Introduction

It can be stated unequivocally that the concept of primary health care, and indeed the general concerns of both the WHO and UNICEF, are of great interest to the ILO especially in the work relating to anti-poverty strategies and the fulfilment of basic needs. The ILO was conceived and mandated with the goal of promoting social justice for all people so as to create a climate conducive to universal and lasting peace. The work programme of the ILO has been developed so as to do the utmost through research, advisory services and technical cooperation to eradicate poverty and deprivation, provide opportunities for all people to reach their potential and improve the conditions of work and life. As long as 20 years ago, the ILO perceived the link between health and productivity, and pointed out that poor health is a major cause of reduced work capacity, increased absenteeism, general apathy and malcontent, and that it is one of the sources of poorly done work. In all of this work, a wide perspective was taken in that consideration was given to the two-way effects on employment, of education, health, nutrition, housing, transport and urbanisation. In 1976, the World Employment Conference emphasised that the long-espoused doctrines of development planning had done little if anything to improve the well-being of the poor and called for strategies designed to fulfil the basic needs of all people in as short a time as possible. Although the definition of what constitute basic needs is a matter of national sovereignty, few would disagree that better health is a major one.

Both primary health care and basic needs are primarily national endeavours, but it is clear that success will require international support both in terms of advisory services and a more equitable distribution of resources. This is an absolute requirement for any advance of the developing countries, and particularly the least developed. It was for this reason that a new international economic order was considered part and parcel of the Programme of Action of the World Employment Conference. This will require a strategy of industrialisation using appropriate technology so that the developing countries can, for example, produce the pharmaceuticals and implements required for implementing primary health care. In turn, such changes will create employment and income and lead to an increased demand for other consumer goods and services. It as well conserves scarce financial resources which would have been required to import these goods.

When closely examined, the connections between health, employment and development can hardly be over-emphasised and seem elementary. Better health should lead to increased productivity and thus income, as well as changing people's attitudes towards the future. One often finds that low income levels (which are often caused by under or unemployment) are positively correlated

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1 Preamble to the Constitution of the International Labour Organisation.


with poor health. But, there is most probably a two way cause-and-effect relationship between poor health and low income, and an improvement in one of them may be impossible without an improvement in the other. Indeed, an improvement in the general health situation of a country may require a total approach encompassing improvements in nutrition, housing, household technology, education, water and sanitation and even transportation. Very little is known about these linkages, and they are almost never taken account of in planning.

The link between improved health, employment and income, however, is not as simple as most believe, particularly in the case of a developing country. One must recall that most developing countries have labour surpluses and that household behaviour in these countries may not correspond to the general notion of income maximisation. In countries where there exists a high amount of under or unemployment, the marginal productivity of labour is virtually zero. In such circumstances, improved health will increase neither total output nor the real incomes of the families affected. Furthermore, household behaviour in developing countries may be such that a target or subsistence family income is the goal. Thus, an improvement in the health status of the head of the household, for example, which results in increased labour force participation or in income for him may be offset by a decrease in the participation of other members of the household. In either case, improved health may not result in an increase in total output or household income in the short run. These tendencies, on the other hand, can be reversed if health improvement is viewed from a wider perspective. We shall return to this question later in the paper.

Health and Employment

The extent of the effects of ill-health on labour force participation and employment are dependent, of course, on the characteristics of the work that needs to be done. The greater the amount of manual and physical activity required, the greater will be the negative effect of ill-health. Given that most developing countries have populations located in rural areas and that most of these people are engaged in agricultural endeavours, it can be expected that a majority of employment opportunities will require a good deal of physical input. This is compounded by the fact that health and income are positively and highly correlated and that most analyses have found that the poor are to be found in the rural areas and in agriculture.

There are at least five ways in which the health status of an individual can affect his labour force participation or employment status. Better health can lead:

1. directly to an increase in productivity;
2. to an increase in the duration of time worked in a given period;
3. to an increase in labour force participation;
4. to an increase in the intensity of job search;
5. to a lengthening of working life.
Income is, of course, a function of all these factors, and employment possibilities are enhanced by continued labour force participation. Thus, they are of prime importance for employment, income and development.  

The effects of improved health listed above are those which in some way affect individuals. There is, of course, one other way in which efforts to improve health can affect employment and income; through the provision of a greater amount of non-human resources. Certain pest control programmes, particularly in Africa, have the possibility of opening up new lands for agricultural endeavours once the disease transmitting pests have been exterminated or controlled. The best known examples of pest control programmes are for malaria carrying mosquitoes, tsetse flies, and blackflies. The latter, for example, transmit the filarial worm which can lead to "river blindness". Onchocerciosis affects more than 20 million people and in some communities is responsible for a blindness rate of 20 per cent. A major ongoing control scheme in the Volta river basin involves Benin, Ghana, Ivory Coast, Mali, Togo, Niger and Upper Volta. It aims to eradicate the parasite, prepare this area for development and resettle the population of this very poor region. 2 Other examples could be cited, but this one serves to demonstrate the important links between health improvement programmes and the development of non-human resources.

In what follows, a description of the effects of improved health on the development and better utilisation of human resources will be given. The discussion also includes the ways in which the ILO is contributing both to a better understanding of the linkages through research and to the implementation of measures aimed at improving the well-being of all people. It should be noted that many of the statements made remain hypotheses, because the research required to prove or disprove them has not been carried out. They remain unanswered questions, and it is the hope of the ILO that through collaboration with WHO and UNICEF as well as other members of the UN family the research will be undertaken in the future.

Health and Productivity

It seems almost incontestible that improved health status will result in an increase in potential labour productivity. Whether or not such increased potential is realised and over what period are dependent upon certain other conditions some of which were mentioned earlier. For those plagued with chronic ill-health the situation is indeed the most unfortunate. They may be forced into lower paying jobs, thus causing what might be called "disguised underemployment". If for no other reason than to


allow such deprived persons the opportunity to reach their potential, improvements in health can be justified. Of course, improved health also will provide the base for sustained economic growth and development. Research undertaken by the World Employment Programme of the ILO has shown that in those countries where growth has occurred along with improvements in the well-being of the poor they began with a relatively healthy population. ¹

Health and Time Worked

Poor health also affects economic participation by increasing the amount of time lost from work in a given period. That is, it is obvious that the poorer an individual's health the greater will be the number of days of work lost due to illness. Gelfand found in a study of Tanzania that workers with bilharzia lost approximately one-third of their working time due to the illness. ² Furthermore, the number of days of work lost tends to be greater the poorer the country. Correa correlated the average days of work lost for usually working people with per capita income for a sample of 32 developed and developing countries and found that working days lost due to illness are inversely related to national per capita income. ³ Assuming a working year of 240 days and using Correa's figures for lost days due to illness, developing countries lost on average 12.8 per cent of total working days as opposed to 3.6 per cent for developed countries. When one couples this with the fact that, even when working, those suffering from ill-health work less intensively the total effect can be devastating.

The ILO has endeavoured to do its utmost in this area through Conventions and Recommendations.⁴ The basis of all ILO Conventions and Recommendations is that "development is not purely an economic concept but that its purpose is fundamentally social and human in character and that economic development does not automatically ensure social progress".⁵

⁴ There is a significant distinction between "Conventions" and "Recommendations". A Recommendation is designed to set standards as a guide to action. A Convention, on the other hand, is designed to be ratified by a member state who thereby undertakes to apply the standards implied by the Convention.
One can note five areas in which ILO Conventions and Recommendations have an effect on lost time due to illness and accidents. These are:

(a) Medical care, sickness, maternity, employment injury and family benefits;
(b) Prevention of accidents at work;
(c) Medical examinations for young people;
(d) Hours of work and daily and weekly rest periods;
(e) Worker welfare.

Space does not permit a discussion of all the Conventions and Recommendations in each of these areas, but an example can be given. Research findings indicate that susceptibility to illness and accident increases with the number of hours worked. Thus 13 Conventions have been adopted for various industries setting out maximum hours of work and rest periods required, the first Convention dating back to 1919, the year in which the ILO was founded. There are, of course, other areas than those mentioned above in which ILO Conventions and Recommendations influence health and we shall turn to these later in this paper.¹

Related to this is the research carried out by the Conditions of Work and Life Branch of the ILO on ergonomics. This research is designed to reduce the fatigue and drudgery connected with work by identifying the ways in which energy is expended at work and the relationship of man to the work environment and machines. This is a relatively new field of work within the ILO, and it is hoped that it can be expanded in the future to cover rural workers more than has been done thusfar.

**Health and Labour Force Participation**

For a variety of reasons, ill-health or simply the fear of illness can inhibit labour force participation. This effect goes unnoticed even where accurate data exist, because those who refrain from entry to the labour force are ignored, and they rely on others for their subsistence needs. A few studies, however, have documented this non-participation. Knowles found that ill-health decreased the probability of labour force participation in Chile.² This effect was also found to exist in the United States. Both poor white women and non white family heads living

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¹ A classified guide to International Labour Conventions and Recommendations can be found in ILO (1976), op.cit., pp. 93-100, and a complete text of them is ILO, Conventions and Recommendations adopted by the International Labour Conference, 1919 to 1966 (Geneva: ILO, 1966). Conventions and Recommendations since 1966 have so far been published as separate leaflets only.

in depressed areas had significantly lower amounts of labour supply depending upon the condition of their health. It is clear that both in developing and developed countries, poor health can have a serious effect on the will to work.

A general improvement in health would ameliorate this condition of course. But very little is known about the number of persons involved and the strength of the effect. Much more needs to be done in this area. The ILO is in the process of developing a multi-purpose instrument for gathering household data which would aid planning for basic needs. The types of questions posed in such an instrument could help to shed light on this form of disguised unemployment.

Health and Job Search

Closely associated to the foregoing point is the intensity with which an individual looks for work. Ill-health both increases the effort price of a unit of time spent searching for work and also the amount of time spent searching. The poorer the health of an individual, the more energy-consuming is any task which he or she must perform. This increases the value of the time spent searching for work. Furthermore, particularly in labour surplus economies, those with poorer health will have a more difficult time finding work. Thus, the time spent in job-search will be greater than for a healthier individual. Both factors will tend to decrease the net return to work which undoubtedly will act to discourage participation in labour force activity.

Health and the Length of Working Life

A casual perusal of available information quickly reveals that life expectancies in developing countries are generally lower than those in developed countries. Ill-health is, of course, the major determinant of this lower life expectancy. This in turn has serious repercussions on the expected working life. Correa, for example, has shown that for countries like India, the lower life expectancy results in a working capacity of the population on the order of one-third that of the United States. A study undertaken by the United Nations revealed that workers in countries designated as industrial worked on average eight more years than their counterparts in countries designated as agricultural even though the former spent more years in school and

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3 Correa, op.cit.
Through the use of a life-table, Mushkin concluded that 25 per cent of the U.S. labour force in 1960 could be attributed to improvements in health during this century.

The fact that working lives are shorter in developing countries coupled with the other negative effects of ill-health means that the net long-term return to work effort is lower. This can act to discourage investments of time aimed at improving human capital, particularly education. Besides taking time away from work, the net return per unit of education is lower.

Health and Female Labour Force Participation

For various reasons, health factors constrain female labour force participation more than male. Families tend to become dependent on the earnings of the male. Consequently, where there is a lack of food or medicines, what is available will be reserved for the main income earner, and the female and children will bear the deficiency. This is particularly true for protein-rich foods such as meat and eggs. Secondly, since it is usually the males who have the possibility of earning the highest wage, income is maximised if other family members refrain from wage employment to attend to household employment. Thirdly, the lower life expectancy and higher infant mortality rates in developing countries tend to increase the number of pregnancies required to meet the desired number of children. This leads to both direct and indirect effects on female labour force participation. The obvious direct effect is that the female time available for work is limited. Furthermore, women in poor health and malnourished can experience acute anaemia during and after the pregnancy. The FAO has estimated that during lactation on average women require an additional 550 calories. Berg has concluded that in Latin America as much as 63 per cent of expectant mothers are found to be anaemic. In India, as much as 80 per cent are anaemic and 10 per cent of maternal deaths in childbirth can be attributed to nutritional anaemias. Furthermore, resistance to a host of diseases is weakened by a large number of pregnancies, and women cannot be expected to work

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3 There may be exceptions to this general pattern, such as the oriental ethos and tradition that what is available be given to children first, then females, while the adult males accept the remainder.


intensively in such circumstances. For women employed in the household, tasks such as gathering wood or carrying water, become chores which consume a disproportionate amount of both time and energy. Thus, the time and energy required for work are limited.

The ILO has been operating both to alert the world community to the particular problems of women and to alter their position through research and action programmes. There have been eight ILO Conventions and Recommendations adopted ranging in coverage from equality of treatment, non-discrimination, and maternity protection to special provisions for women for night and underground work. Three times a year, the ILO publishes a news bulletin entitled Women at Work. It has the purpose of alerting all concerned with information or trends and developments concerning the particular problems of women workers. This bulletin has pointed out that, for example, women everywhere work longer hours, get lower pay, and because of their dual responsibility for home and job, commonly suffer from fatigue.

Finally the ILO's Technology and Employment Branch has produced an issues paper on the role of women in the rural economy which included various hypotheses on ways in which women could be better integrated into the overall development effort through the implementation of appropriate technology. This work is now proceeding to the operational stage. A consultant is in the process of completing a methodological paper which will be followed by a series of country case studies. To a limited extent experimental technologies will be implemented in selected countries, the ultimate aims being to integrate women into development, to free their time and to reduce the arduous nature of the work they must perform.

A Total Approach to Health Improvement

It is now a well-accepted fact that improvements in health are more than a question of drugs and medical care. A host of factors must be considered including nutrition, housing and equipment, education, water and sanitation, clothing and transport and communication. Because of its preoccupation with anti-poverty strategies and basic needs fulfilment the ILO is not only most happy to but in fact is required to join hands with the WHO and UNICEF in promoting the primary health care approach. Indeed all of the basic needs suggested in the Programme of Action of the World Employment Conference will have direct or indirect effects on health.

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The most obvious link to health is through nutrition. One normally finds that discussions of health are linked with nutrition. It is obvious that poor nutrition makes a person more vulnerable to a host of illnesses, and an attack on ill-health which does not include a nutrition component will not lead to great success. Malnutrition and ill-health form a vicious circle. For example, malnutrition may lead to a certain disease, but the presence of that disease may in turn raise caloric requirements. It has been determined that the most important factor affecting caloric requirements is physical activity, \(^1\) and given the nature of economic endeavours in most developing countries, it can be expected that workers there will have higher requirements.

Nutrition and health both have connections with education. Although controversy surrounds it, certain data indicate that poor child nutrition may retard mental development. \(^2\) Aside from this, however, poor nutrition and health may prevent regular attendance at school and may decrease the learning capability of children because of fatigue even when they do attend. This in turn can result in a low level of skill development with the attendant effects on employment after schooling.

Housing and clothing which offer protection from the elements also play a role in this process. Numerous examples could be sighted of countries where many die of such preventable illnesses as influenza, pneumonia and overexposure. The same applies to small improvements within the home which can both save time and improve sanitary conditions. Better cooking utensils can guard certain vitamins which may be lost when other implements are used. Proper food storage can avoid loss due to pests. Improved methods of, for example, carrying wood or water can save time and preserve energy. Aside from the effects on health, small technological changes in the home can free the time of household members thus providing the opportunity for more income earning activities.

Potable water and proper sanitation facilities play an extremely important role in health improvement. Beside the fact that water can be a carrier of many parasites and diseases when ingested, it has indirect effects on health. Lack of proper sanitation facilities can cause water-borne transmission of diseases resulting in serious infection. In this instance, education plays as important a role as proper sanitation in improving health.

Finally often overlooked aspects of health improvement are good transport and communication. The primary health care worker will be required to refer certain individuals to a hospital or health centre. Proper roads or paths and good communication are

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\(^1\) FAO, op. cit., p. 22.

prerequisites for the links between these facilities and the local community. Furthermore, good transport and communications will allow better access to markets, thus allowing greater income earning opportunities. They can help to break the isolation of small communities, thus fostering the spread of contacts and ideas. In fact, the WHO considers transport and communication to be of such importance that a chapter is devoted to their development or improvement in their recently published training manual for primary health workers.¹

It is in the area of a total approach to improving health that the ILO has and will continue to conduct a great deal of research and technical services in support of the primary health care concept and of the fulfilment of basic needs in general. First, there have been ILO Conventions and Recommendations in three areas which will affect health when viewed from a wide perspective:

(a) Worker housing and accommodation;
(b) Minimum wages;
(c) Social policy and basic aims and standards.

The first and second of these will affect health indirectly through providing for certain other factors which can influence health status. The third set of Conventions and Recommendations more generally will affect health through suggesting certain principles and guidelines to be applied in promoting social justice.

The ILO's Working Conditions and Environment Programme (PIACT) undertakes research and action designed to improve the working and living conditions of workers. The main objectives are: (1) to identify ways of making work safer to the life and health of the workers; (2) to recommend sufficient amounts of rest and leisure time; (3) to design work so that it offers the worker the opportunity for self-fulfilment in developing his personal skills. In line with these, multidisciplinary missions have been mounted to identify problems relating to occupational safety and health and working conditions. Some of them have concentrated on the agricultural sector. The Programme also has launched a number of action-oriented research projects aimed at the reduction of the drudgery connected with work, e.g. the impact of choice of technology on hours of work, the arduous nature of jobs and the distribution of work between men and women.

As pointed out in the introductory section of this paper, the major preoccupation of the ILO has always been the improvements in well-being. The World Employment Programme has placed particular emphasis on identifying ways of alleviating poverty, and an important aspect of this work has been aimed at improving the distribution of publicly provided goods and services. This

was reinforced and broadened by the unanimous acceptance of the basic needs approach by the World Employment Conference of 1976.

The entire work programme of the World Employment Programme has now been oriented to the modalities of implementing a basic needs strategy. Some of the more important ones are:

(a) basic needs must be defined by the people in the countries themselves and there may even be regional differences in them within countries;

(b) a new international economic order is a prerequisite to mount a successful attack on poverty;

(c) a basic needs strategy calls for increased and sustained growth at the national level to afford the required resources;

(d) more and better employment opportunities are needed both to increase incomes and produce the required goods and services.

The ILO has undertaken case studies of Swaziland, Bangladesh, the Philippines, Guyana, Somalia, Zambia, Portugal, Sierra Leone, Afghanistan and Kenya which attempt to assess the implications of undertaking a basic needs strategy for those countries. Others are now in progress. In all of the work undertaken thus far, as with the primary health care approach, the participation of the people plays a central role both in the definition of needs and priorities and in the implementation of programmes aimed at fulfilling those needs.

It is also under the auspices of the World Employment Programme that research is undertaken on appropriate technology. The ILO along with the Asian Development Bank and the Swedish International Development Agency sponsored a regional seminar held in Manila in 1977 aimed at defining ways of applying appropriate technology in road construction and maintenance. This has led to the planning of a series of national workshops throughout Asia. An ILO technical cooperation project in forestry in the Philippines helped develop more appropriate tools and implements for this work. These were designed with utmost consideration given to the fact that forestry workers are engaged in one of the most hazardous and strenuous of all occupations. The technology developed was designed to decrease the frequency of accidents and diminish the arduous nature of the physical activity required. Finally, the ILO took part in a WHO sponsored consultation concerning appropriate technology for health, held in Geneva, 5-7 January 1977.

1 These points were stressed in the speech of the Director General of the ILO to the Second Ordinary Session of the Economic and Social Council, 1978.

The ILO’s work on the basic needs approach is now focusing attention on the 1979 International Labour Conference. The ILO was mandated by the 1976 World Employment Conference to produce a report on the state of basic needs and policies aimed at their fulfilment by the end of the decade. This report will form the major document for a technical item on the agenda for 1979. The replies received to a questionnaire, requesting countries to define what they consider as basic needs and what policies are now aiming to fulfil them, will form important inputs to this report. To date, approximately 60 replies have been received from member states. Following the 1979 Conference, it is hoped that much of the research that has been done can be made operational through technical advisory services in planning for basic needs and through research and technical cooperation projects in this area.

**Popular Participation and Social Well-Being**

The principle underlying primary health care, and indeed the basic needs approach, is improved well-being by the people. Popular participation in decision-making and implementation and their effects on welfare have been a concern of the ILO for a long period of time. The world community has now taken up that interest in community participation in improving health (and in other development) programmes. It appears that the challenge of community betterment lies in effective involvement of the community in helping itself. This is an exciting field, and many novel experiments are now underway aimed at promoting popular participation in many areas. The experiences presented to this conference by the regional offices of the WHO are a testimony to efforts at improving health by a participatory process.

The Programme of Action of the ILO’s World Employment Conference of 1976 recognised the value of popular participation in improving the welfare of the deprived. One can deduce four ways in which grass-roots participation contributes to successful community development:

1. by playing a part in allowing people to express their needs;
2. by enhancing the generation of resources to meet their needs;
3. by improving the distribution of essential goods and services;
4. by satisfying the psychological desire to participate in decisions which affect their own lives.

As long ago as 1935, the ILO was conducting enquiries into the ways in which cooperatives could contribute to improvements in health. See Maurice Colombain, "Rural Hygiene and Health Cooperative Societies in Yugoslavia", in *International Labour Review*, Vol. 32, July 1935, pp. 19-30.

These are the reports of the six WHO regional directors (Africa, the Americas, Eastern Mediterranean, Europe, South-East Asia and the Western Pacific), which form the background documents of this Conference and offer vivid evidence of efforts to improve health through popular participation.
Participation is an engine for accelerating growth and for enhancing the generation of resources to meet the needs of the people. Popular participation can be used to exploit public and local knowledge of economic opportunities and of the physical and social conditions which affect the progress of development programmes. Involving the people in decision-making can encourage them to provide labour, skills and other resources either voluntarily or more cheaply with perhaps greater productivity. It should be recognised that success requires more than the effective mobilisation of the masses to execute decisions which are basically bureaucratic in nature. It depends upon mechanisms which induce participation in decision-making itself, together with a process by which the people are organised or organise themselves to insure that the final decisions taken are in their interest.

One point which is clear from the experience gained to date with participatory programmes is that there is not one best recipe for success. The particular form that participation will take is dependent upon the resources and skills available and the particular characteristics of the people and their environment. In fact, there may even be regional differentiation in the form that participation takes within a given country. The cooperative development programme of the ILO is in the process of identifying ways in which cooperatives can be utilised in improving the delivery of social services to the population. A questionnaire has been sent to member states asking them to supply the ILO with information on ways in which their cooperative movements have operated to improve the distribution of social services. A report was produced by a consultant of the ILO of an experiment in the Ivory Coast which attempted to use the cooperatives as delivery points for a package of social services. Such arrangements take advantage of the existing network of contacts and may be able to reach people that might otherwise be overlooked for some reason. The additional benefits of this approach are that little administrative machinery need be created and, because use can be made of existing facilities on a shared basis, total costs may be lower.

Work is also underway in the Employment and Development Department of the ILO on ways in which popular participation can contribute to basic needs fulfilment. A forthcoming manuscript will analyse alternative forms of popular participation and the role they can play in decision-making. Particular emphasis will be laid on ways of organising the rural poor, and a series of country experiences will be included.

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2 The countries are India, Bangladesh, Tanzania, China, Kenya, Guyana and a summary of Latin American experiences.
Financing of Health Care Services

A major concern of governments are methods of financing expansions in health services. Most governments have tended to regard expenditures on health as being in competition with other uses of funds, e.g., investment to increase production directly. In this paper, an attempt has been made to stress the point that expenditures on health can be among the most productive uses of government resources through their effects on the potential productivity of labour. Improved health can be a driving force for economic growth.

Accepting this, it is circular reasoning to approach the financing of health services, as many countries do, by tying increases in expenditures on health to increases in gross national product. Many developing countries are beginning from an extremely unfavourable position in terms of the current health status of their population. Much needs to be done. Thus one finds that in most cases the majority of funds are allocated to curative services. For example, in Tanzania in 1970/71 the ratio of planned curative to preventative expenditures was 10:1, and ultimately curative expenditures were overspent whereas preventative ones were underspent so that the actual ratio turned out to be 17:11. It is clear that funds expended on preventative care can go much further than those expended on curative services. Immunisation is a major and yet simple measure of prevention. It was estimated, again in Tanzania and for 1970/71, that the ratio of costs of case treatment to cost of immunisation for measles and tuberculosis were approximately 16:1 and 32:1, respectively. Curative approaches to health allow people to continually fall ill. Although curative services are necessary in every country, they must not be allowed to detract from prevention which reduces the possibility of occurrence.

The concept of primary health care puts greater accent on preventative vis-à-vis curative services, and it can be undertaken in a relatively labour-intensive way at low cost. In some South East Asian countries, primary health care has produced dramatic changes in health and fertility indices at less than US $2 per capita per year. Other rural projects have shown that effective primary health care can be provided for about US $1 per capita per year using trained village women as community workers.

2 ibid., pp. 150-151.
The question still remains as to where the additional funds can be found to finance the primary health care programme. The ILO has been attempting to help in the search for such funding through its programme of research and technical cooperation to aid countries in setting up or improving systems in which social security finances part of total medical care. There are three major ways in which a social security system, acting in partnership with the overall national health plan and Ministry of Health, can help improve coverage. First, by furnishing an additional source of funds (which to the extent possible places the burden of payment on employers) a viable system of social security can help free scarce government resources. Second, social security can open up medical services, which traditionally catered to wealthier groups, to a larger proportion of the population. They may also be encouraged to seek medical services in situations where they might not have otherwise due to cost barriers. Finally, the social security system can provide manpower and material resources required for the provision of primary health care. In the future, the social security programme of the ILO will investigate what role the system can play in the wider perspective of well-being in general. Particular emphasis will be put on the poor in rural areas who have been the most difficult to include in such schemes in the past.

Direct Effects of the Expansion of Health Services on Employment

Throughout this paper, emphasis has been put on the employment and income effects of improved health on the population in general. There will also be employment effects from the expansion of the health sector. There seems to be general agreement that when properly designed a primary health care system can provide a significant amount of employment opportunities. Most primary health care systems tend to be relatively labour-intensive, and the additional employment created need not compete with employment in other sectors in a labour surplus situation. For instance, it has been estimated that a properly functioning primary health network in Pakistan would afford 70,000 jobs directly. This does not include any estimate for related sector job creation, e.g., health–manpower training or pharmaceutical production. In many cases, the trainees for the programme could be drawn from the educated unemployed or middle school drop-outs. As has been stressed throughout the discussion, such planning will require a total approach to the problem. The above, for example, would call for certain modifications in the educational curricula so that the graduates or drop-outs would be better suited to undertake training for primary health work. A forward looking policy would also require that health–manpower training facilities be planned in advance.

The training department of the ILO has continually been encouraging governments, and particularly Ministries of Labour, to develop a national training policy. One normally finds that each Ministry conducts training programmes aimed at supplying manpower suited to its particular needs. In many cases, duplication results, and resources are wasted. Furthermore, operating independently, their efforts can become counter-productive. A national training policy would entail coordination between, for example, the Ministries of Education, Labour, Health and Agriculture, at a minimum. A second way in which the operations of the training department dovetail with the primary health care approach is in the approach to training itself. Evolving from the finding that centralised training facilities reach only a minority of the population in developing countries, and normally a privileged minority, their emphasis has been on bringing training to the people. Beside the direct benefits on the trainees of obtaining their training in their locality (and thus perhaps also increasing their credibility in the community) there can be a spillover effect of the training on the population of the community. Furthermore, others will be encouraged to undertake this or another type of training. The isolation of the community is broken, and the people are made to feel that central government attaches importance to their needs.

The Role of the ILO in Primary Health Care

The ILO is unique in terms of its constituency. It is a tripartite organisation composed of representatives of governments and workers and employers organisations. By virtue of this constituency and the fact that the Organisation is now firmly committed to advising and supporting members in their attack on deprivation and the fulfilment of basic needs, it has a major role to play in joining forces with WHO and UNICEF to promote the primary health care approach.

A particularly important area of collaboration between WHO-UNICEF-ILO is in the area of occupational safety and health. Emphasis in this work within the ILO is now being put on occupational accidents and diseases in the rural sector. These can be due, for example, to the improper use of work implements or to the use of toxic pesticides. The constituents of the ILO must be encouraged to realise that such risks are a reality and to collaborate with Ministries of Health in the implementation of a primary health care system with foresight to avoid such work-related hazards which lead to disease, invalidity and death. As pointed out at a recent ILO meeting, "national authorities [i.e., Ministries of Labour, Health and Planning] in collaboration with employers' and workers' organisations should assure the implementation of appropriate medical care and occupational safety and health systems that are necessary for ....workers and their families".1

The ILO, through its Programme for Improvement of Working Conditions and Environment, is experimenting with ways and means of extending basic information on work-related safety and health hazards to rural workers. Action in these directions is specifically intended to spread out beyond the limited formal employee sector to reach the much wider informal sector. This work should not be undertaken in isolation from WHO and UNICEF, and there is thus a special role that Ministries of Labour as well as employers' and workers' organisations can play in partnership with the implementation of the primary health care approach.

As pointed out in various parts of this paper, the ILO is concentrating more and more attention on sections of the population which have heretofore not had representation in the organisation, i.e., rural poor and the urban informal sector. These groups form a "non-traditional" constituency of the ILO. Concrete efforts are now being made to organise these groups through action-oriented research and by encouraging Ministries of Labour and worker and employer organisations of our tripartite constituency to reach and mobilise these people. It is clear that the primary health care approach has the same goal. The efforts of the ILO, WHO and UNICEF should not be undertaken in isolation. Economies of scale can be realised if work proceeds in a parallel fashion so that the overall framework for reaching the poor includes the primary health care approach. Both the International Organisations concerned and their respective governmental and non-governmental constituents should be encouraged to work towards this common goal.

Finally, there are many unanswered questions regarding the linkages between improvements in health, employment and economic development. The fact that many of the statements made in this paper remain hypotheses bears witness to this. A better understanding of these linkages would have the effect of suggesting appropriate courses of action. Clearly most of the hypotheses involve questions both of health and the dynamics of employment, and research aimed at clarifying the linkages would benefit from collaboration between the ILO, WHO and UNICEF. A start in this direction has already been made. In support of the UNICEF sponsored International Year of the Child, the ILO has developed a project proposal dealing with the effects of maternal employment on the satisfaction of the basic needs of children in developing countries. This project would attempt to determine the effects of various household employment patterns on the satisfaction of the material and non-material needs of children. For example, certain other studies have shown that maternal employment outside the home can have a negative effect on the nutrition levels of children. It is proposed that five or six country studies be undertaken. The health status of children would play an important role in this work, both from the perspective of curative medical care as well as preventative or protective measures. There are many other ways in which the
organisations can support each other's work or undertake collaborative projects. Action should be taken to establish these ties now. One thing is certain, the poor of the earth have suffered too long with the promises of a better future through a trickling-down of the benefits of economic growth. It is time that concrete actions be taken to improve their lives. In the end, there is no conflict or trade-off between improvements in welfare and economic development.