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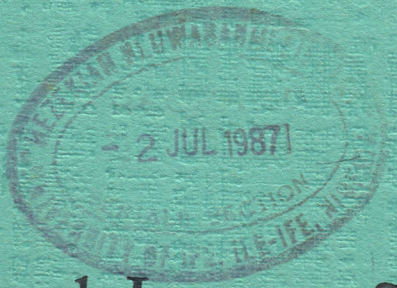

Inaugural Lecture Series 28

HEALTH A HUMAN RIGHT

by Ade. Adeniyi-Jones

UNIVERSITY OF IFE PRESS

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I HAVE CHOOSEN the title "Health: A Human Right" because it seems to offer me many approaches to the subject of man and his health, a subject which has occupied almost all my adult life. It is the field in which I have spent all my working years, approaching the objective of providing health care for people from many angles. Perhaps the diversity of those angles is enough indication that the successes I have had are less than satisfying. But the challenge and the excitement of the chase have been rewarding, and no failure, so far, has been so devastating that it has forced me to give up. I think it is fitting that I try to share with you, at this time in my career, some of the thoughts, some of the questions and some of the frustrations that I have lived with for well over forty years, in one form or another.

I would ask you, for the purpose of our discussion, to accept the definitions I intend to use for the two words "Health" and "Right". And I will assume that we share a common definition for the word "Human". Then I will try to explore some of the features of health, and the factors which determine and influence them; the measures which have been used and are being used to promote, protect and preserve health, skirting gingerly the measures that are adopted to restore health. We will take a look at some of the constraints that thwart measures to deliver effective health care to communities. Then, I hope to draw a picture of what is Community Health and Health Care Delivery as I think it should be.

Health is a concept. But let us define health as a state in which all the systems of the body are well coordinated, functioning with optimum efficiency in tune with the environment in which the organism, in this case, man, is living. This definition makes room for the fact that health is a relative quality. It is a quality which, in a sense, describes the state of a person at any given time. But if we wish to look at it in the abstract and consider only good health, we cannot do better than accept the World Health Organization definition of "a state of complete physical, mental and social well-being of an individual, not merely the absence of disease or infirmity". A simple mechanical analogy is to liken health to a solid disc made up of three interlocking parts which we can label physical well-being, mental well-being and social well-being. Then to imagine the disc revolving freely, on an axis, in a fluid medium. As long as the pieces mesh and are properly balanced, and the fluid environment is appropriate, the disc revolves freely, smoothly and easily, and all is well.

This concept places health, good health, at one end of a continuum which progresses to the other end which is death, moving through disease, injury, infirmity; affected in a degenerative way by time, the process we call ageing. This progress can be influenced, accelerated or retarded, by changes in the environment and by many other interventions.

"Right", for our purpose this evening, I will agree with Sir Harold Himsworth and define as "an expectation in respect of matters affecting the interests of individuals within a particular society which the consensus of opinion in that society accepts as justifiable." (Himsworth, 1973). This is a definition that will apply, validly, if we are in Enuwa as if we were in Tokyo. The feature which makes it universally applicable is that the relevant society must accept the expectation as justifiable. My thesis is that it is the birthright of everyone on this planet to enjoy health, and it is the responsibility of governments to ensure, not only that this is possible, but that the minimum facilities to promote, protect, preserve and restore health are fairly distributed within the territories that they govern. But having said that, with your permission I propose to limit my consideration to Nigeria, for obvious reasons.

One of the important mechanisms which contribute to meeting the obligations that are associated with man's right to good health is Public Health. This has been defined by Winslow as:

> The science and art of preventing disease, prolonging life and promoting health and efficiency through organized community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of social machinery to ensure for every individual a standard of living, adequate for the maintenance of health, so organizing these benefits to enable every citizen to realize his birthright of health and longevity. (W.H.O, 1952).

The significance of this definition is that Public Health is clearly conceived as embracing both environmental and personal measures.

The modern history of public health really began in the early years of the nineteenth century with the eighteen-volume exposition of the German Physician Johann Peter Frank (1745-1831). What Dr. Frank proposed was at that time inapplicable because the machinery for its implementation had not been created. His teachings on hospitals and medical care however bore lasting fruit. About the same time Edward Jenner (1749-1823) rediscovered and introduced vaccination

against smallpox. Fodere (1764-1835) saw and called attention to the relationship between social conditions and health, and pointed out the relationship between industrialization and many health hazards.

The first, shortlived, Central Board of Health (1805-1806), prompted by the threat of Yellow Fever which reached Gibraltar in 1804, was established to advise government on the best way of preventing the introduction of the disease, and of checking it if it did reach England. It lived for eighteen months and when yellow fever disappeared from Gibraltar the Board was quickly dissolved. The Second Central Board of Health was established in 1831 in response, this time, to the threat of cholera. And to meet the ravages of the pestilence, about 1200 Local Boards of Health were established by the Privy Council. Eventually, after much havoc, cholera died out naturally, and the Board of Health was soon dissolved in 1834. The time had not yet come for a permanent organization to protect the health of the public.

The Industrial Revolution and the appalling exploitation of children and women did more to rouse a reaction in favour of public health than did the pestilences. For one thing, John Graunt (1620-1674), with the London Bills of Mortality and comparisons of the mortality experience between towns and country, showed how much greater the risks of dying were amongst town dwellers than among those who lived in the country. Dr. William Farr (1807-1873) went further and described the evils that were behind the statistics. His "little sums about human lives", as he called them, were powerful motivation for producing action (Rosen, 1958).

Jeremy Bentham in 1820 led the growth of humanitarian feelings in the midst of the squalor of the industrial revolution, and Edwin Chadwick, his disciple, with the help of Farr's figures advanced the case for helping the poor. Chadwick's influence led, in 1848, to the third central organization, the General Board of Health in London, and in that same year, the first Medical Officer of Health for London was appointed. In the meantime, Liverpool had stolen the show from London by appointing Dr. Duncan the previous year and thus became the first City in England to establish the post.

Thomas Turner (1793-1873), a surgeon at the Manchester Royal Infirmary, depressed by the marasmic, dehydrated, puny children who came to die in his beds at the hospital, was the first to propose a Voluntary Visiting Association. He urged that the members should go into homes to seek out the cause of "these wretched tragedies in the mishandling of ignorant parents". (Brockington, 1965).

Florence Nightingale, Chadwick, John Simon, Southwood Smith and many others who sought in their different ways to spread the benifits of hygiene to all mankind received unexpected support from

Charles Dickens' novel *Martin Chuzzlewit* (1844). In it, Dickens described, in frightening detail, the women who practised midwifery without training. But it took until 1872 before the Obstetrical Society first set up a certificate for midwives. Within the next 28 years, 500 women were registered, and the era of relatively safe childbirth was launched.

Meanwhile John Snow's brilliant study and the publication of his conclusions on cholera (Snow, 1855) led to the end of another cholera outbreak by the removal of the handle of the Broad Street water pump in London. He had showed that Cholera was spread by the water from that pump. And Louis Pasteur (1822-1895) and Robert Koch (1843-1910), were establishing the germ theory of disease and the beginnings of the science of bacteriology. The growing belief in the realities of contagion had led to the first international health meeting at Paris in 1851 at which twelve countries participated. But, not unlike meetings that we know about even in these days, very little was accomplished. The participants were divided into those who believed in contagion and wanted to extend quarantine and such measures, and those who believed in the miasma theory and objected to quarantine because it interfered with trade. The world was not quite ready for preventive medicine.

The Public Health Act of 1848 and a Sanitary Act passed for the first time in 1866 began to release public health from the cumbersome legal machinery of the Middle Ages and provide the budding discipline with modern legal instruments with which to operate (Brockington, 1965). These, and the Public Health Acts of 1872 and 1875, and others, relating to housing, offensive trades, nuisances, food, midwives and to specific infectious diseases have formed the basis on which the Public Health Chapters in the Laws of Nigeria were formulated. And the development of public health in the world, and particularly in Great Britain, has determined the development of health care in Nigeria.

From the time man became a tribal animal, every society he has formed has demanded some form of clinical medicine, and from the earliest primitive groupings to the present time the need has hardly abated. On the other hand, a society must develop to a relatively advanced stage before the concept of and the need for preventive services become apparent. This will only arise when three preconditions have been met. These are:

(i) The group must be able to see beyond the problem of immediate survival;

(ii) There must be a positive attitude towards health as an asset; and

(iii) There must be a community conscience that places value on individual life and health. There can be very little argument over the fact that preventive medicine has no place in a society that is overwhelmed by the present.

It is only when a person has more than he needs for today that he will try to ensure that he survives to enjoy what is left over, tomorrow. And, if disease is regarded as inevitable, or irrelevant what is the point of preventive measures?

Chadwick confronted Britain with the fact that the average age at death of the well-to-do in England, around 1842, was 44 whilst for a working man it was 22; and that whereas only one out of ten of the upper class children died before one year old, one child in four from poor homes did not reach the age of one. Without the benifit of medical training, and not accepting until his death the germ theory of disease, he recognized the immense importance of environmental sanitation and that the key to its improvement was to be found in the control of water supply, drainage and sewage; with clean water flowing in and sewage flowing freely outward. This principle is said to be as important to preventive medicine as Harvey's discovery of the circulation of blood was to clinical medicine (Brockington, 1961).

Although traditional medicine, like in many other places has been practised in Nigeria from ancient times, this was, and is, individual medicine and is based on one or other of the concepts that disease is evidence of the wrath of the gods or the machinations of an enemy. Therefore counter measures must be related to appeasement of the offended god(s) or the provision of stronger charms and magic than is possessed by or available to one's enemies. Preventive measures are not consistent with such views on disease causation.

The cultural values which regard health as desirable for its own sake is even now not easily identifiable amongst our people. Most, even those who regard themselves or are regarded by us as educated and advanced, are only concerned about health when it is threatened or when it is lost. What we refer to as western medicine is available only to the few who, together with their offsprings, have been the real benificiaries of our current system of health care delivery, and are among the upper crust of our societies.

The struggle has been, and still is, between developing mechanisms for improving the health status of populations and providing ever increasing sophisticated care for the few; what Dr. Mahler, the Director General of World Health Organization refers to as the difference between health abundance and medical affluence. (Mahler, 1977).

Traditionally, universities and their medical faculties/schools/colleges and such have been more concerned with

the products of their educational process than with the ultimate recipient of health care, the public. Highly respected and able medical teachers in our environment have been heard to say they are only concerned with teaching and research and not with service; and, because they have believed that so they should be, have behaved accordingly, developing increasingly sophisticated services in medical institutions; assembling a mass of highly trained technocrats who, in their ambition to be first at this or that, continue to narrow their areas of specialization irrespective of the problems which abound and which are screaming for attention. Social needs and the relevance of health care delivery systems have not been of prominent interest or even of any consideration. But, at least in our rhetoric, a concern for and a concept of National health needs seem to be arising and there is a widening of interest which is trying to extend the concern beyond the individual sick, to an involvement in the delivery of health care to the larger social units of the family and the community. It is now quite clear that medical education cannot be provided in a separate compartment from the system it is designed to serve. This has been the weakness of traditional medical schools and what the "Ife Philosophy" was conceived to overcome. But more of that later.

In every community, accepting for the moment a charge of over-simplification, there are two categories of people. Those who are well and healthy, without symptoms, feeling well, in tune with their environment and having only simple transient problems that can be dealth with easily, simply and mainly without sophisticated technology. I use the word problem on purpose because I wish to include health problems other than illness; things like overfertility, overweight, need for immunization or prophylaxis, environmental sanitation problems and such. These require, when they require anything at all, the intervention of agents who have been simply, easily and inexpensively trained. The other category, very much fewer in any society, have problems of such severity and/or complexity that they need the intervention of highly skilled expensively trained agents, working with complicated and sophisticated technology. In between these there is a grey area in which some members of the community move back and forth, temporarily qualifying for inclusion in one or other of the two categories. If I was asked to give an indication of the relative numbers within these categories, I would immediately give some figure for the world community like 90% for the first; 6% for the second; and 4% for the grey area. For Nigeria I would modify those figures to something like 80%; 12% and 18%. These figures are not entirely intuitive. There are empirical evidences and

pointers which support them. The differences in the Nigerian figures arise because health care depends as much upon the quality of the health personnel and the organization in which he works as upon their numbers. But quality has to be redefined in terms of what is best for the poor and deprived within a community rather than persisting with the customary norms of what is the best care possible for the elite; what the late Professor Alexander Brown called "making the best the enemy of the good" and my colleague and mentor, Robert Wright, calls "the immorality of excellence". The relatively large number in the category of the sick or needing more sophisticated intervention is because of our failure to provide enough of the agents of intervention for those in category one with the consequence that their condition worsen. In other words, the figure represent our inability to promote, protect and preserve, or maintain the health of our communities. Instead we try to provide more and more of the sophisticated restorative facilities, in the main, for situation that could and should have been prevented.

We should forget the lip service we constantly pay to the concept of a University, and what should go on within its precincts, and be willing and able to stand back and take a good look at ourselves. We may then be able to see that what we have believed is a pre-occupation with excellence, is only rhetoric; that to talk about excellence in our medical schools is empty talk, for reasons that seem clearly apparent to me.

In spite of the many enviable distinctions that many of our medical schools have acquired, our institutions are far from able to attain, consistently, and maintain performance standards that can be classed as excellent. To appreciate this, one must be prepared to look at our situation with honesty, without bias, without sophistry, and without dissemblance. Of high importance amongst the many reasons, but not ranked in any order are:

(a) too many of us are learned but not educated;

(b) as a people we do not seem able or willing or both to work together with mutual trust, understanding and cohesiveness;

(c) we seem to lack the will to operate on principles;

(d) we are unable to criticize each other and in turn to accept the criticism of our peers;

(e) we soldom behave as if we understood the concept of "first amongst equals", and do not accept leadership with grace, or accord it conscientious support;

(f) we seldom enjoy adequate or competent administrative support;

(g) we hardly ever have enough middle or lower level work support; nor do we consistently have the logistic backing of efficient communication facilities and other basic utilities to allow us the

freedom to concentrate on the important issues;

(h) we are often too concerned with, and involved in, the "nuts and bolts" of issues to allow ourselves the chance to function at our maximum potentials.

There are more, I am sure, but these are enough to support my point that with such an array of critical deficiencies it is impossible for us to attain, in any consistent way, much excellence. And to provide some justification for me to say that, to talk of excellence under such conditions, is at best a misconception and, at worst dishonest.

Before I leave this matter of excellence there is one more comment I feel ought to be made. To apply the term with any comfort in our special situation, I would look for excellence in performance at every level of our endeavour. I would look for excellence in the performance of every worthwhile function in the whole hierarchy of our undertakings, from the performance by the most lowly worker to that of the most exalted concern. But what I see instead is a pathological absence of discipline, indiscipline of all kinds and at all levels; and in my understanding of the quality "excellence", it is incompatible with indiscipline.

Our universities and medical schools are not meeting the challenge or accepting the responsibility to be in the vanguard of health care delivery that is rightly theirs. We are persisting with our efforts to reproduce many of what those we are striving to copy are already striving to discard. Although the provision of medical care is the legitimate responsibility of government, I believe it is our challenge to develop settings in which we can investigate what is going on, examine alternative ways of delivering health care, anticipate the future and develop new systems, standardize those of them that are amenable to such treatment so that they can be used effectively by persons with minimal education and ability. This, to my mind, is a sacred function of a medical school. But our trend has been to accumulate specialists and encourage specialization, even though, in our environment, specialization in medical practice has not developed out of interest or desire to learn more and more, but out of the desire to earn more and more. We belong to an environment that rewards the acquisition of a qualification better than the quality of performance, an environment that has the self-destructive situation where the possession of the basic, sometimes only theoretical qualification, of a technical discipline makes one an expert; length of service has more promise for advancement than how capable, efficient or industrious a worker is. This is stultifying to the growth and development of our nation.

Various names have been given to the discipline we now call Community Medicine in our endeavour to overcome the separation

between preventive and curative medicine. This is an academic discipline, like paediatrics or surgery, that has for its goal the solution of people's health problems through clinical application of the basic science disciplines like pathology, microbiology, behavioural sciences and biostatistics. However, Community Medicine considers people in groups or communities as well as individually, encompassing the traditional and relevant skills and knowledge of public health and preventive medicine along with the growing concern for the delivery of medical care. The epidemiological method and body of knowledge are in a special position, linking the basic science portion of the discipline with the applied phase in the community. (Wright, 1977). Although this is a commendable attempt to be inclusive, it does not include a central factor, the socio-economic factor which is of critical importance in the promotion and protection of health.

A good deal of the confusion and the multiplicity of designations which have plagued the discipline is the result of the attempt to support the emerging tendency to talk of "health care". At the outset, public health was concerned with overcoming those features within the environment that either threatened health or provided favourable conditions for disease to thrive. Leading this movement were lay men, Bentham, Chadwick, Graunt, Shaftesbury and Shattuck who had considered environmental health, rather than personal health, more relevant to the health of the masses, and the early measures were initiated with scarcely any reference to the medical profession. From the outset, health was inexorably tied to welfare, and physicians were excluded, either by design or by accident from the major policy posts. These served to make public health uninteresting and unattractive to practising doctors. Voluntary hospitals that had the responsibility for medical education were pre-occupied with overt disease. It is not surprising that the knowledge, attitudes, and skills acquired in such environment provide formidable support to the perpetuation of the dichotomy between preventive and curative medicine until this day. Clinical education puts a premium on doing something with an observable effect. Preventive medicine, in contrast, aims at a negative goal — the absence of disease. It lacks the excitement and the satisfaction of searching for a pathology and working for a cure. In spite of the segregation, the benefits of preventive medicine, especially in obstetrics and paediatrics, proved impossible to ignore although it was not until the 1960's that preventive measures began to feature prominently in postgraduate education in these fields. Even so, specializations in the more clinically spectacular, such as endocrine diseases, overwhelming infections, complicated deliveries and high

risk pregnancies, low birth weight and prematurity, tend to occupy most of the attention of these obstetricians and paediatricians. The high dividends of the well-baby clinics and routine ante-natal services fail to attract inspite of their massive potential payoffs. Both the average doctor and his specialist colleague are anxious to return to the drama of the operating theatre or the futile but glamorous activities around cytopathology.

The "Ife Philosophy" is an exciting one in many ways. Basically it is trying to do three things. Its greatest appeal to me is that I see in it a practical attempt to integrate preventive and curative medicine. It recognises the irrelevance, in many ways, of conventional courses to the needs of Nigeria and to the declared objectives of our national health policy. Emphasis is to be placed on preventive medicine and the outreach of doctors is to be maximised. Those who planned the programme recognised, almost intuitively, the limitations of the then current pattern of health care delivery and sought to try out the idea, which makes sense, of a team approach to health care. Unfortunately whilst the term "health care" was being used what was meant was "medical care". Lastly the Ife experiment has been trying to adapt the new philosophies and mechanisms of educational methodology to medical education.

Our problems have been and still are formidable. In the first place we are trying to marry two incompatibles. The Faculty of Health Sciences is trying to produce scientists who will, so we think, become the teachers, the researchers, and the leaders of medical thought in the future. We are also trying to help the nation to produce more serving doctors which those in authority believe is the answer to the health care delivery problems of this country. For the former we needed at the early stages, the rigorous discipline of the parade ground and the numbers and dedication of faculty members to help the students overcome the stultifying effects of the schooling to which they had been subjected. You should notice that I did not use the word "education". You already know my views on discipline in the Nigerian context. The other ingredient was simply not there. We did not have the teachers who had been trained in, and had accepted the new approach to education. Many did not even agree with the philosophy of the Faculty and were not courageous enough to say so. Those who were responsible for providing the resources for the programme did not, do not understand what was happening; and in true Nigerian fashion, were not willing to admit this fact and seek explanations, which, as a matter of fact, was not easy. We had not learnt the new language well enough to use it effectively with those who were not in the same frame of reference with us. The result, as we

all have seen, is distrust and suspicion, a climate that has allowed unscrupulous persons, self-seeking, mischief-making, to erode the mutual trust that would have allowed time for a growth in the right direction to build faith and confidence in the experiment. Before our very eyes we saw discussion becoming disputation, and reasoning turning into polemics. I can recall the excitement of some of the external examiners at the then Part II degree examination. They had come up against students who were showing the beginnings of a capacity for scientific thought in a "medical school!"

The tragedy of our situation however was, is, that the time for a Faculty of Health Sciences has not come. Many of those who were in decision-making positions did not, do not to this day, know that there is a distinction between Medical Science and Medical Practice and saw the faculty only as a mill for producing doctors for the direct sickness/treatment, patient/doctor relationships. And many of us who were "teaching" did not, do not know that the best way to teach is to help the student to learn. All over this and our other Universities we can see support for the aphorism that "very often, those who are trying to teach get in the way of those who are striving to learn."

The fact that the "Ife Philosophy" also contains the idea of delivering care on three levels, a primary, a secondary and a tertiary level has added to the confusion. We in the faculty have been trying to overcome the principle that a medical school should have no responsibility for service. That its function, especially as it is situated within a University, is to teach and do research. Many of us believe, and the belief is fortunately slowly spreading, *that a medical school which does not influence the health status of the community in which it is situated cannot, in the final analysis, justify its existence.* We also believe that in health care delivery example is as effective a mechanism for developing a desirable attitude as it is for an undesirable one. And since we have declared that we were as concerned about the attitudes that those who pass through our hands bring to their work as we are about the knowledge and skill they acquire, we had to have, available for us to function in and teach by example, situations and institutions in which the three types of care take place.

Having seen attempts at doing this in one single institution, the Teaching Hospital fail, after more than 20 years, to achieve good health care, and believing that a major factor of the failure is due to the fact that these types of care get in the way of each other, each detracting from the other, we feel it is worthwhile to try an obvious alternative.

Unfortunately the Nigerian intellectual believes he has a duty to pronounce upon every subject that reaches his notice, and that the

less his knowledge and understanding of the subject, the louder and more dogmatic should be his pronouncement. He did not miss the announcement that the Faculty of Health Sciences proposed to use existing health and medical institutions as its clinical teaching resources. He missed the point of the three-tier pattern of health care delivery, as well as the provision for a referral hospital which has now become an Apical Hospital. He did us tremenduous harm by implying, in his proclamations, that Ife did not intend to build a teaching hospital. He missed the point, and having missed it at the outset has refused to see it since, that a medical faculty cannot function without facilities for clinical instruction i.e., a teaching hospital or its equivalent. We have chosen a complex of hospitals, health centres and a defined community as the equivalent. He also missed a critical point, that it was intended to up-grade the hospitals and other institutions we use to a standard that would make it possible for them to be used, satisfactorily, to teach medical students.

The advantages of such a plan are so obvious to those who really understand what medical education and health care is all about that the need for explanations and elaborations was not immediately apparent. For one thing, here was a possibility of three or four health care institutions, within an area with a radius of about 60-80 kilometers, organized and staffed to deliver high quality medical and health care. Here was a situation which was promising good comprehensive health care for a defined population. But again, we failed to explain what it was all about. Firstly, that health care should not be limited to a hospital, or an episodic fire-fighting response to the appearance of symptoms. But that as life is a continuous process so should good health care cover a person from the cradle to the grave. And that facilities were to be developed to make this possible.

The first obstacle is the fact that the existing pattern of health care delivery had to be modified and it was impossible to do this within a civil service structure. Therefore something like a Health Council and Health Management Boards mechanism had to be devised. When it was devised, a great deal of thought and energy went into ensuring that it functioned exactly like a Ministry of Health, and in fact it was almost to be an advisory body to the Ministry. Most of this is now history but some of the constraints that I tried to indicate when we discussed excellence are to be encountered even up to now.

I would like to try to explain the concept of the three-tier health care delivery pattern which we have adopted. You recall that I had mentioned that healthwise, our populations fall into two categories 80% well, 8% ill and a shifting group of about 12%. If you can, imagine a triangle divided into three by two lines in such a way that

the upper of the two lines cuts through the triangle at a level about 1/6th of the way from the point at the top and the second about 2/5th of the distance from that line to the base, primary care would, account for the space between that second line and the base of the triangle. It is the care that the majority of people need. For little cuts and bruises and stomach upsets, for mild fevers and pains and aches. It is also, or should be, the entry point to the entire care delivery system except for accidents and emergencies. This should be located in health centres of various sizes, and in health clinics. Discharge from here is back to the community. The space above this represents secondary care which is the care provided by hospitals for people who, in the main, have to be carried to the system. They are so sick they need to be under constant supervision and observation. The admission to this level is by referral from primary care except in the case of accidents and emergencies. Discharge from here can be back to primary care for supervision of convalescence, or to the community, completely cured.

The rest of our triangle represents tertiary care. This is for conditions that are so serious, or unusual that they require complicated and sophisticated intervention; such that, because of the cost, complexity, and sophistication of the equipment or whatever that is required, they cannot and should not be replicated at centres nearby. Discharge from this level should normally be back to the community, cured, or to primary care for supervision of convalescence, or to Rehabilitation.

It must be stressed that the factor which should determine to which centre a person is admitted or transferred is the quality of the problem that the condition poses. They key to the whole concept is the organization of primary care. This is something that we have not known before and are, naturally suspicious of. This is where the Community Medicine practitioner functions and where promotion, protection and preservation or maintenance of health takes place. At the other levels, the principle preoccupation is with restoration of health and limitation of disability. It is at those levels that sophisticated medicine will be practiced, and one of the biggest problems that will confront the community physicians and his team will be to distinguish between problems needing sophisticated attention and sophisticated people making sophisticated noises about simple problems.

Primary care caters for clients as well as patients. I define "clients" as those whose needs can be met by promotive, protective, and maintenance services and reserve "patients" for those requiring early diagnosis and prompt treatment to turn them back into clients.

Nigeria is at the dawn of her own era of industrialization. It should not be necessary for us to repeat the crimes against humanity that were perpetrated in the wake of the English industrial revolution, and it is not likely that we would exploit our women and children in the way that produced social activists like Jeremy Bentham and Edwin Chadwick. But our women and children are in an other jeopardy. The basic human needs of food, shelter, and clothing have not been adequately met for a large number of people of this country. Among the more than half the human race that is either under-nourished or malnourished are many Nigerian children.

The fact of health being a basic human right confronts us with a dilemma. Conflicting situations arise and we are forced to make decision which can never be right. For example, why do we spend the time an energy that are involved when we admit a moribund child into a paediatric ward when we can more usefully be teaching mothers and the community how to avoid such a situation in the first place? Or is it right to spend scarce resources on a severely handicapped child who, all our training and experience tells us, will never be able to lead an independent self-supporting existence? Is it right to divert resources that can be used to nurture young, deprived children on supporting the life of an 80 year old man and depriving him of the chance to die with dignity? These and many more like them are questions for philosophers to answer. As Bryant says, the moral issues involved in curing individual patients are well known; but the moral issues associated with providing health care for large numbers of people, especially with limited resources, are not well appreciated, often their existence is not even recognized. (Bryant, 1969).

The National Basic Health Service Scheme which the country is trying to implement can provide some of the answers to some of our dilemmas or can help us avoid them, to a limited extent. We can try to streamline the techniques used in identifying and dealing with many of the conditions for which people seek attention and train persons of low education to deal with them. We can use more time, money, and energy in learning how to get the most out of each health naira that is available.

Our universities, if they wish to avert the condemnation of future generations, must recognize the opportunity that this strategy offers us to redeem ourselves by taking care to the people and forcing them to participate in their own salvation. We must use all our ingenuity to prevent the dilution of the concept by whatever means. Together with our Hospital Management Board we should be setting up demonstration projects to determine how the scheme will work best, ready to hand over to the Health Boards and Local Governments

whose responsibility it is to provide primary care, each successful project.

I agree with so many of the views of Professor Akinkugbe, Vice-Chancellor, University of Ilorin in his chapter on "The Place of Medical Research in Nigeria". (Akinkugbe, 1971). And I agree that exchange of information or, in short, honest critical communication between workers is a *sine qua non* for meaningful research in our context. But next to that in my order of priority, I would place commitment of the worker, his honesty and his willingness to tackle the problems that are relevant to us and our development and growth. If we do establish a coordinating centre, I hope we have a means to force those who operate it to keep in mind the four principles which Akinkugbe ascribes to J.B.S. Haldane and his co-workers in India.

We should not travel in blind faith along to road to Illich's "medicalization of life" with an over-consumption of medical drugs. Already the drug bill of this country is colossal. How I wish for a politician of the order of Dr. Allende, the late President of Chile. He proposed to his countrymen that they should prohibit the importation of drugs into Chile unless those drugs had first been tested on the North American public for at least seven years without being withdrawn by the U.S. Food and Drug Administration. And I would pray that the fate of Dr. Allende not affect anyone bold enough to cause such a threat to big business.

The right to health should not be limited to the well-to-do or the educated. Even the poor has a right to health. Our tendency to concern ourselves with capital costs without thought for recurrent sometimes create the situation where our plans for tomorrow cost us the resource to save the children of today and for them tomorrow never comes.

My hopes for Nigeria has recently received a rude shock. I am devastated by the sight and the sound of our intellectual elite planning in 1978 strategies for the eighties. How realistic can this be? When will they develop the bills of quantities and the costings to give realism to their rhetoric? Or will we in 1985 suffer the mortification and the humiliation of explaining our profligacy?

Our right to health does not depend on what we plan and do in health. It depends on agriculture, our economy, our education. It depends on our sense of justice and fairplay and on our social conscience. It depends on whether groups like this before me accept the fact that we are each other brothers. Man is the only animal in which challenge can stimulate a response that can take the form of rational action. We can plan our relation and response to nature and can survive, patiently endure trials, and learn by becoming aware of our

limitations. Therein lies our hopes to our right to health.

Health is clearly not the absence of disease or infirmity alone. It is equally clear that ill-health is not exclusively caused by germs. What the development in the science and practice of Community Medicine has shown, and shown clearly, is the multifactorial nature of health and disease. The factors that help to maintain health are, first and foremost, the availability of food in adequate quantities and of suitable quality; then, in some semblance of ranking, the availability of suitable employment for every man, the attainment of socio-economic status that ensures for man his dignity and self-esteem; and a contentment of mind which derives from, as well as contributes to, each of these factors.

I have come to the sad conclusion, sad because it has taken me so long to arrive at it, that for the provision of these essentials, health is, at best minimal. It is true that without some well-being very little of them can be attained, but if we define health as a state in which man can function effectively and to his own personal satisfaction contributing adequately to the overall progress, growth and development of his community, then the attainment of those essentials equals health. And they are clearly and indisputably amongst the fundamental rights of man.

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