe was financed by the colonies and the slave trade. Now, 150 years after slavery, Carl Greenidge from Guyana, President of the Council of ACP (African, Caribbean and

Pacific) Ministers, begins negotiations for a LOME IV agreement claiming that the economic recovery of the EEC countries in the last part of the 80s has in large been financed by the depressed commodity prices in the developing countries. Some things apparently have not changed!

The economic crisis in the developing countries has necessitated structural adjustment of their economies, and there is evidence that the effects of this adjustment fall particularly heavily on the poor. During the period of economic expansion the poor did not participate equally in the bonanza — with the economic downturn and income reduction they suffered disproportionately, and now with structural adjustment and economic deprivation it is clear that they will again be most socially disadvantaged. In some countries health indicators deteriorated as a result of the crisis — for example, infant mortality rates rose.

Recently, UNICEF under the leadership of Richard Jolly has been advocating that structural adjustment policies should include provisions for protecting the health of the most vulnerable. The argument is that adjustment is clearly necessary — the long term objective has to be renewed economic growth — but adjustment should be carried out with a "human face" (this is again an echo of Dr Williams's definition of development). They propose six main policy components of this approach:

- More expansionary macro-economic policies.
- Meso policies for prioritising and re-structuring resources and activities in favour of the poor, protecting the basic needs of the vulnerable.
- Sectoral policies aimed at restructuring within the productive sector to generate income and raise productivity in low income activities.
- Improving the equity and efficiency of the social sector.
- Compensatory programmes to protect basic health and nutrition of low income groups — public works employment schemes, nutrition interventions, targeted food subsidies and direct feeding for the most vulnerable.
- Monitoring of the human situation so that needs may be rapidly identified and corrective measures taken.

They emphasise that the above policy options are all feasible — many have been tried and found to be workable. One of the more important aspects of this approach is the possibility that it could lead to a new appreciation of the inappropriateness of the development paradigms of the past and the need to seek models of development for the post crisis era which do take account of the legitimate needs of the social sectors — particularly health. Such a

model of development for example would include paying equal attention to social as to economic indicators and subjecting resource allocation in the social sectors to the same kind of economic analysis and scrutiny as has traditionally been used only in the so-called productive sectors.

To summarise the more important arguments so far, health will have an impact on development, particularly through the preservation and improvement of human capital. Positive economic returns result from investment in producing and maintaining health and there are negative economic results from disease and ill health. Especially, in developing countries, there is a steep relationship between income and some indicators of health, but income loses some of its power as a determinant of health status in the more developed countries. The advent of the economic crisis has sharpened the interest in health and development, as negative development has led to deterioration of the health status of the most important groups in terms of human capital preservation. It is proposed that the structural adjustment which is necessary for economic recovery must take place "with a human face."

We will now explore the Caribbean situation to determine to what extent some of the events described above have occurred, but more importantly to search for some lessons for the future.

Our health situation has shown dramatic changes over the past 80 years. Data collected by Professor George Roberts show that at the turn of the century the infant mortality rate in Jamaica was around 200 per 1,000 live births. The life expectancy was about 35 years. I am fond of referring to the findings of the Moyne Commission which visited the Caribbean just after the 1937 riots to investigate the social conditions which were presumed to have triggered what were euphemistically called "disturbances". The Commission recorded that in 1937 the health situation was deplorable. Barbados had an infant mortality rate of 217 per 1,000 live births — one in every five children never saw a first birthday. This was an improvement, because the figure had been 331 in 1928 — one in every three children died before the age of one! At the time when I was born, I had only about a 30 per cent chance of surviving. Mothers of that era might very well have anticipated Derek Walcott's cryptic line "the wages of sin is birth."

Data collected on a Caribbean wide basis since 1950 now show that for the region as a whole the infant mortality rate was 71 in 1950 and this has dropped to 20.7 for 1985. It is worth noting that the greatest fall, a 30 per cent decrease, was between 1960 and 1965. I will refer to this again and to its possible significance. The rate for England and Wales for 1937 was 58 — it took the

Caribbean another 23 years to reach that figure.

George Cumper has undertaken an extensive analysis of the causes of the improvement in health status of Jamaica as reflected by the fall in infant mortality rate. The key factors were the implementation of basic public health measures, increased use of more efficient medical technology, higher incomes, and enhanced public awareness linked to increased literacy. There are two factors which should be noted, however, as contributing to this improvement in public health which were not stressed by Cumper. The first is the political change which occurred in the Caribbean. We note the dramatic fall in infant mortality rate in the early 1960s. This was a time when the Caribbean countries, having decided that the Federation was unworkable, were achieving their own independence and it will be interesting to examine more closely the relationship between the changes of public health policy and changes of political focus. The other point which is well acknowledged in the Caribbean but has not been analysed sufficiently is the role of the individual public health specialists with the drive and dedication which caused change to take place — men and women whose names have been indelibly engraved in the annals of public health — Byer in Barbados, Johnson, Wedderburn, Peat and Moody in Jamaica, Nicholson in Guyana, Boyd in St. Kitts and later the whole Caribbean, Gillette and Commissiong in Trinidad and Tobago, Wynter in Antigua!

A measure of the sophistication and development of a peoples is the extent to which they revere their heroes and take pride in their accomplishments. Just as we glory in our feats in sports, we as a people should also take some pride in the level of our people's health. We can show the world that it is possible for us to achieve impressive improvement in our people's health. Other countries of the region such as Chile, Costa Rica, and Cuba make no secret of their advances in public health. Our Cuban friends point to their health services as one of the triumphs of their revolution and medical writers hold up Chile and Costa Rica as examples of what can be done as a result of sound public health policy. It is true that many of our systems are fragile, and many of the hard won gains are being threatened, but we should still be holding up our heads and inviting more of the world to see what has been done with our relative meagre resource.

But pride should not lead to complacency; these improvements in health status are not the best in the hemisphere. We see Canada and the United States with infant mortality rates of around 10 and we should ask if there is any reson why this cannot be achieved in the Caribbean. There is a tendency, especially in donor agencies

and countries to look at the Caribbean and say — "you have done very well in health, particularly compared with some of your neighbours or with some African countries." The implication is that there is some pre-ordained level to be achieved by us which is below that in the developed countries. Our experience in cricket and scholarship should have taught us by now that if we place a sufficient emphasis and importance on health there is absolutely no reason why we cannot aspire to, and achieve levels as good as those which obtain in the so-called developed countries. Although, as we have shown, there is a correlation between income and infant mortality rate, there are enough examples of deviations to indicate that it is possible to have low infant mortality rates at levels of GNP which would not normally be associated with such. This disparity is seen even in the Caribbean — the Bahamas with a GNP per capita of about US$10,000 has an infant mortality rate of about 26 while Dominica with a GNP of about one eighth of that figure has an infant mortality rate of about 20.

How did the economic crisis and the consequent various adjustment programmes affect the health sector and health indicators in the Caribbean? The data show that the Caribbean governments, perhaps with the exception of Guyana, did not discriminate against the health sector: taken as a group, the percentage of recurrent public expenditure they devoted to the health sector actually rose slightly between 1980 and 1987. The performance of some countries has been impressive; recurrent health expenditure in Dominica as a percentage of government spending as 11.9 per cent in 1980 and rose to 17.9 per cent in 1985. In the majority of the Caribbean countries the per caput expenditures in health between 1980 and 1987 have gone up or remained the same. The same picture emerges with respect to education. Expenditure on health and education as the major social services has remained high and the two combined account for about 30 per cent of government expenditure.

The case of Jamaica is illustrative. The popular perception is that as a result of the economic crisis of the early '80s the health services were decimated and starved for funds, and that childhood malnutrition was rampant. In fact, during the 1980s the per caput recurrent expenditure in the health sector did not decrease and both governments adopted various measures designed to lessen the impact of the crisis on the poor. The data show that, overall, while there appears to have been a decrease in childhood malnutrition between 1970 and 1978, the situation was pretty much the same in 1985 as it was in 1978. At a time when over 40 per cent of Government expenditure is used to repay the public debt, per caput expenditure

on health in fact rose between 1977 and 1985. The distribution of expenditure in the health sector did change however, and there were massive layoffs of personnel such as the community health aides. The previous government, however, was so concerned about the bleak prospects for the social sector that it launched a massive social well-being programme and tried to borrow heavily to repair the physical plant and to correct some of the deficiencies.

The question is why the health sector was relatively well protected in the Caribbean in this time of crisis and the health indicators in most countries continued to improve. There can never be any simple deterministic explanation. It is possible that the social democratic process in the Caribbean has been so firmly entrenched that there is implicit acceptance of the social necessity of providing for health. Perhaps, we have reached the level of political and economic development which automatically accepts the principle of human capital development and appreciates the necessity of investing in health. Perhaps all governments share the view which was expressed in the election manifesto of the current Jamaican Government which committed itself to a "healthy nation, not simply as a reflection of its health policies, but as an inherent aspect of its determination to put the development of our people first." Another possibility is that health has increasingly become a socially sensitive topic and the media have contributed to developing in the public an awareness of not only what acceptable health standards should be, but also what happens in other parts of the world as a result of neglect of the health sector. This translates into pressure from the articulate electorate, assisted frequently by vocal Medical Associations. The net result is that the Caribbean Governments are spending about five per cent of the GDP on health — a figure similar to many developed countries. In one country the figure was 16 per cent in 1986.

One of the issues of greatest interest to me is whether the situation in the Caribbean can provide empirical evidence that the improvement in health was an engine for and an instrument of development. De Lisle Worrell analysed the performance of the Barbadian economy between 1946 and 1980 and showed that there was an impressive record of postwar economic growth, characterised by increased productivity but with a relative change in the sectoral contributions — a decrease in the agricultural sector and an increase in the tourism and manufacturing sectors. Tourism multiplied its GDP share five times but its employment share only twice. Generally speaking, this shift from agricultural to more skilled work took place without any significant rise in unemployment and an increase in labour productivity. I would propose that

this increased labour productivity would have been impossible without a significant improvement in health status. If one examines the value added per worker as a measure of productivity and compares it with the fall in infant mortality rates there is obviously a correlation, but if one analyses it chronologically, the greatest and steepest falls in infant mortality rates anteceded the increased productivity. One interpretation of the data is that the investment in human capital represented by investment in health, and manifested by a decrease in infant mortality rate, was a major factor in promoting economic growth. Between the years 1946 and 1960 when the infant mortality rate was falling most rapidly, Barbados saw an average 12 per cent annual increase in health expenditure. The same case can be made for education — it too contributes to human capital formation, but whereas education is a long-term investment which in general prepares and adds to the quality of the product, health increases the units of labour as well as increasing their productivity. I think that similar analysis done for the other Caribbean countries will show the same: that the dramatic improvement in health status came before there was evidence of the economic growth.

I wish to address now the major problems which will face the health sector in the Caribbean and the relation between these and the region's development. The epidemiological profile of health in the Caribbean is changing. The countries, with the exception of Guyana, do not face the problems of the traditional infectious diseases. The major problems fall into two categories — those associated with lifestyle and those which derive from changes in the environment. Among the lifestyle problems I include AIDS and the chronic diseass like diabetes and hypertension, cardiovascular disease, alcoholism and drug abuse. When I was a medical student, myocardial infarction was a rarity — now it is a common disease entity in our hospitals. Our disease profile is looking more and more like that seen in Boston or London.

In the case of environmental concerns, it is very easy to see that since tourism is a major money earner and since most of our attraction as a tourist destination is based on our environment, environmental health is critical to us. The relationship between health and tourism in development terms is very close — not only does the health of the people and the cleanliness of the environment contribute to the tourism product, but health tourism does occur as well. From time immemorial tourists have visited spas and places of natural beauty specifically for health purposes.

The approach to the prevention and control of the lifestyle mediated diseases is different from that taken to deal with the

classical infectious diseases. Firstly, there is the need to devise ways and means to change the behaviour associated with those lifestyles, and by and large the health establishment is poorly equipped to do this. The traditional biomedical model of disease which gave rise to the treatment paradigms on which the majority of our health workers have been reared do not deal adequately with the behavioral aspects of health. And the secret to stimulating this change is not to be found in a potion developed by doctors — it is in the use of information to facilitate change. This appreciation of the value of information is one of the most important aspects of the direction our development will take. Increasingly, it is in the use of information as an instrument of change that economic and social development are finding common ground. In the case of health, it is being appreciated that wellness — not simply lack of disease — is associated with certain patterns of behaviour. More benefits of wellness come to those who by training have been conditioned to internalise that information and use it to modify their perceptions of health risks and inform the preventive or corrective actions they take. This is the reason why smoking is decreasing in the professional classes — not because they are wiser, but because they have access to and utilise the information on the dangers of smoking. To the extent that the Caribbean has that kind of socio-political development which permits and promotes wide dissemination of information and promotes the use of that information positively, we will see improvements in the prevention and control of these diseases. Let me cite a columnist in the *Washington Post*:

> "Life is increasingly regressive because the benefits of information are distributed disproportionately to those already favoured by many advantages. The more certain needs of information matter, the more unequal society and life becomes."

It is crucial for the Caribbean to avoid this disproportionate distribution.

Beside the disease or purely health problems which I see the Caribbean having to face, there is another problem which may have an even greater effect on the health of our people. This problem derives from the organisation of our health services. We have seen that the health systems of our countries consume a significant portion of government revenue, yet the management of those systems is primitive. The common health services system in the Caribbean is the public assistance model and at best over the years we have done little beside patch it up. We have steadily increased expenditure in the system without serious examination of choices — without serious analysis of the financial and economic implica-

tions of changes and with the tendency to continue to allot resources pretty much on the basis of historical behaviour or political imperatives. More serious thought simply has to be given to the management of the health services. There must be loud public outcry for the kinds of analyses which will lay the basis for public policy formulation in this area. Our history is full of statements about the need to rationalise expenditure in the services — including the naive assertions that we should stop spending money on hospitals and spend it on less sophisticated methods of care. There is no choice for the Caribbean in this matter — there has to be both: our genius has to be to so increase the efficiency of the whole system that there are more resources available to be spent productively. These kinds of discussions and analyses have to take place in times of plenty and not only when the lean years are upon us.

Finally, I would like to address the contribution that health has made to the Caribbean development process which has been uppermost in my mind for the past four years. I refer to health as a mechanism to promote functional integration in the Caribbean, and thereby contribute to that kind of unity which can withstand the political and economic mini-storms for which our region is famous. We share so many health problems that collaboration can only lead to everyone winning. I have described elsewhere some of the background to co-operation in health in the Caribbean, but I wish to focus briefly on a recent development of the CARICOM Ministers of Health who were stimulated by the Director of the Pan American Health Organisation, to mount a health initiative which they called Caribbean Co-operation in Health (CCH). PAHO and CARICOM jointly serve as the Secretariat for the CCH which was formally launched at the Ministerial meeting in July 1986, and approved by the Heads of Government Conference of the same year.

The CCH seeks to assist the Governments of the Caribbean to improve further the health of their people by identifying and utilising seven strategic priority areas as entry points for facilitating the more productive use of resources and promoting technical co-operation between the countries. It should stimulate inter-country, inter-agency and inter-institutional collaboration and mobilise both national and external resources to address the most important health problems. The priority areas which were chosen on the basis of the epidemiological situation in the Caribbean are environmental protection including vector control, human resources development, chronic diseases control and accident prevention, strengthening of the health systems, food and nutrition, material and child health

including population activities, and AIDS. Over a hundred national and sub-regional projects have been developed in these priority areas and there has been intensive and successful promotion of the initiative within and outside of the Caribbean. One positive result of the CCH has been to enhance national capability in project development.

Although as of now approximately US$31 million have been mobilised for support of projects in the seven priority areas, the mere acquisition of external funding is not the sole criterion of success of the initiative: it is much more important to develop and stengthen the intra-Caribbean linkages in health. I would be false to my own convictions if I did not insist here that if the Caribbean governments had worshipped more faithfully at the altar of functional co-operation, some of the problems of collaboration in other spheres might not have been visited upon us. We who work in health have great expectations for the CCH, not only as a model of sectoral organisation which other sectors beside health might emulate, but also as another instrument of functional co-operation which can be used to give more shape and form to our integration movement.

The idea of co-operation in health would have pleased Dr Williams. He championed hemispheric and Caribbean co-operation as a way to promote development. In the historic meeting of Chiefs of State in Punta del Este 22 years ago, he spoke of the need to make sacrifices for co-operation. He said:

> "... co-operation will undoubtedly involve sacrifices, sacrifices that will at all times test most severely the will to co-operate. If, however, the will is inflexible, if we survive the test no matter how severe, the results may prove to be a glittering achievement redounding to our foresight and statesmanship and entailing material benefits not the least to those who may initially have appeared to have made the greatest sacrifice."

I hope I have shown just cause and reason for considering health as being intimately linked with and perhaps indispensable for development. But I would like to go further, and ask that the moldlers of Caribbean opinion be not only passive acceptors of the premise, but that they be aggressive promoters of, or in the words of Martin Luther King to be "drum majors" for, certain propositions or lines of action which flow from that thinking. Firstly, they must not let our visions of the health goals and health standards of the Caribbean people be constricted by the perceptions of others as to our proper place in the health hierarchy of nations. We must cast about for the mechanisms for improving the efficiency of the delivery of the health services — to put away some of the paradigms which have no underpinnings but those of history or of

partisan politics.

Secondly, we must continue to hold to the thesis which our Governments have thus far demonstrated by deed to be important to us — namely that it is right to invest in the health of our people. Human capital development is a necessary, though not sufficient, ingredient for the overall development of our countries. In addition, if there were further need for justification, the health of the people is an end of the development process in itself. Thirdly, we must insist that all the major health or health related institutions which carry the name Caribbean or West Indian perceive of their actions as having a context wider than health care service, training, advocacy or research. We must compel them to see that they contribute to the development of the Region. Fourthly, we must plead and urge and advocate that the information age does not have to do merely with computers. One of its most important aspects is the provision of information to all the people in a form they can use — in this case information about health to allow them to make the life choices which will contribute to their wellness and that of the Region.

Finally, we must see and embrace health as one of those areas in which all men and women will find agreement, one of those areas of functional co-operation which, if strengthened, will serve to bring the people of this Region closer together.

If these things do come about, there will be no doubt that health will have taken its place as a major player in the development game.