



# The Doctor·Go·Round

Health care in Britain and  
the developing world: medical  
manpower, migration and aid.



# **The Doctor·Go·Round**

Researched and written by

Claire Whittemore

Editor: Robin Sharp

**OXFAM PUBLIC AFFAIRS UNIT**

Parnell House, Wilton Road

London SW1

Tel: 01-828 0346

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Reports in this series are intended as a contribution to public debate on issues of world development and it is hoped that policy-makers and planners will take them into account. They reflect Oxfam's concern for human rights and a belief that new policies are needed to meet the challenges of a rapidly changing world.

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## INTRODUCTION AND SUMMARY

- 1 For hundreds of millions of people throughout the world, especially in the rural areas of Africa and Asia, medical care is scarce or non-existent. Young or old and whatever their illness or injury, they seldom have any means of obtaining proper treatment. The average person in Britain receives more attention from a doctor in a year than someone in Ethiopia can expect in a lifetime.
- 2 Though varying from one developing country to another, the principal causes of inadequate health care can be readily identified. They include very limited funds available for the provision of public services; government policies which frequently give low priority to basic needs and thus an unbalanced distribution of funds between sectors; the misdirection of health funds into services benefitting only the urban minority, and—until recently at least—bad advice from the aid-giving nations which encouraged the building of grandiose hospitals and the training of doctors and specialists in disproportionate numbers to go with them.
- 3 Any effective strategy to alleviate the worst poverty in the developing countries must include provision for better health services, so designed and distributed that they are available to all. As the factors cited above indicate, it is their governments which must find the political will to provide the main thrust. In supporting these objectives, however, enlightened policies on the part of aid-giving nations such as Britain can act as a valuable incentive for movement in the right direction.
- 4 The purpose of this report is to suggest directions for British policy which could help more effectively to meet the health needs of developing countries and which could be implemented without detriment to—indeed to the advantage of—our domestic health services.
- 5 Part One reviews some aspects of health care in the developing world, including medical training, migration flows and the key role of auxiliaries. Given the enormity of the supply/demand gap, it points out that health care needs cannot be met by any imaginable increase in the provision of doctor-services, in view of

the prohibitive costs. The case is therefore argued for a much greater concentration of available health resources on the provision of rural health schemes, using a full range of auxiliary staff to provide the outreach for small teams of fully-qualified personnel in regional or national centres. It also indicates measures the British government could take to assist developing countries in providing health services more relevant to the needs of their people.

6 Part Two examines British medical manpower policy and, in particular, the use of doctors from developing countries in our health service. It questions our continuing dependence on the latter source—in practice if not as a matter of policy—given that their future availability is increasingly unsure. And it concludes that we should be helping the poor countries to retain their doctors rather than giving them preferential work permits in order to prop up the National Health Service.\*

7 The report concludes with a number of recommendations concerning British assistance to the developing countries and corresponding measures required in the orientation of health services in Britain.

\* To avoid possible misrepresentation, we should make it clear that Oxfam would oppose emphatically any suggestion that overseas doctors now in Britain be expected or required to return to their countries of origin.



## **PART ONE—HEALTH CARE IN DEVELOPING COUNTRIES**

### **Problems of Health Care in Developing Countries**

- 8 In most developing countries the great majority of people live on the land and this calls for health policies oriented primarily to rural needs. However, the governments of these countries as a rule do not command either the financial resources or facilities to meet the needs of all their people without spreading resources more thinly than they have so far been prepared to attempt. What facilities and techniques for training they do possess have been imported, usually without sufficient adaptation, and are based on expensive, high-technology medicine inappropriate to poor, rural populations. These problems are compounded by structural imbalances within individual countries, producing situations such as that in India where 80 per cent of the country's doctors live in the cities while 80 per cent of the people live on the land.
- 9 In the latter phase of the colonial period significant efforts were made in some countries to introduce health schemes relevant to the needs of rural communities. But, broadly speaking, these schemes were not developed enough to have taken root and several countries after independence adopted western models of health care incapable, on any affordable scale, of providing the outreach required for widely dispersed rural populations. The adoption of western methods was too often encouraged by well-meaning international aid agencies, advisers and missionaries. In addition, the educational systems adopted in these countries have tended to perpetuate an attachment to professional elitism which provides fertile ground for the growth of restrictive practices.
- 10 In terms of manpower, it should be apparent that health services catering to the majority needs of a developing country require designing—like all other genuine development programmes—from the bottom up: that is to say, starting from the requirements of people in the smallest communities. Local health workers at this level should be linked to a district medical team, which in turn would have access to a regional hospital and from there, if necessary, to more



specialised facilities at provincial or national level. Apart from the relatively few countries which have introduced comprehensive rural health schemes, reliance is still placed largely on the qualified medical practitioner. This explains a large part of the imbalance of medical care within some developing countries, given that doctors who qualify in large training hospitals are generally reluctant to leave the city for a rural practice. Those that do, apart from finding themselves intellectually isolated and earning less, often have to discover the hard way that the modern techniques they have learned are inapplicable to a rural environment.

- 11 The World Health Organisation is currently preparing recommendations to the effect that undergraduate training should reflect the needs of the country concerned and that numbers should be related to the expected demand for their services.<sup>1</sup> This move is to be welcomed, though many will judge it too little and too late. (These recommendations are expected to appear in the first part of a major survey of doctor migration by WHO due to be published mid 1976.)<sup>2</sup>
- 12 One result of the mismatch between job training and job requirements is that doctors take their skills abroad, seeking higher salaries or further qualifications in the western world. Thus the investment in their training is lost to their country—at least for some years—representing a significant misuse of limited resources. (In India, the cost of training a doctor is estimated at about £5,000 and in 1970 over 6,000 Indian-trained doctors were working in Britain, compared with about 15,000 serving the whole of India's rural population of 450 million.)<sup>3</sup> Even if the emigrant doctor returns home, as the majority do after three or four years, it is most likely to be to a highly paid urban post, further exacerbating the bias in favour of services in the cities.
- 13 A number of developing countries have taken steps to prevent or discourage doctors from going abroad after completion of their training. Pakistan, for example, has taken powers to refuse exit permits to doctors and other professionals wishing to leave the country.<sup>4</sup> Less restrictively, a variety of measures is available to discourage migration. The Indian government's decision to withdraw recognition of British post-graduate qualifications from 1977 will have this effect.<sup>5</sup> And Pakistan, in addition to exit controls, has

announced that doctors and other professionals who are allowed to work overseas will have to remit to their country up to 20 per cent of any income earned abroad.<sup>6</sup> While disincentives offer a legitimate means of reducing this loss of manpower, restrictions on the movement of workers in a free society should be resisted on principle, since they are an infringement of human rights. Any regulations introduced to halt this brain drain should therefore be accompanied by measures to redress whatever structural imbalance made them necessary in the first place.

## **The Role of Medical Auxiliaries**

- 14 Health care in the first place is the responsibility not of the doctor but of the individual. This makes a strong case for regarding as the linch-pin of any health service the person with whom the individual first comes in contact when seeking medical help. In the advanced countries this is, rightly or wrongly, the doctor himself. For most of the world's people that contact is, or should be, with someone known as the community health worker, barefoot doctor or village health worker. It is these workers, together with various grades of trained personnel called medical aides, health post orderlies or medical assistants, who are described by the generic term 'medical auxiliaries' and whose purpose it is to intervene at different levels before (and after) the patient sees a doctor, although the patient may well not need to see a doctor at all. The term 'auxiliary' unfortunately carries the implication that the worker is a second class doctor within a hierarchical structure. For most of mankind, it should be emphasised, there is nothing auxiliary about 'auxiliaries'.
- 15 Curative health care as practised today in the advanced countries relies on expensively-equipped hospitals run by expensively-trained personnel, with a high proportion of doctors to patients. Hitherto there has been adequate finance to pay for all this and to back it up with the public health services which are themselves a form of preventive medicine: clean water on tap, sewage disposal, food-hygiene regulations, etc. The developing countries as a group simply do not have the resources to provide hospitals like ours with adequate public health support for all their people. It can be argued that even some western nations are

approaching the limit of their ability to afford this kind of health care system.

- 16 A developing country's medical manpower policy should thus be directed to two main objectives: the provision of a comprehensive network of health workers delivering a basic form of primary health care to all its people, and training for doctors which will give them the appropriate skills and attitudes to work effectively with rural communities. Where a country's health service budget cannot be increased to mobilise greater effort on both fronts simultaneously, the first of these objectives should take priority.
- 17 Over many years some of the leading authorities have sought acceptance for this balance of priorities. While generally accepted in theory, however, only a few countries are in practice seriously expanding their output of auxiliaries.<sup>7</sup> Moreover, in many places where they already exist, auxiliary numbers have been steadily reduced, the new leadership and class structure of former colonies in Africa and Asia encouraging the emergent medical profession to emulate European systems of medical care.

### **Costs and Benefits of Schemes Using Auxiliaries**

- 18 A health system making full use of auxiliaries is not only more responsive to rural health needs but also, in terms of training, places far less strain on a country's educational budget than a service centred on its qualified physicians. There has been much research into the training requirements and scope for use of various grades of health worker and Table 1 indicates the educational level needed in each main category, together with the estimated average cost of training and supporting them proportionate to the equivalent costs for a doctor.
- 19 Within each category, the proportionate costs will of course vary from one country to another. To cite one example, estimates for Tanzania indicate that in 1974/5 the cost of educating and training one medical faculty graduate was £14,700, for a rural medical assistant £880, and for a rural medical aide £425.<sup>8</sup> In other words, eight medical assistants and twice as many aides—all for the price of one qualified doctor.

	<i>Professional</i>	<i>AUXILIARIES</i>		
		<i>Senior Health Worker</i>	<i>Junior Health Worker</i>	<i>Community Health Worker</i>
Examples	Doctors. Dentists. Nurses (in some western countries).	Medical Assistants in E. Africa or Papua New Guinea. Health Officers in Ethiopia. Doctor Auxiliaries.	Medical Aides. Health Post Orderlies.	Barefoot Doctors. Village Health Workers. Part-time Health Workers.
Basic Education.	Primary School. Full Secondary School. University.	Primary School. Less than full Secondary School.	Primary Education.	Any Education.
Technical Training	3-4 years Specialist Training.	3-4 years Technical Training.	1-2 years Training.	Informal – on the job.
Total Formal Education	More than 18 years.	More than 9 years.	Less than 9 years.	Possibly no Formal Education.
Cost of training*	100	5	2.5	1
Cost of salaries*	100	50	25	10 or less.

\* Approximate average cost of training / salaries where professional = 100.

Table 1<sup>10</sup>

Similarly, though the difference may be less dramatic, the salary paid to an auxiliary after training is a fraction of the doctor's. In Tanzania again the three categories would earn basic salaries of £975, £440 and £220 per annum respectively.<sup>9</sup>

- 20 Applying first aid, treating minor complaints and identifying more serious illnesses for referral to other facilities can be the function of auxiliaries in a rural community health programme. They can also be trained to undertake family planning programmes, mother-and-child services and nutrition and immunisation programmes for the under-fives. In addition they may advise and educate the community about public hygiene and help in the control of communicable diseases such as tuberculosis and leprosy.
- 21 Working with a team of eight or more auxiliaries, one doctor's services can be spread to cover a population of at least 10,000—depending on population density. On his own, the doctor will be able to handle only about one-tenth of that number. The team concept is important, with the auxiliary/doctor ratio matched carefully to the particular district or region, because neither can operate effectively without the other.
- 22 Medical projects making use of auxiliaries are supported by Oxfam in several countries. One of these, the Community Rural Health Project at Jamkhed, provides a case-study of the type of rural health care which could be repeated on a large scale by governments (see Appendix). The World Health Organisation has cited the Jamkhed programme as a good model in its field.

### **British Medical Aid Overseas**

- 23 The British government in its overseas aid policy is now clearly and commendably committed to assisting the development of health care systems in the poor countries which are "capable of serving all sections of the community." In a fact sheet on medical aid,<sup>11</sup> the Ministry of Overseas Development (ODM) contrasts its new approach with the previous policy under which a large part of British aid "was to meet requests for new hospitals, or the expansion of established ones."

In line with the overall aid strategy of helping the poorest people in the poorest countries, as outlined in ODM's 1975 White Paper,<sup>12</sup> British medical aid now "is being increasingly devoted to community health and preventive health schemes in rural areas, rather than to large hospitals and specialist curative services."

24 This change of emphasis must be warmly welcomed, along with ODM's statement that it is being reflected in the strategy for research funded by the Ministry in the field of tropical medicine and in its training programmes. It is unfortunate, in this context, that the Ministry can provide no figures to show what proportion of the official aid budget is being directed towards health programmes in the rural sector. In reply to a recent parliamentary question, the Minister stated: "I cannot give a precise figure. But there is no doubt that the greater part of our medical aid benefits rural populations."<sup>13</sup> Despite this reassurance, evidence is still not available as to the extent to which the declared policy has actually influenced project allocations.

25 Until ODM is prepared to be more forthcoming about the implementation of this policy, legitimate doubts will remain about the degree to which one has followed the other, for two important reasons. First, because other aid donors already in the field (e.g. the World Bank) have experienced great difficulty in identifying suitable rural projects for their support, suggesting that the limits of absorptive capacity at this level in the developing countries present more serious constraints to ODM's "new deal" than its policy statements admit. And secondly, because the nature of rural health programmes is such that their primary requirement is for local and recurrent costs—simple health centre buildings, basic equipment, plus staff salaries and expenses. As a matter of policy ODM does not provide assistance towards meeting the recurrent cost of salaries and maintenance and usually a maximum of 50 per cent of any grant is available for locally incurred capital costs. In some cases, the remainder may be applied to the importation of necessary vehicles, drugs and other equipment without distorting the shape of the programme, but in others it must be questionable whether the foreign-exchange component of this aid can be appropriately utilised.

- 26 On the question of aid tied to procurement from the donor nation, Britain has a more liberal record than some other countries. However, given the negative aspects of this form of aid and the limited degree to which any one donor can be expected to untie aid unilaterally, international agreement should be sought to reduce or eliminate this constraint on aid allocations.
- 27 Another matter deserving consideration is the co-ordination between ODM and other departments in respect of policy on health care in the developing countries. For instance DHSS has recently launched an export drive for British medical equipment and expertise. Missions have so far visited the Middle East and Latin America. It is open to question whether a campaign to sell British medical hardware and software on the basis of commercial criteria can be consistent with the objectives of overseas aid policy.
- 28 “In total, British aid to developing countries in the medical sector is currently running at about £10 million a year.”<sup>14</sup> Approximately half of this sum is channelled through international agencies such as the World Health Organisation, the United Nations Children’s Fund, the United Nations Development Programme and the World Bank. To put the changing emphasis of British policy in some perspective, therefore, it should be noted that ODM controls the allocation of under £5 million in this sector—less than two per cent of the annual bilateral aid programme.

## **PART TWO—BRITISH MEDICAL MANPOWER POLICY**

### **Doctors from Developing Countries in Britain**

- 29 Britain depends substantially on doctors and other medical staff from developing countries to sustain the standards of care available in the National Health Service. This dependence, which may be regarded as the soft option for our health planners, sits awkwardly with our overseas policy commitment to helping the developing countries provide better health care for their people.
- 30 The harder but more consistent option would involve (a) assisting the poor countries to retain their own doctors by an appropriate use of funds from the aid programme, and (b) progressively and without delay reducing our reliance on doctors from the developing world—a source which may well dry up as more governments devise means of blocking their brain drain.
- 31 More than one in eight doctors in Britain were born in the developing world and obtained their qualifications before coming to this country.\* The great majority are from India, Pakistan and Sri Lanka. As of 1970 the net inflow of developing country doctors to Britain was about 300 a year\*\* and more than 6,000 of them were then employed in the hospital service where they comprised about one-quarter of the total medical staff.
- 32 The government's Chief Medical Officer, Sir Henry Yellowlees, pointed out in his annual report for 1973<sup>15</sup> that more doctors from overseas would have to be employed in the Health Service if the increase in annual demand remained at the three per cent level of the previous few years. And three years earlier Dr John Kilgour, Chief Medical Adviser to ODM and Under-

\* In 1970 Britain had 70,000 doctors. About one quarter of this number was born overseas, including more than 9,000 from developing countries. (DHSS statistics)

\*\* 1,088 arriving and 766 leaving, excluding temporary registrations. (DHSS statistics)



Secretary in the Department of Health, had written:  
“In the foreseeable future, and not only in the UK,  
the demand for medical time is likely to exceed the  
doctors available to meet it, and in these terms  
there will be a shortage of doctors in the UK for  
many years to come . . . .”<sup>16</sup>

- 33 Since then things have changed. The economic recession has effectively reduced, if not the potential increase in demand for medical time, at least our capacity to afford it. This does not, however, preclude an upswing in immigration to Britain when the ‘pull’ factor of demand reasserts itself in the next economic recovery.

### **Factors Affecting Migratory Flows of Doctors In and Out of Britain**

- 34 A variety of factors may affect doctor migration apart from those induced by recession. One of these is a continuing increase in the output of graduates from British medical schools. Since the Todd Report of 1968<sup>17</sup> proposed self-sufficiency in doctors as a policy goal, the annual number of graduates has risen from 1,800 in that year to 2,600 in 1975 and is projected to rise to 3,750 by the 1980s. But these increases, while reducing our dependence on immigrant doctors, are very unlikely to meet future demand in full.
- 35 As the British Medical Journal has pointed out in a recent editorial:<sup>18</sup> “Our medical schools in Britain produce rather more graduates than we need to replace consultants and general practitioners who die or retire, but far too few to provide enough junior staff for our hospitals.” To underline this point it should be noted that of the 6,000+ developing country doctors working in British hospitals in 1970, no fewer than 5,000 occupied junior doctor posts. There is also little reason to believe that British doctors will in future be more willing than hitherto to accept posts in geriatric, psychiatric or other under-financed sectors of the Health Service. The likelihood is that many developing country doctors coming to Britain to gain a post-graduate qualification will continue to find themselves channelled into these NHS backwaters, filling the jobs which British graduates find least attractive and being given experience which is largely irrelevant to the kind of work for which they will later be most needed in their own countries.

- 36 Examinations in medicine and language for doctors entering Britain have also introduced a new and important factor to immigration patterns. Following the recommendations of the General Medical Council to the Merrison Committee,<sup>19</sup> these examinations are now compulsory for some, though not all, doctors coming into this country. (In the past it was easier for overseas doctors to enter Britain than the United States or Canada, which have had entrance examinations for some time.) Though intended essentially to raise the standard of practice in Britain, the heavy failure rate in these examinations is evidently having the effect of reducing numbers to some degree.
- 37 Another variable in the migration pattern is the outflow of British doctors to jobs overseas. Emigration, in net terms, currently accounts for the loss of about 300 doctors a year.\* Some slight reduction in this number may result from new controls introduced by Canada on their foreign doctor intake.<sup>20</sup> In 1973 about 330 British doctors moved to Canada. The new measures follow repeated representations from the Canadian Medical Association to the effect that the influx of foreign doctors has upset medical manpower and education planning. (In making this case, the CMA also pointed out that "reducing the drain of talented people from under-developed countries will provide more aid than any other programme.") As one door closes another opens, however; and the effect of the Canadian restriction on British emigration may be balanced by the new opportunities for British doctors to practise in Europe plus the sustained demand (at present, at least) in the United States.

### **Need for a Revised Medical Manpower Policy**

- 38 The situation thus remains that, despite some slow-down in the migratory merry-go-round and increases in the number of graduates from British medical schools, Britain will continue to be a doctor-deficit country unless those who determine policy in this sector are prepared to entertain more radical solutions for the provision of health care to the nation.
- 39 The basic premise of any alternative to our present policies must surely be this: that putting our own national health care objectives in the context of global

\* 797 leaving, 526 returning in 1970. (DHSS statistics)

health needs, it is incumbent upon Britain, as upon other advanced countries, to satisfy its manpower requirements from its own resources.

- 40      A concerted programme to train and deploy medical and nursing auxiliaries at appropriate levels throughout the National Health Service would be wholly consistent both with this premise and with the objectives. Results of experiments in North America<sup>21</sup> and certain evidence from Britain<sup>22</sup> suggest that, as in the developing countries, a doctor teamed with suitable auxiliaries can handle a substantially increased case load. With this support he/she can be relieved of the routine consultations and paperwork which in a traditional British practice occupy a large portion of the GP's time. In this way it may well be possible to stabilise the level of doctor manpower, absorbing any increased demand for medical time and simultaneously creating new employment opportunities on a sizeable scale at less cost to the public purse.\*

\* At the time of going to press the Department of Health and Social Security had just published a consultative document, *Priorities for Health and Personal Social Services in England* (HMSO London, 1976), which gives welcome emphasis to the needs of primary health care. The role of primary health care teams, however, is not seen as leading to any real devolution of tasks now undertaken by the general practitioner.

## CONCLUSION AND RECOMMENDATIONS

- 41 A significant advance in British policy has been achieved with the recasting of aid objectives in favour of the rural poor in the less-developed countries. However, even if the Ministry of Overseas Development succeeds in translating policy words into project deeds, the sums involved in bilateral assistance to medical projects represent a paltry percentage of the overall aid budget. Greater endeavour is also required at government and professional level to reconcile Britain's domestic interests in the health care field with the potentially or actually conflicting interests of the uncared-for millions in the developing world. The government departments concerned are therefore urged to give serious consideration to the following proposals for action designed to improve our response to the health needs of the world community:

### Overseas Policy

- 42 — that the intention be declared and positive efforts undertaken by the Ministry of Overseas Development to channel a higher proportion of bilateral aid into rural health programmes, thus making more adequate provision for one of the basic needs which must be met in any effective programme to deal with world poverty;
- 43 — that a new rural medical aid fund be created to provide grants for rural health projects in the poorer developing countries which require finance only for local and recurrent costs, the latter (e.g. salaries for locally-recruited personnel) to be provided on a medium-term basis where the principal constraint on funding by the government of the recipient country is a lack of resources rather than one of political will. This fund could also help to provide training for community health teams in the localities where they would be working;
- 44 — that any British medical personnel sent to developing countries through the medical aid programme, as government advisers, university lecturers, medical school teachers or hospital staff, should be selected for their awareness of the very different health care needs of these countries from our own. It should be ensured that they do not go with the idea of per-

petuating and strengthening western medical practices;

- 45 — that steps be taken to achieve better co-ordination between home and overseas ministries regarding formulation and implementation of policies in the health field, and thus to avoid inconsistencies in manpower planning and in the provision of equipment and services (as between commercial exports and the aid programme);

### **National Policy**

- 46 — that **National Health Service planning targets be reviewed and a feasibility study undertaken by the Department of Health and Social Security to assess the training and other inputs required to meet increases in the national demand for medical time through expansion of auxiliary services;**
- 47 — that the government through DHSS publicly define its policy in respect of the future employment of doctors from developing countries, clarifying its intentions with respect to continued dependence on this source as a means of making good the shortfall in domestic resources;
- 48 — that disincentives to overseas service by doctors (e.g. loss of pension rights and promotion opportunities in the NHS) be removed. At present, suitably qualified medical advisers cannot easily be recruited in Britain for motivational work in rural health programmes and similar posts, where there is a limited but genuine requirement for expatriates due to the lack of locally-trained personnel.

## **APPENDIX**

### **Comprehensive Rural Health Project, Jamkhed**

#### **Background**

In the Jamkhed area of Maharashtra, when the Comprehensive Rural Health Project began in 1970, it was found that, for every 1000 live births, 200 babies died before the age of one; 40 per cent of all deaths were those of children under five; 15 people in every 1000 had tuberculosis and 11 had leprosy; and the annual population growth rate was 2.5 per cent. With central government having too many calls on its funds to finance medical services for the whole country, meeting a problem of this magnitude requires a rurally based health service, operated by staff with rudimentary training, for which people are prepared to pay—a service aimed less at curing disease than preventing it, which is cheaper both in personnel and equipment.

#### **The Project**

The rural health scheme at Jamkhed was started on these principles by two Indian doctors, Dr Raj Arole and his wife. In 1970 they started to build up an 'ideal' health programme in order to show that it could be done and to discover the cost and practical implications. Oxfam's Field Director for South India, John Staley, visited them at the end of their first year and described the project even then as "one of the most remarkable efforts in community health now being made in India."

From the beginning of the programme the Aroles insisted that the villagers play a part in the provision of their own health services. From their simple and moveable base hospital, made of aluminium sheeting, two teams, each consisting of a medical social worker, an auxiliary nurse-midwife and a leprosy technician, go out on four days a week. They now visit 30 villages, covering a population of 40,000 people. The eventual target is 80,000. This system is both cheaper and more efficient than one in which patients come to a hospital:

- a) it means that the team become familiar with their patients' environment and problems and are able

- b) to form a closer relationship with them;
- b) it increases the number of patients seen;
- c) it improves the chances of preventive or early treatment, which is far cheaper than treatment at an advanced stage;
- d) it increases patients' contributions because they neither pay fares nor lose wages.

One of the basic principles of the scheme is that the community should pay for services, with surplus income from curative work helping to finance the preventive. The curative work is already 100 per cent self-supporting, and the preventive work 60 per cent. The Aroles originally outlined five health priorities: under-fives' care, antenatal care, family planning, TB and leprosy. Their work in these fields revealed another pressing need—the prevention of blindness. These six priorities form the basis of the Jamkhed scheme, but in every new village the Aroles visit, they ask the villagers to express their particular needs. In this way the health scheme becomes a matter of intimate concern to the community.

From the beginning of the scheme the Aroles have pursued a policy of involving staff at every level. Often, according to Dr Arole, patients value suggestions from attendants and drivers more than those from qualified physicians.

The most successful attempt at delegation, and one which firmly underlines the community base of the programme, is the use of village workers, which the project started in 1973. These are women, usually middle-aged and married, who are appointed to keep a close watch on the health situation in their village. They are paid Rs.1 (5p) per day, about half to one third what they would earn labouring, but their job is only part-time. They dispense simple medicines, organize preventive health measures and encourage family planning. Dr Arole estimates that up to 60 per cent of cases can be treated by the village workers.

The village worker receives in-service training, and spends one day a week at the Jamkhed centre. These days provide an opportunity for instruction and for the women to report any problems. Back in their village, their familiarity with the villagers puts the VWs in an excellent position not only to keep an eye on the

general health situation, but also to spread basic health education. For instance, with regard to family planning they supply the vital ingredient of "follow-up" which may make all the difference between women using contraceptives and neglecting to use them through distrust and fear.

In many villages, when the Aroles asked what the people wanted most, they were told 'food' or 'clean water'. The Aroles recognised that, in order to advance the health programme, agricultural and water supplies must be improved and knowledge of nutrition spread. From the outset, their work with children under five has included a supplementary feeding programme, for which local farmers try to provide food. To help counter the effects of the 1972/73 drought, the project undertook an emergency programme to feed 3,600 children until the next harvest.

The project was so successful that it became the blue-print for a £50,000 feeding programme launched by Oxfam in January 1973, which at the height of the drought included 25 projects. The Aroles also arranged the drilling of wells in villages within the project area, where drinking water supplies were inadequate. These wells became, in effect, part of the comprehensive community health work, with the project's staff emphasizing the importance of hygiene and ensuring that the wells were kept in good working order.

Since 1972 Oxfam has provided £31,423 towards the cost of the Comprehensive Rural Health Project. This includes purchases of drugs for TB treatment, support for triple and anti-polio injections for the under-fives, the cost of two landrovers and grants for the feeding of pre-school children and for seven drinking water wells.



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