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9. ABSTRACT

The American Public Health Association, under a contract with the Agency for International Development, has designed a program in public health improvement which is called the Development and Evaluation of Integrated Delivery Systems (DEIDS). The activity is designed to assist countries to demonstrate how to establish health delivery systems within seven years. Such projects include, but are not limited to, Maternal and Child Health and Family Planning and Nutrition. The projects are to cover large populations in predominantly rural areas. They are to utilize in-country resources for the service component, although external assistance organized by DEIDS is available for planning, evaluation, training, and limited amounts of essential equipment. It is expected that successful health delivery systems can be subsequently replicated in the country or in the region.

These are phases through which DEIDS projects proceed:

a) Phase I -- reconnaissance within a specific country or region, to gather information about disease patterns, health services as currently organized, local resources, cultural aspects, community involvement, the potential for integration of various parts of public health, opportunities for innovation, current and potential staffing, training, supervision, emphasis upon preventive services, outreach, cost, and evaluation

b) Phase II -- Detailed planning. This phase begins if the survey in Phase I recommends it, and involves experts from the host country as well as experts assigned by DEIDS.

c) Phase III -- Pilot Project Operations, which continue for as long as eight years.

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U.S. VOLUNTARY AND PRIVATE SECTOR STRATEGY CONFERENCE

ON

INTERNATIONAL HEALTH

November 10-11, 1975

Washington, D.C.

CONFERENCE REPORT

Sponsored by

American Public Health Association
Division for International Health Programs
1015 - 18th Street N.W.
Washington, D.C. 20036

FOREWORD

As Co-Chairs of the planning committee and the conference, we were exceptionally pleased with the response received from all those invited to participate. While a few invitees due to other committments were unable to attend, all responded favorably to the need and timeliness for convening such a meeting. The actual discussion and subsequent recommendations bear out the earlier assumptions and need for the meeting.

It is our expectation that the proposed Task Force will draft a plan for carrying out the recommendations of the Conference. This plan should be ready within the next few months. The successful implementation of the plan will depend upon many factors, two of the most important being the degree to which the plan is developed with private sector partners in other countries, and the degree to which the plan is supported by the private sector.

The willingness of individuals and organizations to participate on a voluntary basis is the key concept upon which this program is being built. This is a concept which should be tested and strengthened if people in developing countries are to actively participate in the process of improving their health.

M.S.H. and G.A.S.

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I. Preface

A meeting entitled "U.S. Voluntary and Private Sector Conference on International Health" was held on November 10 and 11 at the Mayflower Hotel in Washington, D.C. under the auspices of the American Public Health Association. It brought together a small group (41 participants) comprising representatives of U.S. voluntary health organizations* and U.S. multinational corporations interested in strengthening preventive health measures in developing countries. The charge given to the participants was (1) to discuss the benefits and constraints that might be associated with encouraging increased voluntary commitments on the part of the private sector of developing countries in supporting preventive health programs. (2) to identify and assess strategies for working with private commercial organizations and private voluntary health organizations of developing countries, and (3) to arrive at a consensus on recommended next steps of action.

A planning Committee (see Appendix A.) guided the development of the agenda and the organization of the Conference. In addition members of the committee served as chairpersons and rapporteurs of Plenary and Discussion Group Sessions.

The report which follows consists of three sections: (1) a frame of reference which is a synthesis of background information sent to the participants in advance of the meeting, which includes some of the concepts contained in the keynote address of Professor Howard Perlmutter (see Appendix B for the complete text); (2) a summary of the conference discussions and conclusions, and (3) recommendations for action.

Recognition is due and offered to the many individuals and organizations that have helped get the Conference underway. First of all, recognition is made of the important contributions of the U.S. Agency for International Development.

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* Non-governmental, non-profit, legally constituted, voluntary, citizen participation organizations having health as their central focus, e.g. Nursing Associations, Public Health Associations, Family Planning Organizations, and Tuberculosis Associations. Other voluntary organizations having health as one of their major concerns, were also participants.

AID provided the bulk of the financing for the study and the pilot projects. Further, AID shared in underwriting the costs of the Conference itself. Travel for nearly all of the Planning Committee Members and Conference Participants was provided by the organizations they represent.

II. Frame of Reference

The expectations of all people have risen to the point where the demand for a better quality of life represents a dominant force throughout the world. Resources, always in short supply, are being sorely taxed by escalating demands for services that are perceived as basic human rights. No longer are the masses content to await the "trickling down" process.

This is especially apparent in the health sector. On the one hand is the expectation of people that it is their right to stay alive as long as possible and, while living, to feel well and be able to function as productive members of society. On the other are (1) limited resources (money, manpower and material) for investments in health, (2) a rapid world population growth, and (3) the tradition of trying to provide high quality medical care for a few as opposed to some health improvements for all.

"Health," as established in the Constitution of the World Health Organization, is "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." This of course represents the ideal and unfortunately there is as yet nowhere in the world where health can be measured in these terms. The realization of the goals, however, is more remote for some than for others. In less developed regions where 75% of the world population lives, (1970) the expectation of life at birth was estimated at 50 years. In the developed regions life expectancy at birth was 70 years.

Within both the economically advanced and the developing countries there

are disparities as well. These are not only in terms of life expectancy but also in terms of access to health care and information. In most developing countries, where the situation is most critical, the people who live in rural areas comprise 80 percent of the total population, and in the best of circumstances less than 37 percent of these rural dwellers have access to any type of modern or scientific health service.

In addition to the recognized benefits acquired from good personal health, the health sector is being increasingly viewed by policy makers and planners as an essential and integral part of the economic and social development process. They too are growing impatient with the "trickle down" concept realizing that health improvements for the less advantaged are needed now. Enhancement of the productive capacity of the labor force and access to new sources of raw materials in geographic areas where low standards of health and health-related problems exist are seen as critical to the expansion of business and industry and to meeting the rising expectations of people.

Some of the most devastating health problems of developing countries are ones that can be significantly reduced through individual and collective action. For example, most of the diarrheal diseases which are a major cause of infant deaths and which drain the energy of children and adults can be prevented by individual initiative and health behavior change. Personal hygienic practices along with potable water are among the necessary ingredients. Why then do these diseases and others that can be prevented, continue to thwart the desire of people to live better and longer?

The governments which are primary providers of health services in the developing countries constantly face difficult choices. Manpower and finances are not only limited but a majority of both are tied up in treating people who are ill and who come to health care facilities expecting and demanding curative services.

Foreign assistance in health, governmental and non-governmental, multilateral and bilateral, has focused primarily on developing health manpower, organizing the infrastructure for the delivery of health services and on the control or eradication of diseases of regional or worldwide significance such as cholera, malaria and smallpox.

Limited manpower and funding restraints in the developing countries have in recent years generated the interest of governments and assistance groups in finding ways of getting individuals and communities to voluntarily assume increased responsibility for safeguarding their health. For some this is seen as a means of reducing the patient load of curative facilities. For others it is viewed as an approach which will foster self-reliance and self-determination and at the same time provide a foundation for achieving better health for all people.

Drawing on the experiences of the United States and other economically advanced countries where the private sector has played an imprtant role in influencing health activities, initiating health services, and stimulating voluntary citizen participation in health affairs, health experts considered it logical that similar actions in developing countries would accelerate health development. Information, however, was not available about the extent to which the private, voluntary health organizations and private, commercial interests in the developing countries were involved in health work.

An initial step in exploring such involvement was a study* to learn the prevalence of indigenous voluntary health organizations and what they and their governments perceived to be their current and future role in helping achieve national health objectives. The study published in 1974 revealed the following:

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* The study was carried out by the American Public Health Association in collaboration with the World Federation of Public Health Association in 63 countries and financially supported by U.S. Agency for International Development.
A copy of the final report is available by writing to the Director, Division of International Health Programs, American Public Health Association, 1015 18th St. Washington, D.C. 20036

a. Voluntary health agencies and societies of health professionals were found in all of the 63 countries.

b. Most felt they were not working to their full potential due to a lack of finances, expertise and full-time staff. A good many had no base of support other than that provided by their government or foreign groups.

c. Many governments in the developing countries wanted the indigenous voluntary groups to place increased emphasis on stimulating changes in the health behavior of people and thereby reinforce governmental efforts to reduce preventable deaths and illnesses.

d. Board membership of most of the voluntary health agencies was limited to health professionals and activities were carried out mainly in the capitol city area, often without the broad support of citizen participation.

e. The private sector and particularly the commercial interests had little contact or direct involvement in the affairs of the indigenous voluntary health organizations othern than occasional financial contributions.

Another dimension of the exploratory study were pilot projects in Costa Rica and the Philippines. These projects were focused on strengthening voluntary involvement in health work. The significance of the findings were considered during post project conferences. In the Philippines, where representaives of 16 countries convened for this purpose, it was the consensus that health improvements would be accelerated if the voluntary and commercial sectors of the developing countries could find ways of developing a consortium of interests and or working together in a partnership arrangement. The opinion was expressed that much could be learned through linkages with economically advanced countries where private sector collabo-

ration, particularly between the private, commercial organizations and private, voluntary health groups has had an continues to have a significant impact on health development.

Historically, corporation leadership and resources in the economically advanced countries have been a major underpinning of strong voluntary organization development. On a non-profit basis, private corporate personnel have played a key role in stimulating and leading the local citinzenry to act on its own in overcoming health problems. The recently completed Filer Commission Report on Private Philanthropy and Public Needs in the United States (November 1975) estimates the level of private corporation giving for health in the U.S. to be $475 millions in 1974. Health was the sector receiving the highest level of corporation support. These figures do not include the many millions of man-hours voluntarily contributed by the corporate employees to the different voluntary organization activities.

U.S. commercial groups, particularly multinational corporations, are becoming increasingly concerned with the health of their employees and the health conditions of the communities in which they work. Health improvements are also seen as essential prerequisites in many areas of the world where natural resources for economic development remain untapped. U.S. multinational corporations are also concerned with their social role in developing countries and are going through a process of "revolutionary transaction" as described by Professor Perlmutter in his keynote address (see Appendix B).

The possible links between the corporations and the voluntary health organizations have not yet been fully explored or developed either in the United States or other coutnries. Therefore, a potential resource for strengthening voluntary citizen participation in health affairs in developing countries remains untapped, and only limited efforts are being made to involve the private sector in the health delivery system.

Based upon the interest and suggestions made by the developing countries, the American Public Health Association, under whose auspices the study and pilot projects were conducted, undertook the task of exploring the interest of U.S. private sector groups in sharing experiences and expertise with counterparts in developing countries.

Preliminary contacts made with U.S. groups encouraged further action and the formulation of the following hypotheses.

a. Voluntary health organizations in the economically advanced countries represent a largely untapped resource for helping counterpart groups in developing countries achieve increased voluntary citizen support and responsibility for health improvements.

b. Multinational corporations in the economically advanced countries represent a potential resource for helping awaken interest in health on the part of the private commercial sector of developing countries.

c. Mechanisms can be established for linking the interests and capabilities of the private commercial (business and industry) and private, voluntary organizations in both the developing and developed countries. A resource coalition can be established to work with people in meeting their own health needs.

d. U.S. voluntary health organizations and U.S. multinational corporations are interested, willing and able to facilitate fruitful coalitions among counterparts at all levels, international and local, in promoting voluntary citizen participation in health affairs in developing countries.

The Strategy Conference represented a first step in exploring the validity of hypothesis "d".

III. Conference Discussion and Conclussions

The focus of the conferees' discussion was directed toward three questions:

No. 1 Under what conditions and in what ways can the voluntary and commercial sectors in the United States encourage the private, voluntary and commercial sectors in developing countries to become more involve in health affairs?

No. 2 How might your organization participate in such an activity?

No. 3 What next steps do you suggest?

a. Issues

The immediate issues with which the Conference participants concerned themselves related to the rationale and values underpinning the theme of the conference and the acceptance and appropriateness of this theme within the context of the larger framework of human and economic development. Justification of private sector support of voluntary citizen participation in health affairs was seen from several facets representing the U.S. participants points of view.

Foremost, and considering the increasing awareness of all people to basic human rights, it was considered that health improvements should be supported and strengthened in developing countries by the private sector. Furthermore, health improvements are a key factor in the economic and social development process, and provide unique opportunities for individual voluntary citizen participation.

Major health problems in developing countries are preventable and are located predominately among the masses of poor people. Personal and community health problems are often the major reasons why poor people,

particularly those in the rural areas, are unable to inprove their quality of life. Experience has shown that realistic and lasting solutions to local health problems requires action by individuals, families, and communities acting in concent with their government, their economic sector and their counterparts in other countries. Government resources or those of the private sector acting alone are not the answer, nor is outside assistance acting independently the solution. Resources, to be effectively used, should work in partnership, each maximizing its expertise in solving these problems.

It was also recognized that voluntarism exists in various forms in nearly every society, and ideas and experiences involved in this process of "social technology" should be made available from one country to another. In addition, indigenous, national voluntary health organizations do exist in developing countries, and they help institutionalize voluntarism as a continuous resource in the country. Therefore these organizations should be strengthened and encouraged to become institutions for promoting voluntary citizen participation in health.

The U.S. voluntary health agencies and societies of health professionals, as well as those in many other economically advanced countries, have a wealth of experience, information and expertise. However, these organizations for the most part have limited linkages with counterpart organizations in developing countries.

The U.S. multinational corporations, as private economic entities, are increasingly becoming concerned with their social responsibilities in countries in which they work. Since the corporations are making sizable investments in the health area they would like the help of the U.S. and indigenous voluntary agencies and societies of health professionals in "determining the effectiveness

of these health investments." There is a growing concern over the lack of models for corporation involvement in health. Those models that do exist are often limited to financial contributions as the form of participation.

The importance of involving the private sector in this process of strengthening health sector resources is extremely critical at this time, especially considering that government resources for improving the health of people in most developing countries are limited. Techniques should therefore be supported which stress better utilization and cooperation of existing resources and the incorporation of untapped resources.

The participants, given the above considerations and their desire to advance continuing cooperation between private sector resources in the United States and the developing countries, supported the concept of forming private sector coalitions for encouraging voluntary citizen participation in preventive health services in developing countries.

Several important qualifications were added to this statement of support:

> First, that the planning of such activities must be undertaken in joint participation or in consultation with the government and the private sector (voluntary organization, business and industry) in the developing country. From the beginning, this participation should be based on working on problem resolution in partnership, as equals, eliminating paternalism and emphasising parity relationships.
>
> Second, that activities of this type should support the national health objectives of the country.

Third, that activities should focus primarily on the investment of nongovernmental voluntary assistance, whether it is in the form of money, material, service or talent, and

Fourth, that the private sector in the developing country should be assisted in accepting responsibility for maintaining and supporting the local activities.

The immediate need recognized by the participants was to identify new mechanisms for strengthening, non-profit, private sector support for voluntary citizen participation in health affairs.

b. Implications and Needs

Having considered the basic issues, the conferees then discussed the practical aspects related to the implementation of these concepts.

Coalitions of the type discussed have direct potential benefit to the developing countries in a number of ways:

a. They would strengthen activities whereby the poorest people may be able to achieve health improvements through their own initiative
b. They would help build locally supported resources to meet health needs.
c. They would help reduce the dependency of people on government for meeting all their health needs.
d. They would assist in opening doors to the business and industrial community in the country which has talent and resources to help meet community health needs.

e. They would create a channel for technological transfer between the advanced and developing countries, fostering communication between people.

For example, private sector support of voluntary citizen participation in regard to a single public health measure, such as the development and use of potable water in all communities in a developing country, could have an immense impact on the health status of the people and their ability to achieve economic development.

Similarly, there are direct benefits for those commercial and voluntary groups from the economically advanced countries which participate in the coalition process. These benefits include:

a. A more politically acceptable approach to international assistance, through cooperation and parity rather than paternalism, reducing the risk of negative foreign reactions.

b. A more effective use of financial resources invested in health by both the multinational corporations and the voluntary health organizations.

c. A broader understanding in the U.S. and other countries of the important role that can be played by the private sector in developing countries.

d. An opportunity for the private, commercial interests to help improve the health of their workers and of the community.

e. An expanded market for new goods and services in developing countries as poor people increase their desire and ability to improve their lives.

The positive value of forming coalitions was acknowledged by the participants and it was further agreed that lack of information was an immediate problem in the implementation process.

An existing information gap is the degree of interest which exists in the voluntary and commercial (business and industry) sectors of developing countries to (1) form partnerships with one another and (2) to form coalitions with voluntary and commercial sector groups in the United States. An expressed agreement on principles and the desire to participate by the developing countries was considered a vital next step in the coalition forming process. This is particularly important if the charge of paternalism is to be avoided.

There is also the need to know which U.S. commercial and voluntary organizations are carrying out health activities in developing countries. Many of the U.S. based multinational corporations have health operations linked into their facilities in developing countries. Little is known about the extent of these operations or their relationship with the community and indigenous voluntary groups. Similarly, much of the expertise of the U.S. national voluntary health agencies and professional associations has not been tapped or brought into contact with indigenous counterpart groups in developing countries. As a result, a great waste of resources is caused by this lack of information since each new effort must start without benefit of the experience of others.

The need exists to develop communication mechanisms which promote better understanding between the voluntary and commercial sectors, so that individuals, groups, as well as countries can learn from one another. Similarly, the general public and the governments need to know what is being done by the private sectors. Measurement of both corporate and voluntary sector contributions

should be illustrated not in dollars but in accomplishments. Forums, workshops, and newsletters are but a few of the communication mechanisms which can be utilized to promote this understanding.

There is a lack of existing models which illustrate effective approaches for cooperation between the voluntary and commercial sector resources. The need exists for new models to be designed, tested, and for specific evaluation measures to be developed. Results should be achievable by other groups. The concept of "experiments in cooperation" rather than "studies" was the suggested theme.

Further, there is need for guidelines which would help the various partners to understand each others' constraints. For example, voluntary organization leaders have little information on the structure, operation and constraints of corporations. Similarly, effective social policies need to be defined for corporation management. Parameters of cooperation need to be identified.

Finally there may also be need for a technical assistance resources to work with the private sector in developing countries in designing, testing and evaluating innovative approaches for achieving voluntary and commercial sector cooperation.

Clearly, no mechanisms currently exist to remedy these defects in the coalition development process.

c. Incentives for Coalitions

In reviewing the potential for developing linkages between the U.S. voluntary health organizations and U.S. multinational corporations, as a first step in the creation of these coalitions, a number of key points of differences as well as similarities were identified which need to be understood as a prerequisite of efficient partnership. They are summarized below:

U.S. Multinational Corporations (Business and Industry)		U.S. Voluntary Health Organizations (Voluntary Health Agencies and Societies of Health Professionals)
I:	Philosophy	
1. profit		1. non-profit
2. do good to further corporate image and objectives		2. do good to lessen human suffering and for the voluntary agencies, work themselves out of a job by solving a problem.
3. insure employee health		3. provide public health
II:	Awareness	
1. weak	of public health issues	strong
2. varies	of local conditions in developing countries	strong
3. weak	of each other's motivation & structure	weak
4. weak	of the impact of the aid they provide	varies
5. strong	of finance	weak
6. varies	of foreign politics	varies
7. strong	of U.S. politics (as it affects corporate decisions)	weak
8. weak	of relevant tax and legal pros & cons	varies
9. varies	of what they are presently doing in health	strong
10. strong	of public image development through mass media	strong

IV. Recommendation for Action

Based on the conclusions drawn from the discussions, the Conference participants proposed an unanimously accepted the following recommendations for action:

That a Task Force be created consisting of private voluntary and commercial sector representatives from both developing and the economically advanced countries, with immediate staff and facilities provided by the APHA, Division of International Health Programs.

The functions of this Task Force should be include, but not be limited to the following activities:

Broaden Base

1. To disseminate information from the Strategy Conference to interested individuals and organizations, and identify those who would be interested in participating in the development of a coalition of private sector resources.

Secure Private Financial Support

2. To develop and implement a plan for securing private sector support for the functions and staffing of the Task Force. This may include establishing a tax exempt corporation or foundation as a mechanism for collecting funds.

Exchange Information

3. To develop and implement a plan for improving the exchange of information between private sector resources interested in strengthening public health in developing countries.

   This may initially include surveying information already or currently being collected on voluntary health organization and corporation involvement in public health in developing countries. The exchange of information may

involve various communication techniques such as forums, workshops, or newsletters. This information system may also be used to help inform the general public of the private sector activities.

Test New Models

4. To explore, identify and test new models which illustrate effective approaches for cooperation between private, voluntary and commercial sector resources.

Develop Guidelines

5. To develop guidelines for effective collaboration between private, commercial and voluntary health organizations.

Organize Resource Bank

6. To develop a plan for identifying existing U.S. private sector resources which would be available, on request, to work with the private sector in a developing country, to strengthen its capacity as local resource in promoting citizen participation in public health affairs.

The Task Force may desire to organize a second conference, for the purpose of reviewing the status of their development, and the plans for implementing the new models for private sector coalitions.

These recommendations suggest the need for the Task Force to convene, as soon as possible, to prepare a timetabel and to determine its development funding needs and potential resources.

The APHA has initiated the process of identifying information resources which already exist, so that an immediate data base for planning can became available.

Appendix A

U. S. VOLUNTARY AND PRIVATE SECTOR STRATEGY CONFERENCE

ON

INTERNATIONAL HEALTH

CONFERENCE SCHEDULE

Monday - November 10, 1975

6:00 p.m.
Registration and Reception (Maryland Room)

7:00 p.m.
Dinner (New York Suite)

8:00 p.m.
Plenary Session (New York Suite)
Chairman - George A. Silver, M.D.

1. Opening remarks
2. Keynote Address:

"From Paternalism to Parity: New Roles for the Voluntary and Private Sector in Developing Countries." Prof. Howard Perlmutter

3. Charge to the Discussion Groups
Chairman Prof. Morton S. Hilbert

Tuesday - November 11, 1975

7:30 - 8:30 a.m.

Continental Breakfast - to be served in rooms assigned to discussion groups

8:30 - 9:45 a.m.

Group Discussions

Group A - New York Suite
Group B - Pennsylvania Suite (left side)
Group C - Pennsylvania Suite (right side)

9:45 - 10:00 a.m. Coffee Break

10:00 - 11:45 a.m. Continuation of Group Discussions

11:45 - 12:15 p.m. Hotel check out time

12:15 - 1:30 p.m. Lunch and Plenary Session (New York Suite)
Chairman - Prof. Morton S. Hilbert

1:30 - 3:30 p.m. Continuation of Group Discussions

3:30 - 4:30 p.m. Final Plenary Session (New York Suite)
Chairman - George A. Silver, M.D.

Adjournment

10/30/75

FROM PATERNALISM TO PARITY

New values for the International Social Architecture of Health Care

Based on a keynote address presented at the U. S. Voluntary and Private Sector Strategy Conference on International Health, November 10, 1975. Washington, D.C., sponsored by the American Public Health Association.

Howard V. Perlmutter, Ph.D.
Professor of Social Architecture
The Wharton School
University of Pennsylvania

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I. A PERSISTENT VISION

My purpose in this essay is to lay the foundation for building constructive linkages between institutions of the U. S. private and voluntary sector and institutions in developing countries with the objective of increasing the rate of improvement of health care for the poorest countries of the Developing World.

As a student of social architecture, I am concerned with the theory and practice of building social, political and economic institutions which are both humane and effective in the treatment of their clients and which develop constructive linkages with other institutions.

A humane institution (a) aspires to achieve increasing legitimacy as an institution through meeting the basic human needs and values of its clients and other constituencies especially those which are disadvantaged, (b) embodies in its structures, policies and programs such values as socio-economic justice, respect and concern for the dignity of every person connected with the institution, (c) accepts the rights of every person as these rights have been succinctly stated in the United Nations Universal Declaration of Human Rights, as follows:

> "Every human being has the right to a standard of living for the health and well-being of himself and his family. This includes food and clothing, housing and medical care and necessary social services in the event of unemployment, sickness or other lack of livelihood."

(d) promotes the basic rights to freedom such as the freedom of the press, to a fair trial, to choose one's place of residence.

In this definition, the most humane achievements of social architecture are those institutions which in their performance show a high degree of identification with human needs, values, and rights.

By effective instititutions, we mean institutions which have the necessary technical capabilities and show efficiency and wisdom in using their limited resources, to carry out their basic missions, as evidenced in their performance.

A humane and effective instititutions promotes constructive and collaborative relationships with other institutions in at least two senses (a) it reinforces the humane character of other institutions and (b) it supports the effort to utilize scarce resources efficiently in pursuit of their legitimate missions.

The need for this kind of social architecture is universal. Most of man's suffering throughout human history, in war, in hunger, disease, poverty, infant mortality, unemployment, pollution, personal feelings of physical, social and economic insecurity, of meaninglessness in life, of terror from arbitrary arrest and torture, the community's sense of vulnerability to outside forces, or lack of hope for the future, are related to controllable deficiencies in man-made institutions and to controllable destructive, exploitive relationships between institutions.

Man has been unusually innovative (a) in creating institutions which abuse or deny the fundamental rights of persons, and (b) in convincing large groups of people that the must waive most of their rights in order to enjoy only a few basic rights.

A tragic view of our future holds that the prospects are dismal that more than a small segment of humanity will ever enjoy the full spectrum of human rights. The study of social architecture takes a more optimistic view. Man, we contend, is capable of learning how to build more humane and effective institutions. Thus, research on social architecture takes as its starting point these tasks: (a) the formulation of testable propositions regarding how and why some institutions become inhumane and ineffective, disregarding human rights, and having destructive impacts on other institutions,(b) formulating alternative propositions and principles which, if followed by institutional leadership, would promote, improve, and facilitate the humane and effective character of the institution and encourage more constructive, mutually beneficial relationships with neighboring institutions.

Increasingly, men and nations have come to recognize that the right to <u>health is a right not a privilege</u> as some professional circles may claim. If we accept rights for all persons, then it is arbitrary where that person is born, in a village or a city. It is arbitrary to what socio-economic class he belongs, in what country or circumstance his birth takes place. When he is born, he immediately has the right to a full life, to be protected from preventable diseases, to be given therapy for curable diseases.

He and his children have the right not to suffer from malaria, kwashiorkor, leprosy, yaws, and schistosomiasis. He and his family have a right to learn how to avoid preventable diseases, to have clean water, to have sufficient protein in their daily diet. Parents in poor countries have rights equal to those in rich countries, to see their children live past five years old. In this view, to be truly humane is to acknowledge and promote the rights to health for all persons; to be in a lesser developed state of humanity is to acknowledge and promote human rights for the few. A truly humane institution acknowledges the rights to health of all persons, therefore, a humane and effective institution makes positive efforts to assure these rights to at least minimal standards for health for all persons.

Thus it is clear that the task of social architecture in the area of promoting health care for the poor in the developing countries involves mobilizing those institutions and their resources, who identify with the mission of improving health for the poor, and identifying those institutions which in their evolution towards more human and effective standards see this mission as related to their primary activities. Let it be clear that the clients are the poor who do not enjoy their minimal rights to health, not the institutions themselves. Institutions are instruments not ends.

Underlying this need to help the disadvantaged in health, is a sense of obligation and duty which is rarely defined. It is perhaps no accident that while mankind has been able to define the

the Rights of Man, there is less progress in the articulation of the Obligations and Duties of one nation to another, one institu- to another, one person to another. We rely largely on a spirit of voluntarism in each of these domains. In the so-called free societies, this voluntarism is truly voluntary, largely spontaneous and often effective. In controlled societies, voluntarism can be compulsory, often with successful results. We note, in passing, that given the extraordinary aspirations inherent in assuring that all persons in any given society have the right to minimal standard of health, some kind of voluntarism would appear to be a necessary element in any massive effort to guarantee these rights.

Let us look at the problem of assuring health for the poor in developing countries in an international perspective. There is an international network of institutions who are interested in assuring health care for the poor. Some are governmental or intergovernmental; some are non-governmental, voluntary, and non-professional; some are professional; some are in the private sector. Many institutions in this network have the resources, the capabilities, and the missions which permit them to identify with the primary objective: to improve markedly the chances for poor people everywhere in the world to get at least minimal health care and to have the knowledge to avoid the most debilitating of illnesses.

In the poor countries themselves, there are governmental organizations, voluntary health organizations such as service agencies, professional and institutional associations, and the private sector which are of importance to the poor themselves, especially to the people who live in the distant villages, in the urban slum or favella. There are the counterpart organizations in advanced industrialized countries, of similar types, governmental, private, and voluntary. There are international institutions like the World Health Organization, The Food and Agriculture Organization, UNICEF, and the League of Red Cross Sociéties, to name a few.

The resources of the international network are enormous in potentiality, if we include not only money but people who can voluntarily help. One major obstacle to the efficient use of these resources is the state of fragmentation of this network. Many times, these institutions operate at cross purposes. There is a feeling of obligation to help the poor in most of these institutions, to be sure. There is also, to some degree a shared sentiment that the poor constituencies of the world have a rightful claim on the resources of this international network. Further, and of importance, there is probably in the hearts of many of the professionals and the nonprofessionals a persistent vision and hope for a world which is healthier for all persons, where all children do not go to sleep hungry, where disease and malnutrition do not sap the strength of the poor, where there is good potable water, where before there was water that carried typhoid, where

there are clean markets free from disease, where there are health centers on the larger towns and posts in the village, where all people know how to live a healthier fuller life. Yet despite these shared values only a fraction of the resources of the international network is used effectively.

The fact that a vision of better health for all persons is widely discussed is, in itself, an event of the Twentieth Century. The translation of this vision into primary missions for specific institutions is an equally important event. The existence of a network of institutions with an overlapping set of missions which contain elements of this vision is a critical condition for progress.

Yet the creation of humane and effective institutions whose primary purposes are to create conditions where the poor can experience their right to minimal standards of health is by no means assured. The present climate and the present premises under which Rich and Poor Countries interact are not conducive to rapid progress.

As we shall elaborate in the sections to come, the climate between the Rich and Poor Countries in which the network of institutions is trying to function can be characterized as a) one of mutual ambivalence b) sometimes mutual distrust and c) not infrequently a propensity for confrontation.

Some values and premises on which the central societal institutions in both Rich and Poor countries have been built are in either a state of decline or are subject to vigorous attack. New values and premises considered radical, extreme and often ominous for these institutions are surfacing more insistently.

The structural paternalism between Rich and Poor nations is increasingly resented. Both Rich and Poor nations are beginning to agree on its destructive impact. A more egalitarian, collaborative mode is desired. But practically speaking it is an elusive, untried mode of interaction.

To continue the architectural metaphor, it is difficult to build effective and humane institutions and constructive relationships between institutions when the foundations for these institutions and their relationships are shifting and unstable.

We propose a three step analysis: a) an analysis of the roots and properties of the shaky foundations, b) an analysis of the values and premises which appear to be in decline or under attack, and c) a search to identify those new values and premises which appear to be in ascendance in both Rich and Poor countries.

II. THE SHAKY FOUNDATIONS FOR BUILDING

The resources and capabilities of the international network of institutions which could support health care in the poor countries cannot be used in an optimal way at the present time for a variety of reasons. First, the competitive character of the helping institutions is one factor.

Secondly, the increasingly tense climate between Rich and Poor Countries is a serious obstacle. It is, of course, dangerous to generalize about all Rich and all Poor countries. But there are some common themes in the multitudinous interactions between Rich and Poor countries that must be understood if the "persistent vision" of better health for the poorest of mankind is to be realized in any future generation.

To be sure, the so-called developing countries are not a homogeneous group. Each country has different perspectives of the immense sea of human suffering in poor countries, its inevitability its causes, and the degree to which alleviating these conditions is a lower or higher priority than economic development objectives.

One crude, but important division, exists between what are called Third World and Fourth World countries. This is not a neat division, but it points up aspects of the differential conditions in the less industrialized world. The Third World nations are now mainly the oil producing nations, most of whom belong to OPEC, the Organization of Oil Producing Countries. Technically, they are not poor countries. They are less industrialized countries; they are

capital rich and technology poor. Most of these nations aspire to building an industrialized country in the modern style. In theory, they have money to build health programs in the villages. But in the drive for industrialization, and an urban focus, there still could be neglect of the rural poor.

Political leadership knows that this neglect has an explosive character over time. Where the rural poor and the peasants in particular live below a minimal standard of health, with no land, and little hope, the gains in affluence of the urban elite are precarious.

The true neglected of mankind live in the Fourth World. Fourth World nations possess neither capital, skills or good prospects for improving their fate. Resources available for health are minimal, in the urban areas, and are likely to be even less for the rural areas. Only the barest few in the society, and especially in the villages, enjoy what we call even the minimal human rights to health. Infant mortality is highest here, life expectancy shortest. Incidence of disease, number of villages without potable water, are the statistical indices of misery, squalor, and hopelessness. No amount of epidermilogical research, however reliable, can quantify the human suffering of the Fourth World. Health in the Fourth World, more than in the Third World is a <u>privilege</u> not a <u>right</u>.

Yet there is a unity of sentiment between the Third and Fourth World, a shared world view, especially of the causes of their fate and especially of the responsibility Rich Industrialized countries have in creating their state of relative deprivation.

One index of the unity of the coalition of Third and Fourth World Countries was evidenced in the recent unprecedented rise in oil prices. Contrary to public opinion the Rich Industrialized nations have been able to absorb the higher energy prices without major dislocations in their economies. They could, for example, charge higher prices for their exports to the OPEC countries, in both manufactured goods and services. The Fourth World had no such equilibrating mechanism. The result is that some of the Fourth World nations are at the brink of bankruptcy. On the surface at least, there is a unanimity of feeling, however, in both the Third and Fourth World that the OPEC action is a historic first step on the road to freeing the Poor nations from their long bondage to the Rich countries.

What are the sentiments, values that bind the Poor together? The claims and allegations are familiar: Poverty and generally the oppressed state of the Poor Countries are a result of Colonialist exploitation in the past. This exploitative behavior of the Rich relegated them to the position of commodity producers and has impeded their development as self-reliant nations. Contact with the rich foreigners has frequently undermined their cherished traditions and values. Foreign institutions have tried

to impose models of growth and development that do not fit the local people and their resources. Whether for imperialist reasons, or simply well meaning efforts, a kind of structural paternalism has reigned in Rich-Poor country relationships, that is destructive of indigenous pride and self-confidence to build self-determining, less vulnerable and dependent societies. In brief, there is a shared distrust for the Rich countries and their motivations regarding the poor countries. There is a continued fear that foreign interventions however benign in their intent will maintain or increase their dependence on foreign institutions and ideas. This will delay the internal sentiment of <u>being liberated from</u> the dominating influence of the Advanced countries.

Surely, these sentiments can be understood by many, in the Rich Countries. But the Poor countries doubt the sincerity and the depth of the empathic responses they see, from the Rich Countries.

At the same time, the Poor countries say they need help. They want untied aid, more technology under better conditions of transfer. They want, in short, all the trappings of an Industrialized society. They want to bargain as equals with Rich countries, as poor relations.

Of more than rhetorical significance is the unanimity of the Poorer countries in the belief that since Industrialized countries are guilty of exploitation, the Industrialized countries must, engage in some kind of <u>reparation</u> process. The Poor Countries

demand new forms of wealth redistribution, leading to what is being called today A New International Economic Order. Whatever the prospects for realization of this New Economic Order are, I am convinced its formulation is of great importance for us to understand as the vision of a better world Poor Countries seek. The New International Economic Order contains an image of a world with international economic justice, wherein some kind of economic parity between Rich and Poor Nations has been achieved. We can expect, over time, that a vision of a New International Social Order will be formulated, based on human rights.

In the Rich countries, there is hardly a unanimity of opinion regarding the allegations of the Poor countries. Sweden and the United States, in international fora, find themselves in frequent disagreement about methods and demands of Poor Countries. The Swedes consider that their identification with the problems of poor nations is more authentic. Sweden points with pride that 1% of their GNP is given in aid, (although they are somewhat embarrassed that a somewhat higher percentage is for armaments!) In the recent Hammarskold report WHAT NOW? it was suggested that the Rich Countries could embark on an <u>austerity program</u> to limit their growth and presumably make more aid available. Some concrete suggestions for Sweden were: a) ceilings on meat and oil consumption, b) more economical use of buildings, c) greater durability of consumer goods, and d) no privately owned automobiles.

More typical is the U. S. position as regards the demands for a New International Economic Order and the allegations regarding exploitation. While there is agreement that the Colonial era was not glorious, the U. S. does not feel guilty about this period. There are strong doubts that (a) it is possible to redistribute wealth on a major scale from the Rich to the Poor Countries. If anything, there is resentment at the technique the OPEC countries are using for wealth redistribution! (b) that the transfer of wealth would make a great deal of difference given the inadequacies in the social and economic infrastructure of even the more advanced of the developing countries. The belief is that the Rich and the Poor Countries will get richer. There is a serious question today whether Iran can actually make significant and durable changes with the new billions of capital it has acquired. (c) That Rich Countries are morally bound to exercise what I have called the Principle of Benign Imbalance. The Principle of Benign Imbalance states that it is just or equitable that Poor Countries should get better conditions than Rich countries in the technological and industrial domains, that only a Benign Imbalance in the direction of Poor Countries will in the long term lead to a world with a greater degree of socio-economic justice.

Despite the Principle of Benign Imbalance, there is, for good reason, no rush in the Rich Countries to export jobs, capital, and technology to Poor Countries under better conditions than to other Rich Countries. In times of recession in the Rich Countries, few of them really want their markets invaded by foreign products

manufactured in Developing Countries at lower prices. In the same spirit, it is easier to get sympathy for aid to New York in such unlikely places as California, than aid to Tanzania or Zaire. There is increasing resentment in the U. S. government regarding the anti-U.S. position many poor countries have been taking in the U.N. More recently, the U. S. is threatening to cut off economic and humanitarian aid to the most anti-U.S. of the Poor countries.

The climate is hardly a constructive one. It is humiliating for Poor Countries to receive aid, and to know that aid can be cut off. Some Rich Countries see the poor countries as parasitic. The Poor suspect that the Rich are trying to keep them in servitude --through aid. The Rich feel superior because they give aid. The Poor feel inferior because they know they need aid. The Rich have a tendency to overvalue the aid they give, especially the importance of technology which has a special mystique. The Poor continue to feel their vulnerability to outside forces, and aggressively attack the Rich in public debates. The U. S. in particular sees the attacks as unfair, since in private they are explained as politically necessary. The U. S. resents that the attacks on other superpowers like the U.S.S.R. are private and not public. The U. S. fumes at the ingratitude of the Poor countries.

Thus the vicious circle continues. The Poor are outraged at the Rich Country's arrogance, at their condescending air, at the structural paternalism that characterize the economic relations between Rich and Poor nations.

Confrontation rather than "dialogue" seems preferable. Mutual mistrust is evident. Ambivalence about giving and receiving aid is customary and explicit. A hatred of Paternalism by the Poor Countries, coexists with a growing need for outside help. There is a vicious circle of tension, recrimination, increasing sensitivity to acts and attitudes of each of the sides. Polarization appears more likely than cooperation. These are the shaky foundations on which international linkages between institutions must be built.

There is clearly tension, to use another metaphor, at the tip of the iceberg. But underneath, we believe there is evidence of a striking similarity in both rich and poor countries: a struggle between two sets of values and premises regarding how to build effective and humane institutions and how to build constructive relations between institutions. The struggle, we shall try to show, in the next section is between a traditional, materialist, elitist conception of societal institutions and quality of life oriented, egalitarian, human rights-oriented institutions, between 'old' and emergent values.

In some quarters, it has been said that 19th century was a period where liberty was sought at the expense of equality; while the 20th century, the search is for equality at the expense of liberty. This makes a nice turn of phrase, but the matter is more complex as we shall try to show.

III. NEW VALUES FOR OLD INSTITUTIONS

New consciousness of human needs, values and rights pose a challenge to existing institutions. Institutional leadership must, in evaluating the new knowledge and new values, determine whether the mission and objectives of their institutions must be reformulated. When old values and premises are declining and the new values seem more humane and legitimate, leaders must take stock of the role and function of their institutions in relation to other institutions in society.

The appearance of new values does not mean that older institutions are illegitimate. Nor does it mean they must immediately adopt the new values and reject the old. Old values may be declining in some constituencies, in some groups of sponsors and stakeholders. But others may relate to the institution in terms of older, and cherished values and beliefs. New values may be held by groups who are suspect, e.g., they are "Left", "radical", or "idealistic students". New values may be at first only gaining in prominence among scholars, journalists, and young politicians.

Typically, established institutions try to ride out the storm rather than examine the merit of the new values. Witness the first unbelieving reactions of government and industry to the ecologists. Now the pollution control industry is a major world growth industry!

It is no easy task to identify new values or cyclical trends, fads, or utopic fantasies. Yet when there is a convergence, world-wide, on certain rights and values as good and others as obsolescent or wrong, leadership which ignores the meaning of these trends takes sizable risks. We have come to identify a set of values which may be in a state of world wide decline, and others which are in ascendance, and promise to continue in the decades ahead. This value change already is penetrating the international network of institutions related to health care for the poor. Thus, they are of central importance in designing institutional linkages in the future.

In the pages which follow, we present two types of propositions: Type A those which contain values and premises for building institutions and interinstitutional relationships which appear to us, on the decline, and will increasingly be seen as leading to th the building of institutions which are less humane and less effective; and Type B propositions: wherein new or emergent values and premises are identified: 1) which old institutions will need to take account of in redesigning their missions, policies and programs, or 2) which new institutions will utilize as the basis for their emergence, their comparative advantage and distinctive competence compared to old institutions.

PROPOSITION 1A is that a) Econocentric, b) Palliative, c) Elitist, d) Trickle down theory values and premises for building health care institutions will decline in the short term and run the risk of disaster in the long term.

First, a definition of these values and premises:

1. Econocentrism is the belief that development is primarily an economic process, and hence development is measured in economic terms such as minimum wages, GNP/capita, allocations of money. Health care and health education is justified for its peripheral contribution to economic development. And health frequently has a low priority, in poor countries.

2. Palliative incrementalism is a premise that token attention to health care for the poor is considered enough to 'keep them quiet. This term was used by Denis Goulet in his fascinating book The Cruel Choice.

3. The Elitist orientation suggests that health care should be oriented to the few who are affluent. More attention is directed towards curing the more exotic diseases of the most privileged groups in a society.

4. Trickle Down Theory is a theory wherein the poor are supposed to get better conditions after a period of time, usually after the needs for health of the most affluent are satiated. The benefits to the poor are a function of the efficiency of the trickle down process.

PROPOSITION IB holds that a new set of values and premises are in ascendence, which will influence the international network of helping institutions in health care. These premises are:

1. Human development or quality of life oriented, where development is focussed on human growth, on increasing the proportion of people who enjoy human rights, especially the least advantaged in a society such as the poor in the villages.

2. Concerned with Step function change, that is, change on such a scale that a large number of previously disadvantaged persons move to a significantly better quality of life, to at least a minimal standard of health care.

   For example, if every village in a poor country had potable water, a step function change would most likely have occurred. Step function change would thus be a) widely experienced, b) widely known, c) largely irreversible d) moving from substandard to standard on some parameter of health care.

3. Oriented to egalitarian or preferably Benign Imbalance principles. Egalitarian values aspire to equality of rights although not necessarily equality of conditions in a total society. Benign Imbalance values support more allocation of resources and efforts to the neglected areas of a society on the assumption that more must be done to bring that sector of the population up to a humane, minimal standard.

4. Flow down and ground up values involve a) the acceleration of benefits from the affluent to the least advantaged b) coupled with a building of self-reliance in the village societies, in the area of health care.

We are in the midst of a revolution in man's awareness of his rights as a human being, including the right to health. The present population of the world is sparse, compared to the six of seven billion persons we expect on the planet by the year 2000. By 2075, the expected population is 40 billion persons. Thus, we must consider a world where 40 billion persons may be aware of their rights to health! Clearly the present efforts to meet the health needs of the poor will be grossly inadequate. At the present rate of voluntaristic activity, the gap between awareness and reality will become colossal.

Robert Heilbroner in his Inquiry into the Human Prospect paints a scenario of despair for both Western capitalism and socialism in the short and middle term. Increased industrialization at the rate necessary runs a serious ecological risk for the earth. Democratic institutions, Heilbroner says, cannot deliver the conditions necessary to assure the basic human rights of these new billions. Two consequences, he considers probable: a) the increase in terrorism from the poor nations, who, now possessing obliterative nuclear weapons engage in blackmail for the redistribution of wealth from the Rich to the Poor countries; b) the rise of authoritarian regimes, mainly repressive in character, who

promise to deliver such basic rights, as the right to health, and employment, but not much more. Freedom is considered a luxury. Compulsory voluntarism supersedes voluntary voluntarism in institutions.

In this scenario, compulsory voluntarism will keep the streets clean, barefoot doctors in the village, professors and students of agronomy on the farm. The egotistic orientation of Western medicine will thus be avoided. The status-oriented army of medical specialists will be accused of decadence and become enemies of the people! Medicine with the poor would become a matter of law, and career obligation not of choice. Most premises and values will underlie the social architecture of the era to come, according to Heilbroner.

Democratic institutions because of their elitist character in a sea of human misery would, in Heilbroner's scenario, be considered archaic and inhumane. Econocentric, palliative, elitist, and trickle down measures will be associated with the democratic approach. And massive controls on the individual person will be justified as necessary to assure the masses of at least minimal standards of living.

We can imagine that such vast social changes might bring counteractions, and violence of an unimaginable scale. We could move from despair to catastrophe.

Heilbroner considers as less probable the transformation of existing institutions to new modes of identification with the poor. And indeed he may be right. Today the Rich countries are asking themselves if they have gone too far in being preoccupied with their own poor. They question whether the poor can be saved. They wonder whether poverty is not in fact one of the natural conditions of a society. The poor, they say, may be necessary and permanent residues of societies. The affluent or advantaged will increasingly not be able to pay for the human rights of all persons.

PROPOSITION IIA holds that despite the propensity of governments to want to control health care of the outlying areas from the urban centers, there will be increasing ineffectiveness of health care institutions built on these values and premises.

1. Proliferation of statecentric institutions, where large government bureaucracies monitor and design health care activities for the village poor from their distant urban location.

2. Building knowledge centers and training centers, in the urban center, such that experts, and persons with skills are considered to be close to seat of government, while the poorly trained and the least capable are sent to the outlying areas.

3. Viewing the village as the periphery of society, even though most of the people may live in villages. The periphery has a low priority in the minds of central administrators.

4. A preference for centrally conceived, standard solutions for problems of the village, usually based on the urban experience and urban institutions.

5. A belief in the inherent and continued dependency of villages as institutions, with their permanent volunerability, their inherent lack of leadership, and talent, and of capacity for self-reliance.

PROPOSITION IIB offers as counter values and premises:

1. That government bureaucracies are the periphery, or at best one kind of coordinative center to be supplemented with regional and local centers.

2. The village is a key center of society when it achieves a minimal size. The village becomes a central societal institution.. The village is considered to have immense unused human resources. Villagers are considered to be able to be able to learn relevant knowledge and skills.

3. The village is a humane and innovative institution in the area of health care. Villagers can generate a new knowledge and new skills with appropriate support. They can

combine a personal caring for others with better technique and understanding of personal hygiene.

4. Self-reliance, pride in community, a spontaneous willingness to help others are village values which can be encouraged and learned, if external institutions are supportive.

Here I must recount a personal experience in order to lead up to the main point. As part of our annual summer vacation on a Greek island, we have visited a small village named Promyrion on Mount Pilion. The doctor who was also the mayor provided a most enjoyable learning experience for me, while giving us the traditional Greek hospitality of the village. He opened his dialogue, which was held in the public square, with the village populace gathered around: "When are you in the United States going to move from a preoccupation with the illnesses of the few to health maintenance and preventive medicine?" Unguided by central directives he had worked out a concept of a caring community with a preventive health orientation that would have been difficult to legislate from a central office in Athens.

He explained how his village was being educated for health an and healing in everyday events. He explained how he encouraged neighbors to visit with sick friends to make sure they were taking their medications. It was important to show the patient that someone cared whether they got well or not. The mayor explained how he anticipated certain kinds of complaints, mainly psychosomatic,

when there was an expectation that the olive crop was going to be bad. His community was his hospital. He was providing the leadership on the spot, in direct human encounters.

He did not mention that he had to suffer the burden of programs administered centrally with commando-like visits to villages, with little continuity, and depth in their impacts. I don't know, in fact, but I would submit there was more to learn from the Doctor from Promyrion about building involvement in health education, and a humane and effective community that he could learn from most of his urban colleagues. Even granted that this man was unusual (very few villages have doctors in developing countries) the proposition still would hold that the talent for understanding health maintenance and illness prevention of involving his community in the healing, helping process, is widespread and exists in every village. If only we could find ways of supporting, nurturing, rewarding this talent, these precious resources would not be wasted or ignored.

In his farewell news conference, Dr. Addeke H. Boerma retiring head of the Food and Agriculture Organization addressed himself to two related issues as regards the war on hunger. He first appealed to the developing countries themselves to undertake "courageious action" so wealth can be transferred from the smaller group of richer people to the large poor population." He also appealed to the food short nations for the "mobilization of the masses" to help overcome their problem."

"Unless they are personally involved in the countless aspects of rural development and thus acquire a sense of pride and self-reliance in working for their own betterment, no number of projects and no amount of investment will win the battle against poverty, hunger, and malnutrition. This not only a prerequisite--it is a must."

PROPOSITION IIIA holds that in the relationship between Industrialized and Less Industrialized countries of the Third and Fourth World, the following values and premises are becoming increasingly untenable, or will decline; in influence:

1. Unselected transfer of knowledge and techniques, the easy assumption that 'anything' conceived in so-called Advanced countries automatically applies to Poor countries.

2. Ethnolcentrism, the belief that experts from advanced countries are inherently superior to local experts, almost irregardless of their qualifications.

3. Advanced country orientation, the belief that it is in the inherent interest of a poor country to be transformed into the kind of society most advanced countries have.

4. Dysfunctional mimesis the process where locals are co-opted into the advanced country, trained there, supporting their xenophilic inclinations until they reject their less developed home country or go home to make over their home country in the Advanced Country Image.

5. Dependency creating, seeing all relationships as interminable, and dependent.

6. Paternalistic, wherein the Advanced country is a kind of benevolent parent trying to help a difficult child make his way into maturity, with the impatience and, frequently the condescension of the suffering parent.

PROPOSITION IIIB holds that opposing values are beginning to emerge and have equal validity for institutional design and mission formulation. These values are:

1. Selective transfer of knowledge and techniques, transfer under special conditions of applicability, screening the knowledge which is not even valid in the Advanced country or the techiques equally ineffective,

2. Polycentrism wherein the focus is on the uniqueness of the cultural, institutional, environmental properties of a society, at least at the outset; especially as regard health care institutions.

3. Poor country orientation where the distinctive conditions of poor countries have primary focus, especially the great shortage of professionals in health care, and the limited available funds for any kind of activity.

4. Indigenous innovations, discouraging imitation of advanced country solutions but creating solutions, including health roles which fit local conditions.

5. Selective interdependence seeking linkages with Advanced countries in areas which appear to have the highest payoff in terms of learning and practical utility.

6. Parity between professionals of advanced and developing countries. We shall say more about the distinction between paternalism and parity in our concluding section, because of its fundamental character.

The best of innovations is frequently treated with considerable suspicion, if it comes from a land different in values and beliefs. One of the main objections to foreign interventions in developing countries is that there is the presumption that the correct model for behavior resides in the advanced country. Thus developing country leadership accuses countries like the United States as contributing to the erosion of basic values and traditions without adequate replacements.

We should not forget that many of the solutions in advanced countries regarding the humanization of medicine have not worked. There is a temptation to take ideas which have not worked at home, to other countries in the hope that their standards will be lower. How interested are doctors in the U.S. in health education? Among the poor especially? Does the U. S. model for medicine, characterized as one of specialization, disease focus, special care for the affluent, and assembly line treatment seem as the appropriate for poor countries? There are doubts at least. Is not our focus still on treatment of the few who can pay, not on the

poor who cannot? There are dangers to pretending that we have ready answers for application on a large scale in poor countries.

And lest those countries with socialist systems of health care feel their models are more appropriate, the same cautions prevail: humane, appropriate, caring medicine for the masses over time and acceptable to the doctors themselves is not yet a durable achievement--as the present problems in the U.K. will attest and the patients in Sweden will readily admit.

Fundamental to the creation of a climate of learning is the recognition that while neither side has the answers, new solutions can be forthcoming. As regards the social technology of voluntarism, there is a great deal to learn from both advanced and developing countries regarding, financing, organization, professional administration, fund raising, and program management. But there are conditions which are quite unique in each country. For example, relations with government are often closer in developing countries, linkages with foreign institutions a mixed blessing, in some countries. This proposition indicates simply that because there are no precedents in advanced countries for dealing effectively with the poor on a massive scale and with little resources, it is quite likely that new institutions will be needed, new social experiments tried , while learning what is relevant from the social technology of voluntary health organizations in the U. S.

PROPOSITION IVA deals with the role of government and other institutions in promoting human rights especially the right to at least a minimal standard of health for all persons. Some governments may today regret they opened the Pandora's box of human expectations regarding their citizens' rights in society. Political, social, and economic institutions are tempted to continue to:

1. Ignore human rights to health on the grounds that these are nebulous rights since health and well-being is hard to define and not really highest in priority.

2. Deny rights to health on grounds that health is a privilege, and not part of any social contract.

3. Postpone dealing with human rights to health on grounds of limited resources, or higher priorities for other objectives such as economic development and military expenditures.

4. Give unacceptable tradeoffs for attention to health, such as drastically limiting freedoms in order to assure a standard of health care.

In the middle if not the short term, we would expect that these values and premises would be less favored.

Instead a PROPOSITION IVB will suggest there are new emergent values which will conflict with those of IVA. In some countries and some conditions, these new values will gain prominence.

1. Governments, social and economic institutions will promote a consciousness of all human rights, including the right to health.

2. The minimal standard of health education, personal hygiene and environmental requirements for health living will be known and publicized to all persons in a society.

3. In the service of promoting human rights for all citizens, voluntarism will be considered a positive value and citizen participation in health education will be supported.

4. The concept of human obligations and duties will be connected with enjoyment of human rights. In a poor country, especially, duties must accompany rights. This holds for the privileged as well as least privileged sectors of society.

There is still no adequate theory which is widely accepted connecting human rights with responsibilities. Such a theory would have to deal with issues as a) the duty of the advantaged to help the less advantaged on moral grounds and enlightened self-interest, b) the poor must work to preserve their rights as persons and the rights of others in their situation. Having rights then is not a passive and dependent posture; it means having obligations to assure that others have their rights.

Despite the Heilbroner scenario, we consider it equiprobable that increased government repression, torture, intimidation, the killing of dissidents, be they intellectuals or peasants will turn

out to be a precarious policy. Governments are increasingly vulnerable. It is risky to design institutions which try to reverse the increasing awareness that every person on earth has human rights, is entitled to at least a minimal standard of health care, and to a humane standard of living irrespective of what his father had.

No government can, for long, design structures and policies to coerce masses of citizens, so that they must wait two or more decades before they can have these minimal standards, while the privileged have them today.

Recently the Catholic Archbishop of Madrid warned the new king of Spain: "that he will preach and shout, if necessary, in defense of justice, human rights, and democracy." More institutions in developing countries may come to see that supporting human rights in health in performance, not rhetoric, are imperatives for village social architecture, which is durable over time.

While a dead peasant killed by the army may be quiet today, there is no guarantee that the sons of the peasants, the army, or even the landowners who deny health rights to the peasants will be able to raise their children in their own country in the future.

There is no way, in our view, to avoid the judgment of existing institutions as regards the willingness to support the developing of more effective policies to assure human rights to health. No doubt, there are great practical considerations in poor

countries regarding the right to health. But the Church, the Army , the Corporation and Government must stand up and be counted in defense of human needs and rights to health. Leadership will be judged in future generations as to how soon they were able to identify with the miseries of the largest numbers of people.

PROPOSITION VA deals with the question of the relationship of political ideology to the building of humane and effective institutions concerned with health care. Today, in many countries, socialism is considered to have as its major objective the care of poor and the disadvantaged. Capitalism, in these countries, in its focus on individual achievement and rewards tends to be less concerned with the disadvantaged and the poor of the village societies. Our proposition holds that the humane and effective character of any health care institution will over time be less connected with such factors as:

1. Ideology, wherein a political system takes credit for the humane and effective character of an institution, thus justifying its intervention in the activities of an institution on ideological grounds.

2. Since ideology is not subject to question in some societies, there is limited discloure of the humane and effective character of the institution.

3. The institution is justified by the ideology and not by its performance. Therefore the client's views of the effectivenes of any given health institution is considered irrelevant.

4. Since ideology tends to be monolithic, there is a preference for standardized solutions to health problems and little experimentation and empirical testing of each approach.

PROPOSITION VB takes the view that building humane, effective institutions can be separate from political ideologies.

1. The effectiveness of an institution can be determined on transideological grounds, thus making it possible to learn from all effective and humane institutions whether they appear in capitalist or socialist societies.

2. In order to assure the humane and effective character of an institution related to health care, for example, there must be a transparency of the activities of the institution and of the results achieved.

3. Client validation of the humane and effective character of the institution is a fundamental aspect of the evaluation process. This means that essentially the best people to validate an institution are the people who are served by it, not the people who control it.

4. Institutional pluralism and variety of experiments and approaches are more preferable than standard ideological solutions, to health problems, and health care.

This proposition is important, lest it be considered that only the socialist ideology can be concerned with health care for

the poor villages, and that capitalist and mixed economies are necessarily elistist. Given the unprecedented scale of prospective and present human deprivation, it would be dangerous and premature to conclude that any political system has an exclusive patent on the design of health care system for the poor.

The most frequently cited form of village social architecture is that of the People's Republic of China. The evaluation of the quality of village medicine has been quite favorable. But there is little assurance that other societies can develop a sense of collective self which appears resonant with Chinese culture. Nor do we know what price is paid for total system approaches of this character. We do not have a long time perspective of the social architecture of Maoist health care institutions, no do we know what innovations Western society would need to make to borrow some of the Chinese premises and fit them with Western self concepts.

Designing social architectural innovations for illness prevention is an underdeveloped area, a neglected human capability everywhere in the world including the Rich countries. Man, until recently, believed he would achieve dignity through his tool using faculties as evidence in the Industrial Revolution and Modern Science. Increasing skills in the building of humane and effective institutions, including health maintaining institutions has not been part of what Jacob Bronowski called the Ascent of Man. Our social architectural innovations in the health area have been

mainly for the more privileged and more affluent. The disadvantaged in body and spirit have come out as second and third class citizens.

Building institutions which are concerned with health of all persons regardless of their state of poverty, their sanity, their political influence, race or religion is still a primitive art. No ideology can claim to have the answers.

We do not mean to underestimate the progress observed in such experiments in social architecture as the Tanzanian ujamaa, the socialist village which is the cornerstone of Tanzania's development Ujamaa is a Swahili word which literally means family-hood. The ujamaa has come to mean Tanzania's unique socialist experiment.

The ujamaa village is supposed to be a self-reliant community. This community provides employment opportunities to every member of the village. The ujamaa is supposed to give each villager an opportunity to receive adult and primary education, medical treatment, and pure water, improved housing, and other essential services necessary for an adequate standard of living and fuller human development. By the end of 1974, it was estimated that about 80% of the peasant population lived in planned villages. 1.5 million lived in old non-ujamaa villages; 3.0 to 3.5 million lived in ujamaa villages (approximately 5,000 villages); 2.5 to 3.5 million lived in new non-ujamaa development villages.

Access to basic health, adult education, primary education, and communication facilities has been greatly improved, according to the Dag Hammarskold Report on Development and International Cooperation. But it is readily admitted that the ujamaa is in a state of transition. Cases of "regression, authoritarianism, or clientage are found." Whether the ujamaa will evolve into a "true socialist village with communal property, enterprise and few individual incentives, is yet to be seen. More than likely, when all the non-ujamma villages experiences are added to the ujamma experience, and when urban Tanzania has moved to a firmer economic footing, the unique insights will be best understood not in terms of socialism but in terms of Tanzanian social architecture, and those experiences in the health care area can be evaluated on non-ideological grounds.

It may turn out that learning from trials and errors will lead to prudent mixtures of the right to hold ownership to some land, some private enterprise, and a new blend of communitarian and individualist premises which improve the workability of the great variety of villages, and make possible a wider spectrum of humanrights than Tanzania can afford today.

There are experiments in the United States in public health education, there are community projects in other countries in the area of health education for the village, that can be added to the pool of learning.

PROPOSITION VIA is concerned with the relationship between a) institutions concerned with health care for the poor, governmental or voluntary and b) institutions who can bring resources to the task of providing health care for the poor. Declining values and premises will be, in the international network of institutions,:

1. Going-it-alone wherein each institution by virtue of its distinctive competence and unique mission prefers independence from other institutions.

2. A preference for competition between institutions wherein institutions with similar clients to be helped prefer to ignore what the other institution is doing, or even to undermine the efforts of other institutions.

3. A concern with amassing resources and controlling these resources for one's own institution's benefit.

4. Limited objectives for institutions. Since resources are limited, objectives are narrowed to the available resources not to the nature of the problem.

5. Token coordination with other institutions and then only when absolutely unavoidable, such as during disasters. Competitive relations are the favored mode especially for institutions with similar missions and identical clients.

Competition between commercial institutions is necessary and usually desirable. But when a massive effort to provide support for major human needs is necessary, in a continuous and effective way, new values and models will be needed

PROPOSITION VIB presupposes a massive shortage of financial resources over time given the scale of human deprivation in many countries. Institutions must act as constructive members of the international network relatable to health care for the poor with these premises:

1. Coalitional thinking in which the synergic potentials of linking with other institutions are systematically analyzed and evaluated. A primary coalition for consideration in the health care for poor countries is with the client institutions themselves, such as the village. Secondary coalitions are those between the helping institutions of the international network.

2. Authentic cooperation between institutions wherein a deep penetration of the bases for common efforts is made in relation to the same clients and similar problems.

3. Resource sharing wherein common resources, financial and human, are mobilized and shared in some common mission.

4. Interconnected objectives were interinstitutional planning is formalized to some degree to assure that objectives achieved by one institution will support and facilitate the achievement of objectives by the linking institution.

5. Interinstitutional innovations wherein by sharing plans, persons, and resources a new institution utilizing the strengths of each member of the coalition is brought into being.

The change from a competitive to a cooperative orientation between two or more institutions is imposed not only by a shortage of resources, but also by the dysfunctional consequences of having helping institutions actively trying to compete for the same client e.g., the child who is undernourished. The energies absorbed by interinstitutional conflict in the helping professions are wasted energies. When massive changes are necessary, this fragmentation process in the international health support system is a luxury. Thus interinstitutional innovations are necessary to channel the conflict created by overlapping missions into more synergic efforts.

Cooperation between voluntary and commercial organizations is probably at a primitive state of affairs compared to its potentiality in the international domain. As an example, we shall point out later in greater detail, that an evolution of the multinational corporation towards the new value system we are discussing here would open up new and interesting possiblities for coalitions.

F. T. Cary, Chairman of the International Business Machines Corporation wrote recently in The New York Times (Nov. 8, 1975),

"The unanimous passage of the United Nations Resolution urging action against world poverty gives multinationals a chance to demonstrate that they are the most productive device ever invented for speeding development. At the same time, the multinationals must demonstrate the kind of behavior that will make them welcome everywhere.

They must not only obey local laws but must take account of national development policies and local customs and hire and train local people. They must speed the transfer of technology to developing nations.

If the multinationals together with governments can resolve the differences, we can become true partners in development."

Finally, PROPOSITION VIIA attempts to summarize the previous propositions. We suggest that in the decades to come an institution will be perceived as lagging if it takes a negative position regarding the new values. These lagging institutions will be characterized as less humane and effective, and will lose support from more and more constituencies. Lagging institutions will provoke antipathy, and be considered less legitimate and less indispensable than other institutions. To review, these are likely to be the features of lagging institutions:

1. A tendency to deny and resist actively the emergent new values and rights for all persons.

2. A refusal to take a stand regarding the validity of these rights in an attempt to achieve a position of moral neutrality, or amorality.

3. Achieving only a superficial understanding of the clients changing consciousness of his values and rights, especially the poor as a growing constituency.

4. A tendency to see all who identify with the new values as threats to the established order, thus contributing to a climat of polarization and confrontation between groups, who hold different premises.

5. Evidencing a sense of hopelessness about the scale of human problems of the poor in the future.

PROPOSITION VIIB attempts to define, by contrast, the conditions under which institutions will gain ascendance, leading institutions will be considered more humane and more effective, more legitimate, and more indispensable by more constituencies. These institutions will be considered the key institutions in the international network related to health care or relatable to health care. They will gain support, both financial, and personal attracting persons with real talents, gifts, and motivations to help in this domain. These are the features of leading institutions:

1. A tendency to accept the growing consciousness of human rights and a desire to mobilize those who are committed to their realization.

2. A willingness to take a stand in favor of these rights despite apparent unpopularity, in some circles.

3. Achieving a profound understanding of client needs through extensive person-to-person experiences.

4. A tendency to seek out and mobilize institutions who hold the new values and who seek change through non-violent action.

5. Evidencing realistic hopes for the future with a commitment to learn how to build self-reliance in villages, and promote at least the minimal standards of humane care for all persons.

To illustrate what kind of transformation process an institution may have to undergo, we turn as an example to a more detailed discussion of the multinational corporation, a member of the private sector whose contributions in the domain of health care in the villages are yet underdeveloped.

IV. THE LIBERATING OF THE MULTINATIONAL CORPORATION

We turn now to an institution under attack for its premises and values, the multinational corporation, or MNC. The MNC is a profit-making institution, typically operating in two or more countries. It conducts research, manufacturing, marketing and distribution of its goods and services on a global scale. While in the 1960's the MNC was considered a unique institution because it was able to coordinate men, money and machines on the world scale, in the 1970's the MNC, especially the U. S. MNC is considered a viable institution of dubious legitimacy in many circles.

In the home country, the labor unions allege that MNC export jobs and technology, avoid taxes, and generally weaken the home country on the world political scene. In the host countries, both advanced and developing, the U. S. MNC is considered an instrument of U. S. interventionist foreign policy. In socialist and Marxist circles, the multinationls symbolize monopoly capitalism, imperialism, neocolonialism, as well as the exploitive tendencies of superpowers. Facts and myths are organized to produce a pattern of misbehavior that does not fail to capture the headlines.

I believe the MNC is a scapegoat for many of the world's frustrations and ills. It is true that the MNC has acted on premises and values which either are becoming obsolete or are being questioned. But the premises are also held in many other institutions. The MNC's themselves are currently involved in a

self-appraisal process regarding their social responsibility in advanced and developing countries. Their role as a purely economic institution is in question; but their desirable social roles and social responsibilities are unclear. The abuses associated with some MNC's have received a great deal of attention, and corrective policies should be expected, in the area of bribery.

As an international institution, the MNC as an aggregate have vast untapped resources. In general, the MNC is well managed, with technical expertise at world standards of excellence. The MNC can raise capital, and find outstanding talent around the world. It has geographical experience in advanced and less developed countries. It can use its international network to find and retrieve scientific and technical information. The MNC creates wealth. The MNC has a capability in setting objectives and reaching them at a profit, to be sure. But it makes philanthropic contributions in most of the countries in which it operates. Its executives do engage in voluntary activities.

In an international network of institutions relating to health care for the poor, it can play two sets of roles:

a) commercial, providing goods and services which are relevant to improving the poor's chance to reach at least minimal standards of health care,

b) philanthropic, providing money, managerial talent, and information relavant to health care and illness prevention.

Potentially the MNC can perform some linkage roles. It can connect both advanced and developing countries; it can build on its relationships with government and the private sector in poor countries.

The critical questions are:

1) To what degree can the Traditional MNC, based on its present values and premises make a constructive contribution to health care for the poor?

2) To what degree can and must the MNC evolve into what we shall call a Liberated MNC built with new values and premises which can take on a leading role in this domain in the decades to come?

What <u>are</u> the values and premises of the <u>Traditional multinational corporation</u>? First and primary, the multinational corporation is oriented towards profits, and to its shareholders in the home country. Its products and services typically were designed and developed in the home country. The key people at the headquarters tend to come from the home country.

In developing countries the corporate image tends to be that of a rich, powerful, elitist and organization having more in common with the local oligarchy and aristocracy than the "people."

The MNC, unless host country laws do not permit it, prefers 100% ownership of its affiliates in order to control the affiliates policies, products, use of transferred technology. The MNC prefers to "go it alone." It prefers to own and control its resources.

The liberal, laissez-faire economic theory is preferred by free enterprise. This leads usually to a belief in "trickle down theory."

Management needs to keep advanced technology in the home country, partly to keep the affiliates dependent, to further the indispensability of the firm in the host country for decades to come.

Country management is necessarily rewarded for staying profitable at a level that invites further investment. This profitability is achieved by producing good products, carrying the company name, usually at competitive prices. Thus, its main commercial role is in the sale of its products, service after sale, at a profit.

The MNC typically takes no strong position on human rights, which would be markedly diverse from local customs. It tries to be "neutral," favoring political stability and social peace. It is generally considered as a leading economic institution, in most countries. It provides good products, employment, technology and pays taxes.

There is little systematic data on the philanthropic activities of the MNC world wide. Each affiliate tends to do what is acceptable or desirable by local standards. Philanthropy is considered to be enlightened self-interest. A diverse number of small, but worthwhile projects may be supported, with obviously not a great expectation of significant social change as an outcome.

Despite popular journalism, and some spectacular episodes, the MNC is most typically not a seeker of political power, nor a subverter of governments. MNC's resist being instruments of home country foreign policies, if only for the good reason that they would like to be considered good local citizens. But the values and premises on which the MNC is built are not the only ones. Indeed, if there is a worldwide value shift, can the MNC be immune to these changes, and still continue to be viable?

Suppose the MNC aspired to adopt some of the emergent values, and to become what we shall call a Liberated Multinational Corporation.

We shall use the term "liberated" in two special senses:

a) a non-violent self-questioning process whereby old values and premises once dominant in the organization are evaluated for their humane character and their future implication for the survival of the organization,

b) a renewal process where new values are adopted which make the organization more humane and more effective. We note that a similar kind of liberation process could be conducted with other institutions, including voluntary health organizations.

The Liberated MNC would be oriented both towards profitability and legitimacy. The MNC would be accountable multinationally for its key investment decisions; its social

responsibility to its various constituencies at home and abroad, would be made clear.

Products and services would also be designed specifically for developing countries, including the poor of the developing countries. These products and services would be based on an understanding of the needs of the people, their priorities, the conditions of usage.

The Liberated MNC would aspire to become an egalitarian institution, a corporation with a human face. It would be known to show genuine and sustained interest in the disadvantaged groups, including the rural and urban poor. To this end, it would engage in a great variety of coalitions of a commercial nature with the host government or other local institutions to benefit, for example, the villages with relevant expertise and training.

By its policies and practices, it would work for flow down and ground up theory. This would be evidenced in its performance, in developing self-reliance in people associated with the institution, and in its village clientele. It would be known as an institution oriented towards human development.

Country management would be rewarded for profitability as before but also for its reputation of building a leading enterprise valued by all social classes, especially the poor. Country management would be required to take positions, identifying with human rights, including the right to health, as well as human obligations to help others achieve their rights.

The Liberated MNC would take pride in being considered a leading socio-economic institution.

The philanthropic roles of the Liberated MNC would be carefully planned. Philanthropy would be concerned with results, and especially with step function changes, especially in poor areas, to help them reach at least the minimal standards of quality of life.

The Liberated MNC would be willing to experiment with coalitions with other kinds of institutions, as long as a major contribution could be made, with visible milestones of progress. Coalitions with government or other institutions would have benefits in the area of personnel development. Future talent can be identified in successful joint projects. Managers whose area of technological competence for the most advanced technology may have a real contribution to make in the kinds of situation which the villager lives.

The critical choice for the liberated MNC is its identification with the village society and its needs, since a large part of the population in a poor country is found in villages.

What are the main constraints against building an MNC with the Liberated values and premises? Here are a few. The traditional assumptions have worked well and are expected to continue to work in advanced countries. For some MNC's the poor countries are the least important markets. Most have around 80% of their sales in the rich countries. The corporate self-image is that they are not

a charitable institution, as might be inferred from some of the premises of the Liberated MNC. Philanthropy can only be a very peripheral activity, and is based on profitability first. The financial community tolerates only, to a certain degree, discussions of social responsibility, and much prefers optimistic forecasts about future earnings. Besides, they would say, charity begins at home!

There is, understandably, no clear ideas as to how viability and legitimacy considerations would be systematically and quantitatively brought into key capital investment decisions. Senior executives have furthermore strong suspicions that they will be damned as evil no matter what they do. Some have memories of good (usually paternalistic) efforts that did not spare them from being tarred with the same brush that all foreign firms are subject to.

There is difficulty in imagining how the MNC could simultaneously satisfy at home and abroad the conflicting demands of the various constituencies of an MNC. New and more vocal claimants are surfacing each year.

There is also the fear that in tightly controlled or politically unstable countries, the liberated position would be seen as too activist, provocative and intrusive. Many governments, the MNC's say, misunderstand their good intentions or misuse even the most benevolent of offers for information. Some report that they have been disappointed in their attempts to work with government

because of red tape, because of the distrust of the bureaucrats and local business of foreign business help. The shortage of trained personnel in the government is an obstacle also, the MNC's say. Coalition with government, a few say, may be a first step towards socialization of the enterprise.

When the MNC takes a philanthropic role it has a strong and understandable desire to get credit for what it is doing. Getting mixed up with other organizations may dilute the credit they get. Furthermore, coalitions are difficult to make work, to get effective decisions, rather than mediocre compromises.

Some senior executives are in a state of inner conflict. On the one hand, they hear the mounting attacks on the MNC and on the other in private they are told not to listen to what is said in public rhetoric. As long as they bring money, technology, make good products, hire local people they are good citizens. For those who are "out to get the MNC", no amount of good behavior would change their views, they say.

It would also be a mistake to consider the MNC a monolithic entity. The corporate headequarters may be quite convinced that a concern with social responsibility is necessary. The affiliates in various countries may be frankly skeptical. As long as they are profitable, why should they waste their time on ideas created in the home environment which are, the country managers can say, applicable to local conditions.

There are also some powerful forces in the direction of the Liberation process. Some firms say they are already on the way to building a firm liberated on some but not all of the parameters mentioned above. But they have not named this process, a liberation process! Most senior executives believe that the MNC in the foreseeable future will be under continued and escalating attack. They admit they have no clear model for developing a viable and legitimate MNC. The search for a positive image is considered enlightened self-interest. Few large firms do not have senior officers in the Public Affairs area! The markets in the developing countries are the growing markets. New strategies are being designed for even the most hostile of environments, e.g., joint ventures, packages of capital and technology. We must not underestimate the flexibility of the MNC. After all, MNC's are already acceptable in the U.S.S.R. and the People's Republic of China.

The forces for a more liberated approach are beginning to be felt in the affiliates, too. While the programs conceived in headquarters for the headquarters environments will not be easily transferred, with encouragement, innovations are forthcoming at the country level. The country managers not infrequently are members of the oligarchy. Some live in fear of kidnapping. Others hear their children and worry about the decades to come. There is no shortage of concern about the future, given the social unrest in many Poor countries. The leadership of the more forward looking MNC's know they must find a constructive and legitimate role in the Poor countries, with a long-term view. But, understandably, the

the executive mentality is attracted to result-oriented projects not symbolic and token efforts. They sense that host countries are beginning to distinguish good from bad MNC's. The good MNC's are likely to be the ones which have values which resonate with those of the poor countries social and economic objectives. The good MNC's will help get things done!

There is also fear that the present distrust will escalate with even more terrorist activity, with MNC's as favored targets.

Senior executives as human beings may recognize that the growing consciousness of their constituents of their rights is an irreversible process. Some are realistic enough to accept the inevitable, and indeed identify with the inevitable. Senior executives realize, as is indicated in the quote from the IBM Chairman above, that it is time to get off the defensive. While the poorest are not yet their customers, they are future stakeholders in the MNC. This can lead to a willingness to try new models of cooperation with government, new kinds of coalitions concerned with visible, step function contributions to a society.

Clearly there are and will be some governments who, under conditions of constructive cooperation would be favorably disposed towards a firm being on the side of helping the masses of persons enjoy their rights to health.

The Liberated MNC should value executives with liberated values, who are willing on a voluntary basis to help in national

efforts in the villages to assure health care in all parts of their country. A liberated MNC executive in a country would share the Persistent Vision: that all the poor in his country have a right to at least minimal standards of health, and that all the children in his country should drink clean water, know what improvements in personal hygience would reduce the likelihood of childhood diseases, and avoidable physical suffering. For it may be that what is needed is not "cash handouts," but executive time and commitment to voluntary organizations, with the village as the favored client system. One side effect would be the transformation of the MNC to a more humane and effective institution, because of its humane and effective leadership.

Of the several thousand firms around the world, in the U. S., Western Europe and Japan, who could be classified as MNC's, we would expect a different balance of forces for liberation values, and for the traditional approach. The leadership of the MNC is a critical factor. On balance, our view is that if the transition to a new value system continues, the forces towards building this kind of MNC will inevitably increase.

We would be remiss if we did not raise similar kinds of questions about existing voluntary health organizations. A similar kind of analysis might be conducted. What are the values and premises of the great variety of voluntary health organization? How much do they identify with the new values? How liberated are they? Such an analysis would be needed for:

(a) The Service Agencies concerned with both the health and non-health sectors, and those organizations concerned with specific problems like leprosy, tuberculosis, blindness, health services for women, children, refugees.

(b) The Professional Associations who are concerned with the broad range of health problems, professional standard, health legislation, setting of national priorities, the dental, medical, and nursing associations, and the multidiscipline associations like public health associations.

(c) The Institutional Associations like the associations of Medical Schools, Schools of Public Health, the Hospital Associations and Health Organizations.

For as we shall indicate later, if the private and voluntary sector are to cooperate, they must have similar values.

V. FROM PATERNALISM TO PARITY

From the vantage point of the Twenty-first Century, and no doubt in the midst of the Global, Regional and National crises of the future, the social historians will view with rational retrospect the unbalanced condition of the planet, the fact that about three quarters of the world's investment, services, and wealth and almost all of the world's research was in the possession of one quarter of the people of the world. They will study the historical documents, the statistics and demography of human suffering, and duly note the meager level of untied aid, and its uses, and will marvel that Man of this era was able to avoid direct humane solutions to the global inequities. They will read with interest the Cocoyuc Declaration of 1974, and especially this passage:

> ". . . the failure of world society to provide a safe and happy life for all is not caused by any present lack of physical resources. The problem today is not one of absolute physical shortages but of economic and social maldistribution and misuse; mankind's predicament is rooted primarily in economic and social structures and behavior within and between countries."

How noble and how Utopian they may say that there were dreams of a World Society which could provide safety and happiness for all persons! How insightful to recognize that the roots of the problem were not in physical shortages, but in maldistribution and misuse of these resources, and that man's institutional environment and his behavior was the cause of his predicament. Yet, in the wisdom of hindsight they most assuredly will ask, "how was it

possible that, having made such acute diagnoses of the mess, it took so long to find workable models of collaboration, design humane and effective institutions, and learn the behaviors necessary for constructive relationships between what were called the Rich and Poor Countries of that time?"

The more compassionate of the social philosophers will try to seek in the character of the present relationships what is going wrong. The will look at the Poor Countries in their postindependence period, and understand:

1. How the frustrations at slow progress in relation to their aspirations led them to search for the Demons who were holding them down. The egoism of the Rich, their willingness to transfer resources without restrictive conditions, their institutions like multinational corporations, Technology and Industrialization, in exploitive Western forms, were considered by the Poor countries from time to time as the causes of their underdevelopment and misery.

2. How at the same time the Poor Countries sought self-reliance, and independence from foreign intervention, and to build their own non-aligned models of national destiny, they were constantly tempted to emulate the Industrial forms of the Rich Countries, and ofttimes envied them for their achievements.

3. How despite a desire for self-determination, they took the counsel of the experts and specialists from the Rich countries, their economists, and military advisors.

4. How in the quest for national pride a few countries preferred not not have foreign help and let hundreds of thousands starve than admit the difficulties of building an independent state. The psychological and political costs of relying on foreigners were considered too high.

5. How in the assertion of their national independence they used the international arena to attack, and affirm their unwillingness to sell their support for agreement on issues which did not carry the message of their liberation from foreign domination.

6. How in the negotiation process with Rich Countries, they felt their bargaining chips were few and their capacity to behave as adult equals was constantly subverted.

7. How there was, perhaps less conscious, a fear that they would be abandoned in their efforts to be self-reliant.

Two illustrative quotes convey a prevailing sentiment:

The late Dr. Kwame Nkrumah, Prime Minister and President of Ghana in his book Africa Must Unite wrote:

> "Thus all the imperialists, without exception, evolved the means, their colonical policies, to satisfy the ends, the exploitation of the subject territories, for the aggrandizement of the metropolitan countries. They were all rapacious; they all subserved the needs of the subject lands to their own demands; they all circumscribed rights and liberties; they all repressed and despoiled, degraded and oppressed. They took our lands, our lives, our resources and our dignity. Without exception, they left us nothing but our resentment. It was when they had gone and we were faced with stark realities, as in Ghana on the morrow of our independence, that the destitution of the land after colonial rule was brought sharply home to us."

More recently, Michael Manley, Prime Minister of Jamaica declared in a speech a year ago:

> "All the worst features of exploitive capitalism were exported to the Caribbean by colonialism. Between these two forces we were bequeathed a society which is elitist in structure, acquisitive in motivation, and dependent in psychology. .
>
> Our elite regard itself as belonging to a superior order of man and justified exploitation by assuming the essential generic inferiority of the exploited.
>
> Since the elite held all the levers of advantage, acquisitiveness could only underwrite their social and political advantages with material wealth."

It should be noted that Jamaica is trying to transform itself into a non-capitalist society. Yet, youth and other groups consider the call for fundamental change, to eliminate elitism, acquisitiveness and dependency as a psychological condition, as insufficient. For this sector of youth, the enemy are in power and the means to get change, they say, must be violent.

The social philosophers may equally take note of the new reactions of the Rich Countries, especially in the U. S.

1. The Western Rich Countries are increasingly disturbed at the ingratitude shown by the Poor Countries. These attacks are interpreted as rejection of the political and economic systems of the Rich Countries. Western countries feel that these public attacks of the Poor Countries are unfair or hypocritical since a) they continue to seek aid privately, b) the Poor Countries

seem reluctant to attack Eastern countries in public, while criticizing them in private.

2. The Western Rich Countries feel they permit a wider spectrum of human rights in their countries as compared to Eastern European countries, yet the Poor Countries do not acknowledge these differences.

3. The Western Rich Countries are beginning to feel that aid does not really benefit the people but serve to maintain regimes which are not concerned with the distribution of income within their countries, or the human rights of their citizens.

4. More recently, the U. S. position in the United Nations has been to "speak out against unfair allegations." The Western Rich countries are urged to rid themselves of unjustified feelings of guilt regarding the Poor Countries.

P. T. Bauer, a professor of economics who specialized in the economic development of underdeveloped countries, wrote recently in an article entitled "Western Guilt and Third World Poverty," a series of counterarguments against the claims of the Poor Countries regarding their sense of exploitation. He says that Western policies and activities are promoted by a sense of guilt. Policies motivated by guilt,

". . . do not usually promote the welfare of the people they are supposed to help. Appeasement of guilt has nothing to do with a sense of responsibility. . ."

Elsewhere he writes in this article:

> "The most brutal maltreatment of minorities and the most extensive official discrimination on the basis of color, race or religion in the Third World are often excused by saying that they have been inspired by the West. In fact, colonial governments have usually protected minorities and not persecuted them. . The view that these policies and attitudes have been inspired by the West implies again that peoples of the Third World have no will or identity of their own and are simply creatures of the West.
>
> Toleration or even support of the brutal policies of many Third World governments then seems to reflect a curious mixture of guilt feelings and condescension. Third World governments are not really guilty because they only follow examples set by the West. Moreover, like children, they are not altogether responsible for what they do. In any case we must support them to atone for their alleged wrongs, which our supposed ancestors perpetrated on their supposed ancestors. And economic aid is also necessary to help the children grow up. Similarly, the most offensive and baseless utterances of Third World statesmen need not be taken seriously, because they are only Third World statesmen (a license which has been extended to their supporters in the West.)"

These perceptions and sentiments are now reflected in the institution-based transactions between Rich and Poor Countries. On balance, they are now obstacles to building constructive relationships between the Rich and Poor Countries. On the other hand, the social philosophers of the future may marvel that, despite the rising cacophony of the debate, both Rich and Poor Nations insisted that some kind of "dialogue must continue, however, euphemistic the term dialogue has come to signify. History will record, I believe, that no matter how imperfect the communication process

between Rich and Poor Countries became, all parties sensed, in an existential sense, that the Planet Earth has imposed on all people some kind of destiny -- a better, more humane world or disaster.

There are many theories about what is really happening between Rich and Poor Countries. All theories, no matter what bias, have perhaps some merit, in that they focus on some special aspect of the complex set of personal and institutional relationships on the Rich - Poor dimension of the human race.

Our view is perhaps incurably optimistic. We interpret the processual aspects of the Rich - Poor Country relationship in these terms of reference: we are moving through a very difficult period a) where the Rich Nations are being required to give up those policies which were called Paternalistic and malevolent (e.g., exploitive, colonialistic, imperialistic) and those policies and attitudes which are paternalistic and benevolent (condescending, patronizing, infantilizing) b) to a state of affairs in which countries, institutions and persons act on a parity of egalitarian basis, wherein authentic collaboration is possible.

A great deal of unlearning or behavior patterns is required in the transition period between the more malevolent forms and even the benevolent forms of paternalism, until a condition of parity of fraternal cooperation is achieved.

We call this transition period the parity achieving process, wherein the countries called Poor, achieve a self-reliance and

self-confidence, and a sense of controlling their own destiny. This period is considered a necessary stage before both Rich and Poor Countries can behave like genuine partners.

Both malevolent (exploitive) paternalism and even the benevolent forms of paternalism (which Western intellectuals find tempting at times) have as a common core the belief that the Poor Countries must be treated like helpless or rebellious children. These helpless or rebellious children, the paternalists say, are floundering and do not know what they want, nor are they responsible for what they do. However, empathic the benevolent paternalists think they are, I am convinced that the statesmen and the citizens from the countries called poor, eventually come to see through to the core beliefs and resent paternalistic attitudes.

All human beings in responsibility are desirous of dignity and self-respect. They want genuine adult to adult, person to person relationships. They are adults physically and emotionally; any other kind of encounter is demeaning.

We shall now turn to (a) an analysis of the behaviors and attitudes which paternalistic institutions encourage in their membership, (b) Then we shall give our description of the ideal state of parity between institutions and persons and behavioral description of the authentic collaboration process, (c) Finally, we shall give a description of the parity achieving process in which the unlearning of the paternalistic behaviors and responses occur.

Our main thesis is that: building constructive relationships between institutions, like the U. S. voluntary and private sector and their counterparts in Developing countries under paternalistic premises, attitudes and behaviors will be increasingly ineffective and undesirable, and that building durable and constructive relationships under conditions of parity ought to be the long term objective.

Paternalism and Its Discontents

What is a paternalistic relationship (of the benevolent kind)? How do persons occupying roles in institutions with paternalistic missions see themselves? And how are they seen by persons and institutions in the Poor Countries at the outset, and over time? We shall not review the last five hundred years of colonial and post-colonial history. Those instances where a colonial power has treated the indigenous people with cruelty or kindness, or where the resources of the country have been pillaged or developed, leaving few or many trained persons for the independence era, will not be discussed. A distinction is made by some scholars between the domination of peoples in the colonial era, no doubt, with malevolent consequences. The psychology of the colonizer and the colonized in Algeria has been treated by various scholars and writers. Fanon's A Dying Colonialism and Mannoni's Prospero and Caliban are instructive documents, and give insights that should not be forgotten.

We shall focus on the institutions and persons today from Rich Countries who give aid and technical help to Poor Countries who now are independent. Those advisors who may be hired by the developing countries to help them formulate policies, may also fall into the paternalistic posture.

One observation should be made at the outset. Many Poor Countries, and no doubt many U. S. legislators would accept the proposition that U. S. foreign policy frequently mixes paternalistic roles with ideological purposes. Aid is seen as a way of justifying the American Way, or to prevent competing ideologies from gaining too strong a foothold in Poor Countries. Where U. S. investment has a major interest, aid is seen as a kind of guarantee. Thus political and economic purposes, for most developing countries in part explain aid, for the recipients. Similarly for some forms of charitable behavior.

The paternalist may accept these motivations as natural. But as an individual in a role with a paternalist mission there are some satisfactions which explain, in part, the impacts that the institutions has on the host country people it serves.

The paternalist frequently defines his role as charitable and humanitarian, since he is helping a needy country. He gets satisfaction from the process of bringing money, knowledge and know-how to people who need them. Paternalistic institutions usually believe they have a moral purpose.

But in addition, foreign paternalist institutions in a host country necessarily give authority roles to foreigners. In the host country, these foreign experts and representatives command respect, attention, and may carry the symbol of status and immunity. All this appears harmless enough, but the paternalistic institution which brings resources, gathers power. These resources can be made available or taken away.

The paternalist, consciously or not, invites emulation, and with sufficient power can require others to follow what he considers to be the best course. He can try out techniques that did not work at home. His audience in the poor country, may be a compliant one, because he brings modern techniques which are considered to be better than the local methods.

The paternalist institution, has people who have the secrets of advanced technology with all its mystique. So foreign experts are put on a pedestal and domestic experts are considered inherently inferior. The paternalist may come to believe he is naturally superior and the local talents are naturally limited. After all, he is the delegate, and the carrier of the culture of a rich and powerful country. Such are the heady wines of paternalism!

The persons and institutions fromthe Poor Country may, at the outset, accept the political and economic motivations of the Rich Country. They are poor and while they may not like it, the Poor Country knows it needs foreign help. For some Poor Country persons, there is a sense of security in the dependency relationship with a

foreign institution. A wise and benevolent foreigner with a few but acceptable ulterior motives has come to offer protection from dangerous outside forces. The foreigner may come from a powerful country. The home country has impressive technological prowess (and even large armies). It may even seem normal for a while that the paternalistic institution tells the host country what it needs. The Poor Countries at this state may be uncertain what they need in order to "be developed." The paternalistic institution furthermore appears to give more than it gets, at least in some area. Support, loyalty are hardly expensive.

At this stage, it takes the two parties to make a paternalistic relationship. For the Poor Countries, the choice for a long time is not between paternalism and some other kind of relationship, but between paternalists from the East and West.

We hold that, in the contemporary situation, the paternalistic relationship is unstable. The new values, we discussed above, and especially rising nationalism are forces against the acceptance of paternalism. There are many factors which contribute to the erosion of the relationships. A key factor is the perception that the paternalistic institution and those who hold key roles in them treat their counterparts like children. Another factor may be the growing belief that the paternalistic institution is not really interested in the Poor Country for itself but as an instrument in achieving political and economic objectives. The paternalist may be seen as taking more out than he gives economically, that is, he is exploitive! Furthermore, a stream of experts come from the

foreign country and act as if they were inherently superior to their Poor Country counterparts. The paternalistic relationship becomes stifling. The Poor Country counterparts may feel dominated, patronized, or just looked down upon.

The pateranlist may react to the growing negative sentiments by threatening to leave, by accusing the local counterparts of disloyalty. The local person feels more like a second class citizen in his own country.

The paternalist, consciously or not, sends such implicit messages as

1. "We know better than they do what programs they should have."
2. "Let's not bring the local institutions into the project, since they don't have capable people."
3. "Let's give the local institutions the impression that they are participating."
4. "Let's bring their people to the home country so they can really learn the right way."
5. "They are like children. The want everything but they don't want to work for it."

These messages encourage the rising anti-paternalistic sentiment.

Many persons who occupy roles in institutions with benevolent paternalistic missions may be dedicated, sincere, non-political and may deplore their home institution's condescending policies. But

when the anti-paternalistic sentiment begins to increase in the country, these persons are seen as the exceptions who prove the rule.

The anti-paternalistic groundswell may begin with the more radical students, the turbulent youth seeking their own inner liberation. Or it may start with nationalistic leadership who have a policy of non-alignment with Rich foreign nations. Nationalism is an irresistible and powerful force, which often appears to the paternalist as self-destructive, or as ingratitude.

Among the paternalists, there is shock and disappointment, a feeling of loss of prestige, respect and affection. It is hard for the paternalist to hear the message: "we want to be free of your influence now, and be self-reliant!" The paternalist hears this message as an immature rebelliousness, since, in his view, the Poor Countries are not ready to strike out on their own.

A neutral observer is more likely to see the real situation. The old roles do not fit any longer. A new set of role relationships are required.

The Quest for Parity: The Ideal State

Paternalism becomes obsolescent. Why not proceed directly to parity, to egalitarian and authentic cooperation? It appears easy for the Poor Countries to shed the paternalistic relationship. The paternalistic institution may intellectually understand that the rules of the game have changed. But in practice it is not so easy, for either party.

In the minds of the delegates from the Rich and Poor Countries the difference in technology, in standard of living may remain very great. How can these facts be changed?

First, let us examine the ideal state of parity. What does authentic collaboration among equals look like, feel like? How do good "brothers" behave, in good times and bad? We give our view of the parity syndrome in interpersonal terms, intermixed with characteristics of interinstitutional parity. Institutional parity between Rich and Poor nations would follow similar premises, roles and policies.

First and foremost, among true and equal partners, or between institutions which relate as equals, the two parties see each other as adults. Each adult has his strengths and limitations. Each institution has its distinctive competences and weaknesses.

A desirable condition for partnership are shared values, and concerns, such as the belief in the right to health for all persons, or the village as a self-reliant center of health care and education.

Each party must feel he can influence the decision making process, and the results of the collaboration are jointly identified with. The objectives, and criteria for success should be jointly set. Each party ideally should be learning from the collaborative process. And each party should feel he brings, and be perceived as bringing, something of unique and equivalent value to the joint work. Neither party should feel it has "all the answers." Each

party has complementary resources. Each party should have mutual respect and trust for the other's competence.

Reciprocity should be a norm. If one side disagrees with the other, then the other side is permitted the same rights to clear the air. And in the resolution of conflicts, it is likely that each party will be partly at fault.

The ideal parity state is a fraternal model, where there is approximately equal power, and mutual dependence, that is interdependence. The joint project is mutually conceived and dissoluble upon mutual agreement.

We believe these behaviors are intuitively understood as the basis for productive collaboration between two partners. Two institutions working together with the ideal parity gound rules must feel they can do more than each institution working alone; they could, for example, take one step function changes.

Consider what would need to be unlearned if two parties engaged in a paternalistic relationship heretofore now want to behave in an egalitarian way. The list is long and the possibilities for regression to the paternalistic state constant. The Rich countries have to give up telling the Poor Countries what to do; they have to work with people they must learn to respect; they have to feel they get as much as they give. They must be able to take criticism and of course 'dish it out.' The Poor Countries have to believe in their own ideas, in their capacity to select good and relevant ideas from their partners. In short, they must have confidence in

themselves, accepting their strengths but recognizing their limitations, as do their Partners. Both have to expect that if they criticize their partners, their partners have to feel free to respond. If they condemn their partners in public, they should not be surprised if their partners become angry. Both must feel sufficient mutual trust, and comfort with their partners to engage in open, honest communication. Above all, they must feel that the partners are engaged in a common mission, and have similar values. Finally, there must be a feeling of reciprocity. Each partner must feel he get as well as gives.

Such, in our view, is the ideal parity state towards which Rich and Poor Countries must move.

The Parity Achieving Process: A Transitional Stage

The parity syndrome is an ideal state of authentic or genuine collaboration between Rich and Poor Countries. But the transition from the paternalistic mode, even the more benevolent kind of paternalism cannot be too abrupt. Both Rich and Poor Countries need time to unlearn the former patterns of transaction. The unlearning process is not automatic. It proceeds by trial and error. The tendency is for those who held paternalistic roles is to continue to prefer them, and to see as unreal, appearing to be "equals" with those who are in fact dependent and underdeveloped. The Poor Countries may be equally uncertain. Paternalism is seen by most to be a structural feature of our lopsided world. More than often, when progress towards parity appears slow, some Poor

Country leaders may, not always consciously, feel nostalgia for the benevolent paternalistic relationship.

First, I shall describe what I feel are the distinctive features of the parity achieving process, the transitional period between the paternalistic relationship and the ideal parity situation. Then we shall point out those features of the parity achieving process which are similar or identical with the ideal parity or authentic collaboration situation.

The distinctive aspect of the programs, policies, behaviors and interinstitutional coalitions, in the parity achieving process should be governed by what I have referred to above, as the Principle of Benign Imbalance. The Principle of Benign Imbalance states that the more disadvantaged the country, and the more limited its resources, the more the Rich Countries should behave in such a way as to contribute to an equilibration process. The Rich Countries should design their policies, realign the missions of the transacting institutions to correct the difference between Rich and Poor in selected domains, bolster and strengthen the Poor Countries in such as way so that the relationship moves towards a true partnership.

The role relationship, however, in the parity achieving process is not of equals. The advantaged countries are helpers, assistants, facilitators, always aware of the unique concerns, and aspirations of the people they work for, the Poor Countries.

It would be easy to confuse a relationship based on the Principle of Benign Imbalance with benevolent paternalism. There are very important differences however which are translated into actions and policies. Unlike the benevolent paternalist, the Rich Country helpers are not motivated by guilt, or the feeling that they must protect the Poor Countries as irresponsible children. The parity achieving process requires that the temptations of Rich Countries to manipulate their counterparts, or subtlely bring them around to the right way must be attenuated. The parity achieving process? We list them here:

1. While the Rich Country helpers can present information, and exert influence on the decision making process, the major responsibility for the decision is with the Poor Country.

2. The Rich Country should promote and help the development of Host Country experts, and build on domestic capabilities.

3. Projects should be undertaken where the Rich Countries in a specified time phase out their help so that the Project is self sustaining. Of course, new projects may be designed.

4. The Poor Countries should get better conditions for the transfer of relevant knowledge, techniques, or resources than advantaged countries.

5. The Rich Countries should refrain from developing, by the control of the foreign resources, a power relationship which reverses the roles as they are defined at the outset.

6. The Host Country decides what the objectives are, and what the criteria of effectiveness or success will be. If the Rich Country cannot identify with these objectives they should not participate in the helping role. But the Rich can offer information and suggestions, of course.

7. The Host or Poor Country decides who the helpers will be on the basis of their evaluation of the helpers' attitudes and capabilities.

Translated into the health care area, the Rich Country helpers are assistants would:

1. Show a constant awareness and respect for the social and economic objectives of the host countries, and relate to the health needs and rights as they are formulated.

2. Relate to their counterpart organizations in the role of helper, facilitator, assiting in identifying those obstacles to health care and maintenance in villages.

3. Act as facilitators in the development of voluntarism in the Poor Countries at the village, town and urban level.

4. Act as supports of local experiments and ideas for teaching preventive health care education and providing relevant social technology for improving voluntary organizational functioning.

5. Measuring the success of their help in terms of (a) the experienced self-reliance in the Poor Countries, and (b) the extent and nature of the emergency of highly motivated local leadership in the health care area at the village and town level.

6. Encourage and assist, where asked, and under conditions specified by their counterparts, in the development of local innovations in the teaching of preventive health care.

7. Assist in finding resources, coalition partners and getting general support for the high priority programs in the village area which bear on preventive health care, always accepting that local leadership will be in charge of and accountable for the programs undertaken.

What are the similarities between the parity achieving process and the authentic and ideal state of parity?

The institutions and persons who work together in the role relationship we defined, of host country prominence and control, should:

1. Have a shared set of values regarding health care and the importance of the village as a center for learning and action.

2. Have mutual respect for each other and professionals and adults.

3. Engage in open and trusting communication

4. Trust each other's intentions and capabilities

5. Feel that neither part has all the answers

6. Consider each party has valued resources, and a constructive contribution to make to the joint work.

7. At the outset, feel that neither party could achieve step function change without working together.

8. Accept each party's strengths and limitations.

Strictly speaking a state of complete reciprocity cannot apply in the parity achieving process, in the short term. The Rich helper however should feel he gives as much as he gets in the long term. The satisfaction he gains from seeing persons achieve their rights to health must, in itself, be rewarding.

The Development of the Coalitional Potentialities of the International Network: The PRIVOL

What roles can the U. S. private and voluntary sector play in the improvement of health care in the town and villages of poor countries? In view of our analysis above, we would suggest that coalitions between and within Poor Countries would have the best chance of achieving the kind of parity situation we advocate, and avoiding the controversial aspects of paternalism. International organizations like the WHO would also be able to achieve a more neutral climate in our present situation. But given the massive character of the problem of health prevention, and the limited resources available, we would hold that under specific conditions, in a parity achieving situation, there would be some major possibilities to explore in some countries.

Some of the conditions would include:

1. The requirement that all institutions public and private have a common vision of improved health care and hold similar values, such as the New Values we described.

2. There must be an authentic concern for building self-reliance with villagers on a parity rather than a paternalistic relationship.

3. The coalition partners should be chosen because they have a common concern for step function change in a specified number of villages.

4. The partners should with the help of the private and voluntary sector be able to raise the money and personnel required to reach the objective, with minimal government allocations, although with government approval, of course.

5. The entire effort must be seen and recognized as contributing to the economic and social objectives of the country.

6. Local private and voluntary sector take a leadership role with the foreign institutions providing help of all kinds in the roles of facilitator, catalyst, but subordinate to the host country institution.

7. The effort be devoid of ideological objectives.

To illustrate what might happen in a given country, with cooperation between the private and voluntary sectors, including the affiliates of multinational corporations with liberated values, let us consider a possible model. We shall assume, in addition, that institutions from Rich Countries would join the coalition as helpers. We would begin, with the help of the villagers, to identify a real and important problem for them, let us say, assuring a supply of potable water for all members of a town or village. This would probably lead to an identification of the information needed to assure personal hygiene practices that would maintain the potability of the water. An illustrative social architectural design of a coalition between the private and voluntary sector, called PRIVOL,

is presented in Figure 1. This sketchy outline presupposes that the consortium would set realistic objectives and operate in such a way that the villagers come to feel this is their program, and that with initial knowledge and resources from the outside they can maintain the potable water system themselves.

A committed leadership is a necessary ingredient, at the PRIVOL and village level. A climate of cooperation and mutual trust are indispensable to the PRIVOL and between the PRIVOL and the village. For blueprints are what is implied, frames for action. Only persons with motivations, skills and resources can assure the building of a constructive and humane institution in this domain.

Figure 1

AN ILLUSTRATIVE SOCIAL ARCHITECTURAL DESIGN OF A PRIVOL

Vision: A world where all persons enjoy their rights to health, and at least minimal standards of health care.

Mission: To help a defined number of villages in our poor country be assured of potable water and of information regarding personal hygiene to prevent avoidable disease.

Concept of the Institution: A non-profit, educational and financial institution supported by a consortium of private and voluntary organizations in advanced and developing countries.

Primary Client: A specific set of villages in a specific set of Poor Countries.

Sponsors: Primary sponsors: The villages themselves.
Other sponsors: Host governments, voluntary and private sector in the host countries, U. S. and other Rich Countries' organizations in the private and voluntary sector.

Distinctive Competence;

1. Providing public health information for villages relating to potable water.

2. Assistance in building and maintaining potable water system from a technical point of view.

3. Assistance in building a self-reliant organization, or role so that villagers can themselves maintain potable water in the village in perpetuity.

4. Financial assistance in the initial period until self-maintaining.

Results Expected: Within a specified period of time, all the client villages in that country to have potable water, a self sustaining system, and information as to its importance in disease prevention.

A new institution which is humane and effective cannot be designed in the mechanical sense of the word design. An institution is not a juxtaposition of men, missions, resources, sponsors, and an isolated factor called "cohesiveness."

An institution is a vital whole composed of persons whose energies, skills and sentiments, and identification with the mission, make the values it embodies come alive, in relation to real persons, the clients.

CONCLUSION

1. The rising concern worldwide with human rights of the poor and the disadvantaged in all nations is bound to produce major transformations in our existing institutions, governmental and non-governmental.

2. There is a great gap in our humanity and the development of humane and effective institutions which deal with the basic human rights of mankind: food, habitat, health, and education.

3. The poor in all nations have a right to health. In a world of increasing population, this poses new challenges for existing social, political and economic institutions. Scenarios of despair stem from the belief that:

   a. Western capitalism and socialism cannot cope with problems of this scale.

   b. The world will become increasingly prone to terrorism as these social injustices mount.

   c. Repressive governments will become more common in order to meet man's basic needs. Freedom then would become a luxury, a second class human right.

4. The right to health is transideological. It cuts across nations and politics. Thus the problem should be viewed in transideological terms.

5. It is not by government alone that a poor country will be able to deal with the rights to health of its villagers. Private and voluntary organizations have a constructive role to play.

6. Whether the private and voluntary organizations in the Rich Countries play a constructive role or not is a function of two main factors:

   a) the adoption of a set of new values, which favor building societies from the ground up, which is non-elitist, and favors the spreading of a full spectrum of human rights to all sectors of a society. Self-reliance is a fundamental value in the New Value orientation.

   b) The movement from paternalistic to parity relationships between institutions and persons in Rich Countries and Poor Countries.

7. New partnerships and new institutions can be designed based on the New Values and Parity Achieving principles. We have suggested a new type of coalition called a PRIVOL which could contribute to self-reliance in the village based on preventive health education.

8. Rabindrath Tagore has written: Ultimately only those values can be truly human which can be truly universal. We add only

those institutions are truly human which guarantee human rights for all and create a sense of obligation to guarantee that others have the same rights to health.

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