# On the Other Hand

## Ethical Dilemmas in Polio Eradication

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In the June 1997 issue of the Journal, Taylor et al. present what they consider an ethical dilemma in polio eradication.[1] The arguments for their moral predicament are that (1) countries are pressured to defer action on their own priorities, (2) financial benefits are greatest in rich countries, (3) the greatest costs are borne by poor countries, and (4) negative effects are greatest in poor countries. We disagree with these arguments and offer the following comments.

1. *Countries are pressured to defer action on their own priorities.* The eradication of polio is endorsed by a global resolution of all member states of the World Health Organization (WHO).[2] The 1988 resolution "declares the commitment of WHO to the global eradication of poliomyelitis by the year 2000." This commitment was confirmed at the World Summit for Children in 1990. At the 1996 summit of the Organization of African Unity, African heads of state ratified a resolution for eradication of polio in Africa.[3] Action has followed. The first series of National Immunization Days in 30 African countries reached more children than any other health intervention ever, with coverage of more than 80% in 25 countries. National Immunization Days have served as a stimulus for renewed interest in and commitment to immunization by governments and their partners. The statement that "poor countries are expected to divert their own limited resources for a global goal which has low priority for their own children" is hardly consistent with the expressed commitment and action by these countries.

2. *Financial benefits are greatest in rich countries.* The authors argue that savings from polio eradication will accrue almost entirely to the industrialized world. However, the national burden of polio on economies in poorer developing countries is not trifling. The positive benefit/cost balance of polio eradication will be significant, especially since these countries bear only a fraction of the eradication cost. We do agree that the benefits harvested by rich countries should be used to strengthen health services in poor countries. We are committed to working with our partners in the eradication initiative, using available resources to build sustainable health systems and to support continued development after eradication is achieved.

3. *The greatest costs are borne by poor countries.* This misconception arises from the Latin American situation. It is not the case in poor countries in Asia and Africa. The authors state correctly that the American experience can be applied only in countries with established sustainable health systems. To estimate the value of certain contributions to polio campaigns—for instance, voluntary work, advocacy efforts, and indirect costs, such as health workers' salaries—is difficult. The direct incremental cost, however, relates mainly to immunization campaigns. For poor countries, the bulk of such campaigns is funded by donors. External donors contributed 89% and 91% of the costs of immunization campaigns in Cambodia and the Lao People's Democratic Republic, respectively, and the campaign in Mozambique was funded exclusively from outside.

Polio eradication attracts significant funding that otherwise would not be available to the global health sector, for example, funding from Rotary International and from bilateral donors such as Britain, Den-

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mark, Japan, and the United States. Funds are used primarily for National Immunization Days, but also for routine health services such as the cold chain, which provides surveillance and laboratory services for infectious diseases.

4. *Negative effects are greatest in poor countries.* The authors refer to the "diversion of resources" reported by the Taylor Commission.[4] We are unable to see that the report substantiates this claim. On the contrary, the data indicate that negative effects of polio eradication were greater in Mexico and Colombia than in poorer Bolivia and Guatemala.

There is mounting evidence of sustainable improvements in health services as a significant effect of polio eradication in several countries.[5,6] Negative effects must be mitigated and polio eradication in poor countries must aim for maximum returns for routine services. The limited documentation indicates that a significant positive net effect of polio eradication accrues across large sections of primary health care. WHO is currently undertaking a comprehensive analysis of this association.

In conclusion, the challenge to polio eradication is to rid the world of a crippling disease forever. A desirable secondary gain is the strengthening of health services. WHO will continue to pursue this double mandate with time-tested strategies, so that the gains go beyond the narrow domain of eradication. Benefits from the eradication of polio will be permanent for all future generations. Wealthier countries and individuals have an obligation to help those with less resources to achieve this goal, which has been endorsed as a priority by all the countries of the world. □

## References


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# Hyder Responds

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The recent article by Taylor, Cutts, and Taylor (June 1997)[1] raises concern regarding plans for global polio eradication and attendant ethical ramifications. In an overall well-researched paper, there were some comments that need further clarification.

1. The authors state that the savings from polio eradication are located primarily in the developed countries, since "paralyzed children in poor countries have little access to care." First, lack of access is unfortunate but does not devalue either the disease or the diseased. Second, there is a cost in providing these services, and any health plan that caters to this population would have to include such costs. If there were no need to consider them under the case of eradication, they would represent potential "cost savings."

2. Taylor et al. state that, in Southeast Asia and sub-Saharan Africa, "polio is responsible for less than 2% of years lived with disability," citing results from Murray and Lopez.[2] This figure has been estimated through the use of total and disease-specific losses of time lived with disability (Table 1). In comparison with other causes in sub-Saharan Africa, the proportion of years lived with disability caused by polio is similar to that for tuberculosis, greater than that for measles, and much lower than that for malaria. Relative to losses from polio in other regions, it is the highest among those considered (Table 1). Updated versions of global burden of disease data indicate that the proportions may be lower.[3] This figure does not indicate that polio's impact on total disability can be considered less important than that of other diseases and is certainly a result of decreasing incidence due to previous interventions. The ability to effectively reduce that remaining proportion, at an acceptable cost, would be a deciding factor for planners.

3. The authors also raise the notion of maximizing benefit from money spent and correctly indicate that preventive services such as immunization will have to

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