country as a whole. For this, the basic necessity is to enlarge the size of the divisible pool and to allow larger transfer of resources from the Centre to the states.

The memorandum makes four specific suggestions on sharing of tax proceeds: the surcharge on income tax should be brought under the divisible pool or it be merged with the income tax; 100 per cent of the proceeds of the income tax together with the surcharge should be in the divisible pool; at least 50 per cent of the proceeds of the corporation tax should be included in the pool; and the size of the divisible pool of the Central excise duties should be raised from 20 per cent to 60 per cent and all types of excise, special and regulatory duties and cesses should be brought within the divisible pool.

BANGLADESH

Politics of an International Health Programme

John Briscoe

THE Cholera Research Laboratory (CRL) was established in Dacca, East Pakistan, in 1960 by the South East Asia Treaty Organisation (SEATO). The CRL is presently operated under a bilateral agreement, which expires in September 1978, between the governments of the United States of America and Bangladesh. Over the past two years a small group of American scientists who had previously worked, and are again working, at the CRL have taken the initiative in attempting to transform the CRL into a permanent international centre for health research. Support is being sought from the developed countries of Western Europe, Oceania and North America and from Japan. The Ford Foundation has provided $ 140,000 to cover the costs involved in the transformation.

In February 1977 two articles in the *Bangladesh Times* publicly expressed the concern of many Bangladeshis at this process. Subsequently there have been numerous articles in Dacca newspapers on the undesirable implications of the proposed institute for the development of health services and for the further reduction in the ability of Bangladeshis to control their own destiny. The CRL is a health institution controlled by the United States of America. Since it is a health institution, the CRL cannot be understood without reference to the rest of the health sector in Bangladesh, and since it is a US-controlled organisation the nature of the relationship between the US and Bangladesh, too, must be considered.

[The author of this paper, a foreign scientist who has worked at the CRL for 15 months, is the first employee of the CRL to publicly express concern at the adverse implications of the proposed institute for the health of the people of Bangladesh.]

Characteristics of Health Sector

Health in Bangladesh is poor. The crude death rate, which is about 80 per cent higher in rural than urban areas, averages about 17 per 1,000 per year; average life expectancy at birth is 48 years; infant mortality is about 140 per 1,000 live births; 40 per cent of all deaths occur in the one-to-four age group and maternal mortality is 5.7 per 1,000 live births. Most deaths are attributable to infectious diseases and malnutrition. Since the mid-1960s the proportion of the population which consumes less than 80 per cent of the required intake of calories has risen from 5 per cent to 41 per cent while the income of the top 15 per cent of the population has increased. Excepting the eradication of smallpox, which accounted for one of every 40 deaths in 1960, and the reduction in the incidence of malaria, very little progress has been made in the control of infectious diseases over the same period. It thus seems certain that health in Bangladesh is getting worse for the majority of people.

In response to these health problems, the health sector of Bangladesh exhibits the following characteristics:

(1) Hierarchical, hospital-based, specialised medicine, as opposed to democratic, home- and clinic-based, deprofessionalised medicine, is fostered. Standards in medical schools are set so that graduates may practice in developed Western countries. Training emphasises the diseases which are prevalent in the rich countries.

(2) Urban, technologically-intensive medicine, as opposed to rural, labour-intensive medicine, is practised. Despite the fact that over 90 per cent of the population live in rural areas, 70 per cent of all recurrent expenditures for health are spent on hospitals located in the towns, and 85 per cent of the doctors are based in urban areas where they are available to 'entitled employees' or those who can pay for their services. While the First Five Year Plan has attempted to address some of these imbalances by devoting 58 per cent of the health sector development allocations to thana-level health complexes, it is technologically-intensive, hospital-based curative medicine which these health centres will deliver. As in the urban areas, it is largely the rich in the villages who benefit from the presence of these health centres since the bulk of the time of a Thana Health Centre physician is spent on private practice and since most medicines, either due to a genuine shortage in supplies or due to the diversion of drugs onto the black market, have to be purchased. The high price of drugs is directly linked to the domination of the drug industry by foreign corporations. In one typical drug company 76 per cent of the shares are owned by Americans, with 6 per cent of the shares distributed to local doctors for the explicit purpose of encouraging the sale of the products of the company. Since the primary purpose of these companies is to pay high dividends to their shareholders, medicines are expensive and beyond the reach of the vast majority of the population.

(3) Exclusive reliance is placed on modern Western medicine as opposed to the integration of modern and traditional medical systems. Despite the fact that about 90 per cent of the population seek medical care from the traditional village healers, there has been no attempt at integrating modern interventions of proven effectiveness into a system that is well established and widely accepted.

(4) Curative medicine and the delivery of personal health services, rather than preventive medicine and environmental services, are emphasised. When compelled to do some preventive work in the rural areas, the leadership has characteristically chosen military-style campaigns against specific diseases such as smallpox and malaria, avoiding the messy problems associated with mobilising the 'dirty

superstitious and illiterate' masses. The pattern of production in this health sector, in which the CRL has occupied a niche comfortably for 15 years, is thus very similar to the pattern of production of health services in most capitalist developed countries. Where malnutrition and infectious diseases are the main causes of morbidity and mortality, the best strategy to combat the problems which affect the majority would be precisely patterns of production opposed to those currently prevalent in the health sector. This would imply an emphasis on rural, labour-intensive and community-oriented medicine, while giving far greater priority to the preventive and environmental health services than to personal and curative services.

Determinants of Underdevelopment of Health

Poverty and inequality are both the fundamental determinants of poor health for the vast majority in Bangladesh and the factors which account for the lop-sided development of health services. While the central role of the colonial relationship with Britain in the development of this poverty and inequality is well known and need not be restated here, it is necessary to trace certain consequences of this colonial history for the development of health services in this area.

Western medicine was introduced into India in the eighteenth century, principally to serve the British military and civilian populations. Medical services were subsequently made available to a very small, select segment of the local population. The colonial character of the health services profoundly affected almost all aspects of medical education, including the institutions, the course content and the value system and social outlook of local physicians. Medical students were drawn from the elite and the select among the select educated further in the royal colleges. This arrangement proved convenient to both the colonialists and the few privileged Indians. Indian physicians were assured of power, prestige, status and money at home, while their foreign mentors were assured of a considerable influence on them because the top leadership of the medical profession in the sob-continent remained heavily dependent on them.

With the advent of formal independence in India and Pakistan a new rationale was needed to justify the perpetuation of this system of relationships. This neo-colonialist ideology has been clearly enunciated by the US professor and administrator, W W Rostow. Rostow's exposition on underdevelopment ignores the historical and contemporary relationships between the rich and poor countries and posits that poverty can be overcome through cultural and technological diffusion from the rich to the poor, and through the augmentation of scarce national capital. It is this sociology which provides the ideological basis for institutions such as the proposed international centre for health research.

The cultural diffusion argument finds expression in the health sector in the necessity for maintaining the highest international standards which have been evolved in response to the needs of the bourgeoisie in developed countries. No attempt is made to define standards which take account of the needs and resources of the majority of Bangladeshis. The elite who control the health sector and their foreign advisers lay the blame for ill-health squarely at the door of the poor. Until the 'anachronistic set of beliefs' and 'backwardness' can be educated out of the majority of villagers, programmes should be geared to the more motivated members of the community, namely the rich and the educated.

In terms of this theory medical technology will be developed in sophisticated local or foreign laboratories (such as the CRL) and will then diffuse out to the general population. The fact that, for example, an effective tetanus vaccine is available and yet half of the neo-natal deaths in rural Bangladesh are due to tetanus is ignored by proponents of this theory.

The capital scarcity argument is used to explain the fact that no modern health services are available to the majority of the population. While it is certainly true that there is insufficient capital in Bangladesh given the present expenditure on prestigious national research institutions, the maintenance of a large bureaucracy and the present system of training highly-qualified doctors, for Taka 10 per capita per year — the per capita health budget in 1975 — the entire population could be provided with primary health and family planning services. Under the present system only a small proportion of any additional capital in the health sector is used for improvement of services to the majority of the population.

Foreign Aid and Health Sector

The standard Western conception of Bangladesh is of a desperately poor country which is of no geo-political significance and which receives aid only because of strictly humanitarian concerns. A recent report of the Committee on Foreign Relations in the US Congress has shown that the purpose of major US aid to Bangladesh — the delivery of $400 million in food aid — has been to help US agri-business dispose of unsold surpluses, to finance the running of the Government of Bangladesh and to 'buy' urban stability by suppressing food prices. As shown by the critic in *Bangladesh Times*, the reasons for the funneling of $ 2 million of US funds annually to the CRL also appear to be more complicated than pure humanitarianism.

The CRL was set up by the South East Asian Treaty Organisation, a mutual 'defence organisation' through which the US and its allies conduct the Vietnam War. SEATO's stated objective in funding the CRL was "to

lift the standards of the people and to bring economic and social progress to these countries ... because they realised that it was the surest method of protecting [these] people from aggression and from the subversion which so frequently comes from within". Since the CRL has failed so completely to effect any improvement in the social and economic condition of the people of Bangladesh, there were apparently other reasons which prompted SEATO to pour so much money into the CRL. An indication of the importance of cholera research to the US Government in its involvement in South East Asia is that between 1963 and 1971 69 per cent of direct US assistance for cholera emergencies went, not to the endemic areas of Bangladesh, but to Vietnam. If this figure included the contributions by other US government agencies such as the Department of Defence, who provided technical teams, air transport, etc, the proportion going to the war zone would have been far greater.

Since the cessation of the Vietnam War the US Government has understandably lost some of its interest in the control of cholera. While USAID has continued to finance the CRL the nature of the research undertaken has changed considerably, with population and family planning research assuming an increasingly important role. The major population control study at the CRL is financed by the Office of Population at USAID and has been used by the head of that office to 'prove' that population growth can be reduced without any change in health conditions, poverty or social injustice. As has been the case since the introduction of Western medicine in India, international health programmes seem to have more to do with the needs of imperialism than with the health needs of the poor countries.

The present leaders of the CRL have recognised some of the shortcomings of the institution and have initiated some constructive changes, particularly in the areas of health service delivery and training. However, since the Director and the four Scientific Directors have all previously worked at the CRL for a total of about 30 years, it appears unlikely that the nature of the institution will or can change.

The reaction of the CRL to criticisms concerning the proposed institution has been predictable. Realising that the face of American domination was no longer acceptable the CRL has responded in the classic tradition of Anglo-Indian colonialism. The survival of the institution as an outpost for foreign researhers is seen as contingent on the development of a small number of highly visible Bangladeshis who have a powerful vested interest in maintaining the *status quo*. Thus two Bangladeshi scientists have been designated to the post of Scientific Director, given expensive rent-free houses (as are all foreign employees) and assigned a major role in public relations at the CRL. For the other 700 Bangladeshi employees, employment conditions remain substantially unchanged.

The links between the local elite and the institution are being further reinforced by the active recruitment of foreign-trained Bangladeshis who would not return except on the promise of highly-paid positions in a prestigious institution. As has been the case in India, these professionals are likely to further distort the priorities of the health sector by promoting the creation of new doctors who wish to specialise and go abroad.

The apparent reason for the choice of Bangladesh as the site for the proposed international centre is that the CRL provides an excellent foundation on which to build a sophisticated research institution. But this appears to be a highly unsuitable base on which to build if the health of the people of Bangladesh is of central concern. There may be a place for skilled foreigners who wish to assist, but this role would appear to be, not in foreign initiated and dominated institutions such as the CRL or the proposed international centre, but in institutions which have been developed by Bangladeshis and which are addressing themselves to the fundamental factors which are responsible for ill-health in Bangladesh. As more and more third world countries refuse to accept foreign-run institutions — the Johns Hopkins programme which operates through the CRL, for instance, was thrown out of India several years ago — the number of available sites for an institution such as the proposed international centre has progressively declined. It appears that the extreme dependence of the Government of Bangladesh on foreign assistance has seriously compromised the country in dictating the course of its own development.

I have discussed the CRL and the proposed changes at length with the villagers with whom I work in Matlab Thana. All of them feel that the continued operation of the 'SEATO Company' (as the institution is known to them) would be to their benefit since it provides employment and a valued service which would otherwise not be available. As I have talked with these people, however, they have all sooner or later asked why the CRL came to Matlab in the first place. Some suggest that the SEATO Company is hoping to make a lot of money from the development and subsequent sale of a successful cholera vaccine; some believe that the numerous blood samples which they have given are sold overseas; all feel sure that there must be some reason other than the stated one of a deep concern for the health of the people of Matlab Thana and Bangladesh.

In conclusion, while the CRL is certainly neither the most important foreign institution in Bangladesh nor the most important factor in the inappropriate development of health services in this country, the permanent establishment of such an institution would appear to have adverse direct and indirect effects on the long-term prognosis for the improvement of the health of the people of Bangladesh.