ISSN 0125-7447

รายงานการเฝ้าระวังโรคประจำสัปดาห์

WEEKLY EPIDEMIOLOGICAL SURVEILLANCE REPORT

VOLUME 17 NUMEER 36
SEPTEMEER 12, 1986

บรรณาธิการ

รายงานฉบับนี้แปลกไปจากปกติเล็กน้อย โดยที่เห็นว่างานสาธารณสุขมูลฐานกำลังเป็นที่กล่าวขวัญอย่างมาก และเป็นนโยบายของกระทรวงสาธารณสุขที่จะพยายามให้บรรลุถึง "สุขภาพดีถ้วนหน้าในปี 2543" บรรณาธิการเห็นว่าบทความเรื่อง No " health for all " without " peace for all " น่าสนใจมากเพราะได้ให้แนวคิดของการดำเนินการสาธารณสุขในประเทศที่ยากจนบางประเทศ ตลอดจนได้กล่าวพาดพิงถึงปัญหาการเมืองที่เป็นอุปสรรคขัดขวางการดำเนินงานสาธารณสุขมูลฐาน จึงได้นำบทความเรื่องนี้ลงไว้ให้ท่านผู้อ่านได้นำไปพิจารณา อภิปราย และหาแนวทางที่ดีสำหรับประเทศของเราต่อไป

Samir N. Banoub

No "health for all" without "peace for all"

Primary health care strategies call for both community participation and government finance. Health expenditure differs greatly between developing and developed countries, both in absolute monetary value and as a percentage of government expenditure. The countries with the higher gross domestic products per capita spend higher proportions of their resources on health than do the poorer countries. Indeed, the absolute monetary value of allocations to the health sector in poor countries is minimal.

India may be used as a model to illustrate the difficulty in financing health for all. It has been asserted that the social services in this country as a rule receive step-motherly treatment *(1)*. Health has a low priority and the total public expenditure on health

services of all types is less than half the education budget. The present expenditure on health for the private and public sectors combined is only about 2% of the gross national product. The bulk of health expenditure is incurred on curative services, or within urban areas, and the main beneficiaries are the top 20% or 30% of society. The alternative model proposed for health for all by the year 2000 assumes that the funds given to health will be equal to those given to education, and that each of these social services will ultimately get about 6% of the gross national product. The total expenditure on health would need to rise by the year 2000 to about six times its present level, assuming constant prices and a doubling of the gross national product per head in the intervening period.

The health sector has to compete strenuously for finance with other programmes. Countries and communities which, before Alma-Ata, were hardly striving to make basic health services universally accessible, are now facing the challenge of "health for all by the year 2000", and this means finding additional financial resources. At the same time, many countries of the developing world, namely, those that gained independence after the Second World War, or, in the case of Africa, after 1960, are suffering from the proliferation of local wars, political unrest, and civil disturbances. The "cold war" is getting hotter in some regions of the world. Local wars wax and wane, principally among or within less developed countries. During the period 1972–1981, world military expenditure increased by 25% in real terms, while the rate of economic growth slowed in both developed and developing countries *(2)*. Among the latter, military expenditure increased by 60%. This represents a rise from 17.1% to 22.5% of world military expenditure, part of which could be due to exchange rates becoming less favourable for developing countries buying equipment from developed ones.

The ratio of health expenditure to military expenditure is about 1:1 in developed countries, while it is 1:8 in low-income countries. In some developing countries the disparity between health and defence

expenditure is probably even greater, since underreporting of defence expenditure is suspected.

Because of the sensitivity and confidentiality of war operations, little is known about the morbidity, mortality and disability associated with them. Acute, restorative and rehabilitative surgery for casualties among civilians and the armed forces are diverting resources from primary health care and the public health services. Major health and social problems exist in many parts of the world as a result of mass movements of war refugees. If data were available on these matters, perhaps they would prove wars and military operations to be the most serious epidemics in some regions.

Obviously, if peace were achieved, and if there were minimal political unrest in developing countries, the race for arms purchase and military expenditure could be eased. From the health point of view, there is an urgent need to work towards peace settlements in war zones or war-prone regions. The United Nations should do more to achieve this end.

A small fraction of the money spent on arms would suffice to develop primary health care. For example, the 6000 million dollars needed annually to provide safe water for the whole world, as projected by the United Nations Water Conference in Mar del Plata, Argentina, in 1977, amount to only a fortnight's expenditure on military affairs by the developed world *(3)*. Treaties between arms-producing countries are needed to limit the production and sale of death machinery. The problem is complicated, yet radical and innovative approaches are essential if the international community really wants health for all by the year 2000. □

References

1. **Indian Council of Social Science Research & Indian Council on Medical Research.** *Health for all: an alternative strategy.* Pune, Indian Institute of Education, 1981, pp. 201–203. Summarized in *World health forum,* **2**: 500–511 (1981).
2. **Sivard, R. L.** *World military and social expenditures 1982.* Leesburg, VA, World Priorities, 1982.
3. **Agarwal, A.** *World health,* August–September, 1980, pp. 14–17.

คัดจาก " World Health Forum 1986, Vol 7, No 1, 87 - 88