CHAPTER 1

PARADIGMS, POLITICS, AND POLICIES

There is health and there are medical services. There is no such thing as health care. Although the term is used everywhere, it is a semantic aberration and a confusing misnomer. It inhibits and undermines awareness and understanding of the role of social, economic, and political factors in health and disease.

This current conflation of health with medical services has not served people well while market-oriented corporations and entrepreneurs together with their state surrogates that expect to benefit from this paradigm do not do so to the envisaged and hoped for extent; nor as profitably. Personal and public health are not good and services are not always and for all parties affordable, effective, or sustainable. The system is fraught with contradictions and subject to crises.

This chapter explores these issues. I have quoted extensively from what others have written to strengthen my argument.

In 1978 the Assembly of the World Health Organisation (WHO) set as a major social target of governments and of the WHO the attainment by all citizens of the world by the year 2000 of a level of health that would permit people to lead socially and economically productive lives.

In countries where socioeconomic resources are fairly equitably distributed, which do not subscribe to the medical paradigm of health or where medical services are not, or only minimally, commercialised, there has been progress towards a population-wide raised level of health. In South Africa where

socioeconomic inequality and the medical paradigm are entrenched health status has not improved and may have deteriorated.

Understanding health and disease, developing policies, making decisions, and planning action on health should be premised within, and derive from, society. As Vincente Navarro[1] wrote:

> I do not use a disciplinary analysis of the components of society in order to later understand society, but rather, and as the Marxist method does, I focus first on the analysis of the entire social system, and then use the understanding of the whole as the necessary basis for the analysis and understanding of the parts. In other words, I try to show how medicine – the part – is determined by the same forces that determine society – the whole.

The proposals and actions of the many lobbies on health and disease should be considered in the context of social, economic, and political reality using an effective and appropriate analytic methodology. As Jaime Breihl[2] wrote:

> Our future obligation is to always bear in mind the contradictions inherent in community medicine and study every concrete experience with the logic of class analysis.

I have deliberately used a Marxist analytic method as well as words and concepts from a Marxist lexicon in order to contextualise health and disease, to further an understanding of the dominant determining variables, and to call a spade a spade. I have tried to use the words correctly.

The semantic ramifications of capitalist ideology are extensive and all-pervading, powerful, and influential. By denigrating and disparaging these words people are deprived of a useful tool for analysis and understanding. The key role of capitalism and imperialism in wars, death and disaster, poverty and ecological destruction, famine, drought – you name it – is obscured. Informed anti-capitalist and anti-imperialist action is forestalled. As Navarro[3] wrote:

> In trying to understand poverty, death, and disease in the world of underdevelopment, a reader may go through the extensive bibliography, existent in developed capitalist countries, on health and medicine [in] ... the Third World and rarely, if ever, find categories such as capitalism and imperialism presented as possible causes of that poverty, death and disease. ... [O]n the rare occasions when they appear, they are usually placed in an introductory notice of dismissal in which those terms are placed in quotation marks as if to alert the reader that they are irrelevant or subject to suspicion i.e. of concern only to incorrigible ideologues who are

> supposedly oblivious to the passage of time. Serious scholars and international officials are supposed to ignore or dismiss such ideological terms and concepts.

Opposition to monopoly capital is slandered as communist. In South Africa the national liberation struggle was identified by the state in propaganda and legislation with communism. The definitions used were ideologically loaded, incorrect, and often even meaningless. This reflected international trends. Derek Summerfield[4] wrote similarly of experience in Guatemala.

> [T]he economic and military elites who denounce as "communist" any call for a change in the miserable lot of landless peasants know that their interests coincide with those of a Western multinational economy avid for cash crops cheaply produced.

Epithets that promote a capitalist and industry-friendly dogma have also been added to the semantic arsenal distorting the meaning of words and concepts. If the use of politicised, ideologically co-opted generalisations cannot be avoided, the particular characteristics of processes (such as development and primary health care) and of people (such as community) in their unique situations should be clearly defined. Taussig's[5] criticism is apt.

> [W]hat is this "community" that researchers posit in the place of an exploited working class? ... As atomised internally as it is exposed to the harsh winds of the national economy externally, such a community is sadly bereft of communality ... [T]he flow of migrants ... adds to the general flux whose only stability lies in the currents of individual self-defence and greed that follow the cash nexus.

what is health?

As Dr Mahler when director of the WHO said[6] in a message to the Inter-Regional Seminar on Primary Health Care that took place under the aegis of the WHO in 1982 in Yexian county in China:

> I fully realize that health is not the only thing, but that everything else without health, is nothing. And I think that it is very important to realise this when we look at development at large. Whenever the health component is forgotten, you forget at the same time the vital factor in development, namely the human being, his creative energy, his physical energy.

Health is more than the absence of disease. The WHO in 1948 defined health as “a state of complete physical, mental, and social well-being”.

Health is both a personal and a social attribute. As Ivan Illich[7] wrote:

> Health ... is simply an everyday word that is used to designate the intensity with which individuals cope with their internal states and their environmental conditions. ... [H]ealthy is an adjective that qualifies ethical and political actions ... which condition the milieu and create those circumstances that favor self-reliance, autonomy and dignity.

Everybody has a right to be healthy. As specified in the United Nations International Covenant on Economic, Social, and Cultural Rights; (Article 12.1):

> The States' Parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

medical care or social medicine

The word health has been usurped by its opposite disease so that health care has become a misleading term usually referring to the care of sick people. It also often unpredictably includes some aspects of disease prevention and health promotion in either or both their individual and group domains. As a result of this misuse of the word action on the social, economic, and political determinants of health and disease lacks semantic and real-life definition and tends to be neglected. When medical care is equated with health care the medical paradigm is reinforced and the role of ordinary people is diminished. The term health care should preferably be replaced by medical care when referring to personal services for sick people, by medical services when referring to personal preventive medicine and medical care, and by social medicine when referring to the whole broad area of action on health and disease. These terms would more effectively and less ambiguously reflect the many distinct but inter-related influences on health and disease. As Morris Schaefer[8] wrote:

> [Opinions that] limit the playing field to what the health sector ... might be able to do ... [lead] to a concentration on disease control and the preventive and curative medical means to accomplish this. [The conceptual framework of social medicine] comes closest to breaching this boundary by giving a place ... to the amelioration of poverty and its sequelae.

In order to identify the relationship between health and social, cultural, economic, and political factors, I will use the term social medicine as defined by Victor Sidel[9] instead of health care. It encompasses:

1. social well-being

the attainment and maintenance of the socioeconomic and political conditions necessary for health and social well-being;

2. public health

the advocacy and implementation of appropriate public health measures to protect and promote health, and to prevent disease in communities and in the nation as a whole;

3. preventive medicine

the protection and promotion of health, and the prevention of disease in individuals and families;

4. medical care

the provision of efficient, effective, safe, affordable, accessible, and equitable facilities to all in need for the diagnosis and treatment of individuals and families so as to cure and/or control their disease, for assistance in rehabilitation after illness or injury, and for care and comfort.

paradigm shifts

Health and disease should be viewed within a social rather than a medical paradigm. The pattern of health and disease reflects the entire social, cultural, economic, and political fabric of society. As the editor of The Lancet[10] wrote about homelessness, so for all of life:

> [P]ublic health is a political question, and the reasons underlying the existence of homeless people in society have political origins. The plight of the homeless should be seen as a metaphor for the current state of our democracy ...
>
> For [John Stuart Mill] the litmus test of a libertarian society was the way in which disenfranchised minority groups were protected from the potentially

> tyrannical power of the majority. Some may say that this important teaching ... has been forgotten for one group in UK society, the homeless. ...

Living and working conditions determine the prevalence and pattern of disease more than any single medical intervention or set of interventions. As Thomas Mc Keown[11] wrote:

> The appraisal of influences on health in the past suggests that we owe the improvement not to what happens when we are ill but to the fact that we do not so often become ill, and we remain well not because of specific measures such as vaccination and immunisation but because we enjoy a higher standard of nutrition and live in a healthier environment …
>
> [T]he recognition of the limited impact of medical procedures was a key which would unlock many doors. Misinterpretation of the major influences, particularly personal medical care, on past and future improvements in health has led to misuse of resources and distortion of the role of medicine.

Stella Lowry[12] also criticised the medical paradigm when she wrote:

> There has been a change of emphasis in public health in the 1970s and 1980s. Health issues have become individualised – people should stop smoking, eat less fat, use condoms, not share needles, have regular cervical smears. Even the campaigns to prevent hypothermia have degenerated into an obsession with individual behaviour: stay in one room, wear several layers of clothes, and knit yourself a woolly hat. [W]e have become so obsessed with individual responsibility that we have stopped looking at how more widespread intervention might help.

The proposed paradigm shift from medical services to social medicine does not ignore the important role of medical services . As Schaefer[8] wrote:

> Without discounting the importance of immunisation and contraception, the health of most people in the world depends less on access to medical services than on efficient farming, distributive justice, ensuring domestic tranquillity, and broad-based sustainable development of natural and built environments.

and as Illich[7] stressing another feature of social medicine wrote:

> The destructive power of medical over-expansion does not of course mean that ... inoculation, ... well-distributed health education, ... general

> competence in first aid, equally distributed access to dental and primary medical care, as well as judiciously selected complex services, could not all fit into a truly modern culture that fostered self-care and autonomy.

There is an increasing awareness that there should be a change in emphasis towards social medicine. This is conditioned by social, cultural, and economic forces and rapidly expanding scientific developments. It is idealistically promoted by social reformers – for use in poor and rural communities. In rich market-driven economies there is instead an escalation of the current model towards computerised, machine-based high-tech repair and spare-part surgery, stem-cell derived regeneration, targeted pharmaceutical sophistication, and developments in the pre-emptive elimination of genetically identified portents of future morbidity. Both are motivated by the same monopoly capitalist forces that had prompted an earlier shift from a social to a medical paradigm.

In industrialised countries the appearance of the medical model of health at the end of the 19th century paralleled the increased reliance on the human body as an efficient working unit. So-called scientific medicine was oriented towards the repair of isolated damaged parts of a human machine. And, conveniently as Breilh[2] wrote the individual could be blamed for the damage and not society:

> [I]t was an ideology that by stressing the significance of disease as something that affected the individual and by emphasizing individual therapeutic response absolved the economic and political elements from all responsibility.

capitalist contradictions

The role and structure of the medical industrial complex (medical and paramedical personnel and establishments, medical aid schemes, medical risk insurance agencies, and the pharmaceutical, medical equipment and allied industries) is determined and maintained by the needs of the dominant class and not by the needs of the majority of the people. Private corporate enterprise and the state according to Brielh[2] finance:

> the development of a complex infrastructure which gradually diverted service funds to research work dependent more on the needs of productive expansion than on social benefit.

The inherent contradictions in the system undermine profitability within the medical industrial complex. Scientific medicine and the medical model are very expensive and often unaffordable even in the rich developed world where

unemployment and under-employment rates are up. Work-place automation has reduced the demand for labour, industrial production is contracted out to less developed countries where labour is cheaper, and the throw-away ethos has undermined the repair/service sector, not to mention the inherent periodic financial crises that cause the decine of debt-fuelled consumption, the engine of capitalist commerce. In less developed countries even low-tech medical care is often not affordable; they cannot even pay for life-saving cheap medicines.

But the world seems hooked on personal medical care. Public addiction is reflected in a push-pull, love-hate, rejection-dependency pattern of behaviour. There is also the thrust of the impoverished and the deprived to acquire what they do not have – the attention of highly trained professionals, the medicines, and the machines of the medical model. This addiction is fostered by capitalist ideology and advantage. As Navarro[13] wrote:

> Addiction and dependency on consumption – either of goods or services ... result from the basic needs of an economic system that requires for its survival
>
> (a) the creation of wants however artificial or absurd ....
>
> (b) the existence of a passive and massified population of consumers, and
>
> (c) the replication of consumer ideology whereby the citizen is judged not by what he does (his job) but by what he has (his consumption).
>
> Within that system the citizen, the consumer, is made to believe that his fulfilment depends in large degree on his consumption be it of drugs, pills, prescriptions, cosmetics, and whatever else may be required for his fitness.

This expensive, high-tech, mechanistic, medical model is nevertheless ambivalently aso rejected because of its insensitive nature. People want to be treated with dignity and respect. They want their autonomy to be recognised. They want to participate in managing their own health and disease. Some people are going (or returning) to alternative or complementary and traditional forms of care, others do not comply with medical prescriptions (particularly of drugs) and yet others only seek medical care as a last resource, often dangerously late.

The rejection of medical intervention is perversely related to income and education. The management of preventable and severe illnesses caused or aggravated by social and economic factors and within the medical sector by delayed attendance or non-compliance is usually expensive and high-tech

dependent, and often also unsuccessful. It is the poor and the less educated who present late and then often to emergency departments in non-profit and public institutions.

If demand is down and if, when there is a demand, it can only be met by very expensive means and from people who cannot afford to pay, profits will be reduced. If the service is free, the demand for high-tech medical salvage could be less and costs to all sectors of the economy commensurably lower. But there may be no direct profit to private enterprise in a free and low-tech service. This then is another free-market contradiction.

Medical expenses in United States of America industries increased from about 5% of wages in 1970 to more than 15% in 1990. As a manager of a large USA company employee insurance department wrote[14]:

> Increasing health care expenditures require diversion of corporate funds from other priorities (eg research and development, capital expenditures, and stockholder dividends) that directly contribute to the ability to compete.

President Clinton was equally blunt when he told a joint session of the United States of America congress in an address[15] on proposed changes to "the costliest and most wasteful system [of medical care] on the face of the earth":

> Rampant medical inflation is eating away at our wages, our savings, our investment capital and our ability to create new jobs.

The advantages to corporate business of state support for medical care and a reduction in its cost is obvious but there is a contradiction in the divergence in the effect on the medical industrial complex which stands to lose in the proposed dispensation, and the effect on other elements of capitalist enterprise for which the changes have become essential. According to the press report[15]:

> Apart from extending coverage to every US citizen and resident, [the new arrangement] would impose government controls on overall costs and rationalise an inefficient, bloated, and unfair health insurance industry.

The matter is further complicated by the simultaneous convergence of interest between these two groups – the individuals and groups that own and control the medical industrial complex also own and control the large industries, and conglomerates that are contracted to buy the services. In practice the changes are resisted by the medical industrial complex.

While high quality appropriate care as well as the related concepts of cost-effectiveness and efficiency are recognised as important and legitimate means towards preventing disease and achieving cure, control and rehabilitation their current ideological hegemony reflects attempts to sanitise and perpetuate a profit-driven medical model. Within a capitalist, consumerist, materialist, free-market culture discussions on the need for and even research into the quality of care are offered as sops or proxies for non-medical measures to reduce costs. The concentration on means (good care) rather than on ends (good health status) also obscures evidence that the main objective of medical services is its affordability or more correctly its profitability. It is patently obvious that the inherent contradictions cannot easily be resolved within a capitalist market-oriented milieu.

In socially deprived and economically disadvantaged countries and communities an attenuated replica of the high-tech medical model is unsuccessfully attempted. But it is more irrelevant and inappropriate here besides being unaffordable even in its attenuated form and a waste of money and other resources.

The effect of the inevitable high rates of infant and maternal mortality; TB, AIDS and malaria; acute gastro-intestinal and respiratory infections; and now also the escalating prevalence of non-communicable diseases, located within an increasingly impoverished macro and micro environment, is economic implosion, population migration and displacement, wars, environmental degradation, family break-down, and other social ills with global ramifications, and an accentuation of disease – the cycle is perpetuated. This distress, destruction, disease, and death provokes a misplaced demand for international disease prevention and medical intervention and encourages capitalist entrepreneurship to develop and sell technical fixes like insecticide impregnated mosquito nets, condoms, vaccines and drugs, computer-assisted and low-tech diagnostic tools, and artificial limbs not to speak of the medical NGO and charity industry and well-funded, tax-deductible research.

Who benefits? Not the common man or woman in the street; nor the developed world as none of the consequences respect political boundaries. Another capitalist contradiction.

the proposed solution: primary health care

This is the context in which since the 1960s primary health care or community medicine emerged and developed as an alternative to high-tech medical care. It was an attempt to avert and then to contain the almost universal so-called crisis

in “heath care”. World-wide concern about the escalating costs of the current system of medical services and its failure to meet the needs of developing countries spear-headed the development of the concept. As Breilh[2] wrote:

> Community medicine is one of the few solutions that capitalism can propose for the problems of public health. It provides a means to attend to minimum levels of social demand as well as basic conditions for the protection of previously neglected populations without changing the social relations or significantly diminishing productive investments. On the contrary, it seems that primary care coverage extension projects are efficiently interwoven with other forms of consumer market expansion.

The Alma-Ata Declaration on Primary Health Care[16] was supposed to galvanise people and governments towards a shift in approach. Article III of the declaration stated that:

> Economic and social development ... is of basic importance to the fullest attainment of health for all and for the reduction of the gap between the health status of the developed and developing countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

According to the Article VI of the Alma-Ata Declaration primary health care is medical service with distinctive attributes:

> Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.
>
> It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.
>
> It is the first level of contact of individuals, the family, and community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.

The concept was expanded to include group action on food, water, and sanitation if interpreted strictly and on all determinants of disease if interpreted freely. According to Article VII (3) primary health care includes at least:

- education concerning prevailing health problems and the methods of preventing and controlling them;
- promotion of food supply and proper nutrition;
- an adequate supply of safe water and basic sanitation;
- maternal and child health, including family planning;
- immunisation against the major infectious diseases;
- prevention and control of locally endemic diseases;
- appropriate treatment of common diseases and injuries;
- provision of essential drugs.

Primary health care means different things to different people. In South Africa. the diversity reflects the different agendas of the major role-players and the different needs of the people in this splintered society – developed/under-developed, urban/rural, white/black, rich/poor, employer/workers. The South African state uses the term to mean first contact, low cost, personal medical care as in public (run by the state or by non-government organisations) centres or clinics served mainly or only by nurses offering medical services mostly to poor blacks (meaning non-whites), and as in primary health care nurses (PHCNs) – actually nurse-practitioners acting as cheap mini-doctors. A health grouping within the former resistance/liberation movement added the word progressive to “primary health care” to make PPHC and so hopefully distinguishing its interpretation from that of the state. NPPHCN (they later prefixed PPHC with National and added Network at the end) stressed preventive medicine, first-aid, "basic clinical skills", and liaison (patient-centred links) with professional medical services. The Medical Association of South Africa considers that a general practitioner provides primary health care and can therefore be called a primary health care worker. In some circles a community health worker with very little training in medical matters is also called a primary health care worker.

Although lip service is paid to the relevance of socio-economic factors to health, action directed at improving the health of the people never systematically and meaningfully incorporates social well-being and public health programmes.

In the United States of America an organisation calling itself the Alliance for Health Reform defined primary health care like the Medical Association of South Africa seems to do[17], as:

> first-contact, whole-person medical and health services delivered by broadly-trained generalist doctors, nurses and other professionals.

Despite the increased awareness of the non-medical influences on health and disease the role of economics and politics appeared to be deliberately obscured so that the conceptual paradigm shift implicit in the Alma Ata Declaration and its practical realisation was tentative, slow or non-existent. It is possible that deliberate theoretical obfuscation pre-empted action. The social, economic, and political consequences for the ruling class and its appendages of implementing primary health care as defined by the WHO may however have been perceived as threatening its hegemony. Was the definition of primary health care deliberately blurred to conceal selfish motives? Were the unrealistic objectives of the primary health care concept perverted and politically co-opted by disparate and uncoordinated groups and lobbies or was there a deliberate plot to propose something that could not be implemented? Did the programme merely reflect the superficiality of the analysis of potential difficulties in implementation The report of a WHO symposium on primary health care in industrialised countries in 1982[16] noted some of the observed problems.

> [T]he diversity of opinion arose in part from the vague ways primary health care is defined: in terms of a philosophy; a strategy; a level of health care; and for a set of activities.
>
> [T]he implementation of the Alma-Ata recommendation[s] has been a slow process in industrialised countries. One of the main reasons is the concept of primary health care itself, its poor definition, and a lack of analysis of its implications for industrialised countries. More often than not the concept is understood too narrowly. It is either considered to be relevant for developing countries only or it is identified with the primary medical services (eg general practice) of the industrialised countries.
>
> Rigid attitudes based on self-interest were ... the most frequent quoted obstacle to primary health care. In some cases financial interest (eg in fee-paying systems) has been to blame, in others the cause is related to the dominance in health care and medical education of the purely medical approach.

Breilh's[2] critique of primary health care in capitalist countries helps to explain some of the double-talk. He regards primary health care as an ideological and disciplinary mechanism to perpetuate capitalism. It is a cost-benefit investment for capitalist productivity, stimulating investment and market expansion (drugs, new equipment, construction), reorienting family consumption to capitalist goods,

reducing family waste on non-profitable expenditures such as traditional home remedies, rationalising state expenditure by savings in medical resources (low-cost services, minimally qualified, cheap and voluntary workers), while reallocating state funds to productive sectors, increasing political surveillance, promoting bourgeois ideology, diverting organisations and action towards secondary health and social problems and away from the prime causes, all achieved with low-cost humanitarian publicity and some amelioration of social pressures. He wrote of primary health care or community medicine as he calls it:

> [It] is one of the few solutions that capitalism can propose for the problems of public health. It provides a means to attend to minimum levels of social demands, as well as basic conditions for the protection of previously neglected populations without changing the social relations or significantly diminishing productive investments.

Breilh was a Professor of Social and Preventive Medicine in Ecuador but his description fits the current, South African situation well:

> [Primary health care includes] low-cost services, principally oriented to the non-wage-earning poor who inhabit geographic areas ambiguously called communities. Their operational object is ... the poor urban district or the rural "community", and they pretend to overcome the purely biological focus by considering cultural, political and environmental "components". … [Services are directed at] the basic treatment of elementary cases and the development of low-cost administrative and preventive measures.

He argued that donor funding was not altruistic.

> [These projects may] obtain enormous financial support as means of counterbalancing some of the effects of institutionalized poverty without dealing with its underlying causes.

Embedded messages subtly promote donor values:

> Community education programmes generate and publicize substitute values for the real interests of the working class, and thus contribute to an exclusion or distortion of the people's own ideas … [T]hey transmit to health personnel the official doctrine on social problems, the origin of diseases, and the types of action that are considered licit. This reasoning is designed to conceal the structural determinants of the health-disease process.

According to him primary health care teams operate in reality like a form of medical police. He wrote:

> The medical bureaucratic apparatus, when penetrating into the poor urban district or rural village, is tantamount to an invisible surveillance network that penetrates the daily life of families and has a triple function: to assert the presence and hierarchical role of state representatives among the poor populations; to feed back to the State's information system relevant social data by formal and informal channels; and to achieve adequate conduct of the people by means of a subtle disciplinary apparatus that operates through a reward-punishment method, sanctioning normal conduct that conforms to the dominant ideology.

He considered that primary health care teams infiltrate petit-bourgeois values into people's organisations and form parallel organisations related to minor or superficial health-disease issues divorced from the real interests of the people. Primary care projects, he says, are also associated with violent forms of medical state intervention, such as massive sterilisation campaigns and other forms of coercive and concerted conception control programmes.

Breilh however did not question the value of a social perspective of health and medical care and contrasts the role of medical services in capitalist and socialist countries where he says it is built upon a social and economic structure that promotes equality, equity, and health. This option was however limited by the lack of democracy in many socialist countries. According to Navarro[13] the experience in the socialist countries showed that:

> [To] the degree that class control of the health institutions changed, the product and nature of those institutions changed. Indeed even the definition and meaning of health changed from one where health was seen as an individual effort motivated by enlightened self-interest, to one of community and collective effort.

The practical implementation of “primary health care” was also frustrated. In the early 1980s the then Assistant Director-General of the WHO Tejada-de-Rivero identified four issues still relevant today: vertical programmes, paternalism, stand-alone (isolated) programmes, and dependence on external finance. The report[18] of his briefing to the Inter-Regional Seminar noted:

> In many countries, primary health care is being developed as a vertical programme in parallel with, and independently of, the rest of the health

service system. This misconception leads in some cases to the consolidation of a second- or third-rate type of health care for the poor and in rural areas and is therefore a denial of the very principles of primary health care. The primary health care approach applies to all levels of the health service system. …

In many countries, primary health care is provided in a traditional and paternalistic way whereby health workers detached from the communities they are supposed to serve offer people health care without their full participation. In primary health care the people's full participation is essential. They must be involved in the identification of health problems to be dealt with and in the management and supervision of health services and they must play an active part in the delivery of services and take responsibility for their own health at the family level and individually.

In many countries primary health care is being reduced to a matter of community health workers working in isolation. Overall health management development is likewise reduced to the "one-off" training of such workers. If primary health care means access for everybody to all levels of the health system and if it means the participation of the people, then it is of paramount importance to train all types of health manpower from the sophisticated specialists to individual family members [to understand and appreciate the primary health care philosophy].

In many countries the implementation of primary health care is held up pending the availability of external financial resources. While such resources can make it possible to get things moving and start on some critical activities, they cannot constitute the only source of finance for implementing primary health care. The changes throughout the health system implied in the primary health care approach will require a redefinition and reorientation of the systems for financing health care and a reallocation of national financial resources within the health service system.

Brave words – declarations, statements, and proposals

In the United Nations' Covenant it is proposed that easy and equitable access to affordable, appropriate, and safe medical services should be assured. The covenant states (12.2d) that conditions should be created:

> that would assure to all, medical service and medical attention in the event of sickness.

In the 1940s in South Africa the Gluckman Commission[19] which had been appointed by the government recommended the establishment of a national health service with the following features:

- state responsibility for all medical services
- free medical services for all
- funding provided by a means-tested national health tax
- a network of community health centres
- a referral chain of hospitals with access determined by need
- training of community health workers
- phasing out of private practice
- adaptability to local needs
- decentralised but coordinated service
- equity

The WHO's document on "Health for all by the year 2000" adopted at the 30th World Health Assembly in 1918 stated that:

- national policies ... should ensure that legislative, administrative, and economic mechanisms ... ensure effective participation of the people at all levels of ... policy-making

- member states should have multi-sectoral policies that effectively ... ensure community awareness and involvement

- all member states should have mechanisms by which the services provided by all sectors relating to health are coordinated at the community level.

Section VII of the WHO's Declaration of Alma Ata stated that:

> Primary health care involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors.

Section VIII of the same document stated that:

> All governments should formulate national policies, strategies, and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it

will be necessary to exercise political will and to mobilise the country's national resources and to use available resources rationally.

The Liverpool Declaration on Healthy Cities adopted in 1989 at a WHO conference provides a comprehensive social medicine framework.[20] It stipulated:

1 the right to health

In recognising every citizen's right to health, we accept the responsibility carried by all agencies, throughout our society to take account of the public health costs of all their activities.

2 equity in health – the reduction of inequality

We reject all forms of discrimination that reduces people's chances of good health, and accept the challenge of substantially reducing current health inequalities.

3 community participation

We acknowledge the necessity for meaningful public participation in all processes and activities that affect people's health.

4 inter-sectoral collaboration

We will work with all agencies and groups whose activities are relevant to the promotion of the public health.

5 health promotion

We acknowledge our collective responsibility to promote and create healthy physical and social environments and to facilitate people's choices of healthy lives.

6 primary health care

Primary health care should become the central function and main focus of our national health service.

7 international cooperation

As health promoters in a rich nation we acknowledge our shared responsibility for the health of the world.

8 research

We will encourage in all relevant ways the research necessary to achieve health for all.

A Charter for Action on Health published by the faculty of Community Medicine at London University in 1990 set out a programme for the WHO's goal of "Health for all by the year 2000". The following is a minimally edited version of the charter.

The requirements for "health for all by the year 2000" are:

- peace – not simply the absence of war or social unrest but a climate of stability;
- social justice – the right to the protection of the law and to equality of access to the necessities of life;
- decent housing and sanitation;
- education;
- secure employment – so that everyone has a valued and rewarding role in society;
- equity in health – so that all have the best possible opportunity to develop healthily and to obtain required care;
- public life policies that make it easier to:

  adopt healthy life-styles
  participate in health policy-making
  enhance the role of the family and other social groupings;

- the creation and preservation of a healthy environment;

- the development of medical services which are appropriate to people's needs and wishes;

- acceptance of these goals by the health professions.

Health professionals/workers are given special responsibilities.

- They should work together to provide:

  responsible leadership in health matters
  information on available health services.

- They should:

  set an example in healthy living
  work with other organisations and members of the community to plan ways for people to be healthy.

- They should ensure that people:

  know what determines health
  are able to participate in taking decisions that affect their health
  have sufficient knowledge, freedom and personal resources to choose a healthy lifestyle.

The principles adopted in 1992 by the American Public Health Association for their National Health Programme[21] reflected contemporary thinking on medical services. The wording has been slightly modified:

1 universal personal medical service coverage for everyone in need;

2 comprehensive benefits including health maintenance, preventive, diagnostic, therapeutic, rehabilitative and palliative services for all types of illnesses and medical conditions;

3 elimination of financial barriers to personal medical services;

4 financing based on ability to pay;

5 organisation and administration of personal medical services through publicly accountable mechanisms to assure maximum responsiveness to

public needs, with a major role for central, regional and local government agencies;

6 incentives and safeguards to assure effective and efficient organisation and high quality personal medical services;

7 fair payment to providers of personal medical services using mechanisms which encourage appropriate treatment by providers and appropriate utilisation by consumers;

8 on-going evaluation and planning to improve the delivery of personal medical services with consumer and provider participation;

9 inclusion of health promotion programmes;

10 support of education and training programmes for health workers;

11 affirmative action programmes in the training, employment and promotion of health workers;

12 non-discrimination in the delivery of personal medical services;

13 education of consumers about their rights and responsibilities;

14 attention to the organisation, staffing, delivery and payment for medica services to meet the needs of all populations including those confronting geographic, physical, cultural, language, and other non-financial barriers to personal medical services.

What is to be done – from words to action

The interdependent components of social medicine should be simultaneously addressed if universal good health status is to be achieved. The Chinese experience after the communist revolution in 1949 is instructive. James Grant, the Executive Director of UNICEF, in his opening address[18] to the Inter-Regional Seminar on Primary Health Care described the changes that had taken place in China:

> [I]n the late 1940s ... China was among the least developed countries in both economic and health terms. Malnutrition, diarrhoea and infectious and parasitic diseases were rampant. ... The population was largely illiterate.

> Infant mortality was nearly 200 per 1000 births, the death rate was approximately 25 per 1000, and the crude birth rate was in the high thirties.
>
> In approximately 30 years all this has changed dramatically. ... [H]ealth conditions have improved spectacularly. The infant mortality, death, and birth rates today are well under one-third of the level of earlier years. ... Life expectancy ... has doubled ... and in sizable parts of China it equals that of the industrial countries today with their vastly higher per capita incomes.

He attributed the improvements to:

i a change in the direction and dynamics of the government and the people, ... [and] a serious commitment at the highest level in government to the social goal of health for all

ii the early recognition that the use made of medical knowledge and the efficiency of health protection depends largely upon social organisation

iii the integration of medical care with development and social reconstruction in particular:

- sufficient increases in income and its equitable distribution to permit adequate food, shelter and clothing
- prices that those in need could afford so that availability and access were ensured
- the expansion of literacy and education, water supply and transport services

iv a cost-effective participatory medical care system based on primary health care principles.

Data on health and socioeconomic conditions in Scandinavian countries and the United States of America between 1982 and 1986 demonstrate the association between health and socio-economic factors (see table)[22]. The data suggest that money spent on medical services may be less relevant to health than money directed at improving and sustaining a healthy socio-economic environment.

Parameter	Scandinavian countries	USA
income (per person/year)	$12 500	$15 250
unemployment rate	2.4 %	7.2 %
social class differences	slight	marked
guaranteed universal access to social and medical services	yes	no
% of government spending on:		
health (medical services)	7.2 %	10.8 %
education	15.9 %	2.1 %
defence	7.2 %	23.1 %
indicators of health:		
infant mortality rate	8/1000	11/1000
children's health	very good	fair

No single measure on its own can be expected to succeed in securing and sustaining good health. An integrated comprehensive approach is needed. This should be borne in mind when reading the following sections on some of the more important actions that could contribute to good public and personal health.

ingredients for success

- financial resources
- social security
- national income and independence
- peace, individual rights and social justice
- living and working conditions
- food security and the food industry
- civic morality, family and social solidarity
- education
- political will and revolutionary change
- a non-medical multi-sectoral paradigm
- medical services
- health professionals/workers
- referral systems
- surveillance

- systems analysis methodology
- grass-roots participation, decentralisation and power
- government support
- vertical mass medical interventions
- mobilising popular support
- funding
- development and aid agencies

i financial resources

Only full employment and a living wage (or its equivalent in kind) supplemented by a social security network for those who cannot work can guarantee adequate financial resources for the maintenance of a standard of living compatible with health. As Frank Field[23] commented in 1993 on the report of the UK Labour party's Commission on Social Justice:

> If the objectives [financial independence and life-long learning], along with work, good health, and a safe environment [the commission's five great opportunities], are to be the framework about which the commission will plot Labour's future, the quest for full employment becomes central. ...
>
> Full employment needs to be made the number one political issue. No issue can touch it for importance. The wicked waste of people's lives that results from unemployment is obvious.

In free market economy countries income provides the means and the power to acquire the necessities for life and health. In socialist countries, in countries with adequate welfare structures, and in societies with a viable subsistence economy (like the few remaining pre-industrial communities and the original Israeli kibbutz) on the other hand social security networks and organised, communal, free or subsidised access to food, shelter, water, fuel, transport, education, medical services, legal redress, etc. reduce the level of income needed for healthy, sustainable living.

Per capita income per se is a crude indicator of a population's average economic status and power and does not reflect all the means available for healthy living. In China for example the improvements in health occurred at a time when the country was poor as Grant[18] pointed out:

> [T]he per capita income level in real terms ... is still [1982] no more than that of the industrial countries of Europe and North America two centuries ago.

And, the report of the Inter-Regional Seminar[18] concluded that:

> Perhaps the most important lesson learnt in China ... is that “health for all by the year 2000" is a target that can be achieved ... in spite of limited resources, the many obstacles normally present in any process of social change, and a low per capita income.

In Cuba improvements in health became apparent within 5 years of the revolution. As Mervyn Susser[24] wrote:

> [T]he Cuban economy did not march in parallel with Cuban health, nor did Cuba outstrip the rest of Latin America in economic development. Within the country, income was redistributed, almost certainly contributing to improved health ...

Per capita income as a measure also obscures the gap between the rich and the poor and between the poor (who scrape by) and the very poor or destitute (who don't). The poor may be poor because they are unemployed or underemployed, or if employed, underpaid. Some of the poor and the destitute are now called the underclass which John Galbraith[25] described as:

> These people, this class, are concentrated in the centres of the great cities, or less visibly, on deprived farms, as rural migrant labour, or in erstwhile mining communities. ... The greater part of the underclass [in the USA] consists of members of minority groups, blacks or people of Hispanic origin.

The rich may be rich because they inherited their riches, own the means of production, or are criminals engaged in gun-running, drug dealing, white collar crime, prostitution or sex-work (call it what you will – it's not the profession your mother would have chosen for you), burglaries, high-jackings, kidnappings, you name it. Many who fall foul of the law don't get to own flats facing north (as preferred in the southern hemisphere) and join the underclass. Some people are fortunately gainfully employed and earn enough to be able to choose to live healthy, comfortable lives. That they do not usually choose to do so can be ascribed to countervailing factors operating in our consumerist society.

In South Africa the unemployment rate is very high – 50 per cent of the economically active adult population according to some analysts[26], although the figure usually quoted is 46%.[*] For the employed, salaries, wages and income

[*] Data from 1980 – 1990; formal unemployment at about 40% in 2011

are usually low and according to Francis Wilson and Mamphela Rampela[27] unequally distributed:

> In South Africa ... the proportion of the total population living, in 1980, below subsistence ... was estimated to be 50 per cent. For Africans ... the proportion was estimated to be nearly two-thirds ... whilst for those living in the reserves no less than 81 per cent of the households were in dire poverty.
>
> [T]he most striking feature of poverty ... is the degree of inequality that exists. ... In 1970, the richest 20 per cent of the population ... owned 75 per cent of the wealth compared with 62 per cent in Brazil and 39 per cent in the United States.

All forms of violence and crime are rife. Unemployment, underemployment, criminal activity, an unequal income distribution, social malfunction, civil disorder and disease are all interdependent. As Navarro[28] wrote:

> [U]nemployment is not only in violation of the socioeconomic rights of the unemployed, but also of their civil rights, such as the right to life and freedom from harm. ... As indicated by a [1976] Congressional Report, every increase of unemployment by 1.4 per cent determines [in the USA] 51,570 deaths ... including 1,540 suicides and 1 740 homicides; and leads to 7,660 state prison admissions, 5,520 state mental institution admissions, and many other types of harm, disease, and unease.

Personal income is determined by local and international capitalist control of the means of production and governance, of the military and the media, and by the policies and practices of international finance institutions. As Susan George[29] explained:

> The debt crisis has exacerbated this already tough situation [unequal income distributions] by causing massive job losses and plummeting wages for those who remain employed. ... When the IMF tells a government to cut public spending or else, thousands of civil servants, usually at the lower levels, are sacked ... All Fund programmes include this standard feature.
>
> The job crisis is worst in the South but global in nature. Because adjustment in debtor countries has meant, above all, reducing individual incomes and consequently imports from the North, the ... [International Labour Organisation] says that North America and Europe lost 2 to 3 million jobs between 1981 and 1983.

Peter Townsend[30] writing on the increase in the severity of poverty in the United States of America offers two interdependent explanations:

> [There] is the speeding up of company mergers and the shift to multinational companies. This ties in with the individualisation of pay on the basis of skills. But it also makes unions and old wage agreements redundant and legitimates a much more unequal pay scale.

Trans-national corporations act through and with national financial institutions. Increasingly most of the transactions of the major national banks are channelled through the World Bank and the International Monetary Fund (IMF). The bank and the fund have become the universal lender and a cruel and usurious one at that. Interest alone on the loans is milking borrowers dry. The borrowed capital is always being rescheduled; it pays the lender handsomely in financial terms to do this. Shakespeare was right when he had Polonius say to Laertes in *Hamlet King of Denmark*[31]:

> Neither a borrower, nor a lender be;
> For loan oft loses both itself and friend,
> And borrowing dulls the edge of husbandry.

ii social security

There should be a social security network of sickness benefits, old-age pensions, disability grants, workmen's compensation allowances and unemployment benefits, etc. to sustain and support those who are ill, otherwise incapacitated, or in need, to help people who are poor from whatever cause, and to help those who live in societies where medical services, education, water, fuel, and other social essentials have to be bought at unaffordable rates.

In most capitalist countries social security is neither adequate nor easily accessible; in some it is just not available. Bureaucratic inefficiency in processing social security benefits together with the uncertainty, the humiliation, and the dependency has a devastating effect on people's quality of life and health. It is the vulnerable and the powerless who suffer most.

Existing services should not be cut or starved of resources, as happens under the impact of the policies of the International Monetary Fund for example in Kenya according to Susan George[29].

> During the decade 1964 - 1973 social spending was clearly at the top of the list: "education, health, and welfare services grew annually by about 15 per

> cent per capita, whereas the rate of growth of total expenditure per capita averaged 7.1 per cent yearly". Unfortunately in the following decade 1974 – 1983, [after the arrival of the IMF in 1975] the situation was completely reversed. Defence spending and interest spending on debt increased by 11.7 and 13.7 per cent yearly, while education and health spending registered annual growth of less than 3 per cent and other welfare spending stopped altogether.

Peter Townsend[30] quantified the dependence of the poor on social welfare in the United States of America when he described the effect of its curtailment:

> [An analysis] attributes 1.6 million of the 8.9 million increase in the numbers in poverty between 1979 and 1990 to cuts in social insurance programmes, 2.4 million to cuts in means-tested welfare programmes, 0.2 million to changes in federal taxes, 3.1 million to population growth and another 1.8 million to “demographic factors" – meaning principally a growth proportionate to population of single-parent families and the elderly. ... [But] the biggest single cause of the growth in its severity has been the fall in the real value of low wages.

iii national income and independence – the effect of market imperialism

The income of communities, regions, countries, whether socialist or not, are determined by multinational monopoly capital and its intermediaries in governments, military establishments and financial and other institutions such as the World Bank and the IMF, the Organisation of Petroleum Exporting Countries, the European Commission and the G7 (group of seven most industrialised countries). These bodies are very powerful according to Jeremy Seabrook[32]:

> The missionaries of the west – the negotiators of IMF, World Bank project makers, GATT negotiators, representatives of trans-national corporations – constitute a formidable army of fanatical soldiery in pursuit of an undeclared jihad, which has pretensions to supervise what is now openly referred to as the global economy.

Neo-colonialist exploitation under the guise of dispassionate foreign investment by these powerful and often unscrupulous international bodies is completing earlier colonial plunder and destruction. As noted in a 1974 United Nations Industrial Development Organisation's report quoted by Ray Elling[33]:

> [T]oday, capital, technology, management, and access to markets needed for industry flow to a considerable extent to the developing countries through the subsidiaries and affiliates of trans-national corporations.

The uneven clash of interests between capital and labour, between imperialism and colonialism, or in its current versions, between trans-national corporations and dependent client states, between the north and the south, the first and the third world, has resulted in massive national loans, debts, and economically crippling repayments, the imposition of so-called structural adjustment programmes (SAP), trade sanctions (Iraq 2001 version), and in all types of wars with unprecedented large civilian casualties. All this has adversely affected living standards and the pattern of distress, disease, disability, and death.

Loans to pay for foreign debts are usually conditional on export-oriented economic activity, devaluation and reduced state spending on food subsidies, education, medical services, other socially supportive and people-centred operations, and privatisation of public assets and services. These are essential components of structural adjustment. Economic improvements with trickle-down changes in the standard of living and in health status in the client states were supposed to have resulted from the application of the usually non-negotiable adjustment. Instead the indices of both economic and health status deteriorated.

Disaster and tragedy among the borrowers has been the almost universal experience. Susan George[29] quotes a former governor of the Peruvian Central Bank:

> [He] had to admit that "the social costs of the IMF adjustment policy are tragic. It means the death of some 500,000 children ..."

Of Kenya where the IMF arrived in 1975, she wrote:

> Child malnutrition is one of the best indicators of how well a society is progressing towards satisfying basic needs and promoting greater social equality. In 1918 an official study found 24 per cent of the children under 5 were stunted; in 1982 the figure was up to 28 per cent.

The effect of national financial indebtedness on infant mortality rates (IMR) and life expectancy, two commonly used quantitative markers of health, has been documented. According to her:

> UN agency statistics are slowly beginning to register increasing infant mortality rates ... Evidence indicates that they are climbing throughout the Third World ... Even in the worst off and least developed countries IMR had been declining slowly but steadily for decades. Since the only really new economic fact in these countries over the past ten years has been runaway indebtedness followed by IMF-style austerity programmes, we may conclude that this has more than a little to do with rising IMRs.
>
> Using data from seventy-three African, Asian, and Latin American countries ... [it was] established that the higher the debt, the lower the improvement in life expectancy.

Ray Elling[33] in summarising the outcome of the assistance and advise offered by multinational corporations as solutions for world poverty and other problems, referred to a similar conclusion:

> It is an unhappy fact that the development track pursued by the global corporations ... contributed more to the exacerbation of world poverty, world unemployment and work inequality than to their solution.

The effect of the policies of the multinationals and of international finance has often been obscured by confusing sweet-talk. As a Roman Catholic missionary from Kwilu, a rural region in the then Zaire, is quoted by Susan George to have written[29]:

> For the people here the so-called "economic recovery" so highly praised by the IMF and the rich countries, and by the Belgium press – is an absolute disaster

Susan George argued that third world debt is "an on-going dialectic FLIC (financial low intensity conflict)" rather than a crisis. Pursuing the same metaphor Luis Ignacio Silva the then Brazilian labour leader in an address to the Havana Debt Conference in 1985 claimed that the Third World War had already started. He is quoted by Susan George[29] to have said:

> This war is tearing down Brazil, Latin America, and practically all the Third World. Instead of soldiers dying there are children; instead of millions of wounded there are millions of unemployed; instead of destruction of bridges there is the tearing down of factories, schools, hospitals, and entire economies ... It is a war by the United States against the Latin American continent and the Third World. It is a war over the foreign debt, one which

> has as its main weapon interest, a weapon more deadly than the atom bomb, more shattering than a laser beam ...

Contemporary Cuban history demonstrates in starkly tragic terms the threat posed to personal and national income, standard of living, and directly and indirectly to health by overt imperialist political and economic forces. After the Castro-led revolution in 1959, Cuba initiated an extensive social and economic restructuring and developed as part of the package a national health system which provided a free, comprehensive, and accessible medical services to the entire population. As Diane Kunt[34] wrote:

> Cubans benefit from an abundance of highly-skilled doctors and other trained personnel who focus on preventive activities and health promotion. Cuba has achieved near universal literacy, and health is an integral part of education and social services.

But the extension of the United States of America government's 32-year embargo against Cuba to include trade, mostly in food and medicines, by foreign subsidiaries and trading partners of USA companies has had a deleterious impact on the medical services and on the country as a whole. The effects were compounded by the politically related economic collapse of Cuba's major trading markets in Eastern Europe and extensive damage from a hurricane in March 1993.

Oil shortages emptied to streets of cars, caused power shortages, disrupted factory production, increased unemployment and underemployment, and coincidentally also reduced air pollution. The Cuban diet is less adequate than before in both quality and quantity. The standard of living has fallen. The incidence of some infectious diseases is up. Head lice and aneamia are back. There are more low-birth weight babies than before. There has been an increase in the number of hospitalisations. Medicines and medical supplies are scarce. Replacement parts and supplies for some of Cuba's high-tech medical equipment are under United States of America patent or are manufactured only by United States of America firms and are therefore inaccessible.[48] And, since 1991 nearly 50,000 Cubans have been afflicted by an eye and nerve disease which has been traced to a vitamin deficiency aggravated by the ingestion of toxins such as those found in home-brewed rum.

The United States of America is accused by Victor Sidel in his testimony[34] to a Senate committee of contributing to the Cuban situation and of causing:

> suffering among an entire population in order to accomplish ... national political objectives. ... [I]nterference in the Cuban people's access to food and medicine is tantamount to the use of food and medicine as a weapon in the US arsenal against Cuba.

The Cuban experience is a protracted replay of what happened in Guatemala in 1952, brutally and acutely in Chile in 1973, and in Nicaragua more recently and more covertly. As Derek Summerfield[35] wrote of Guatemala:

> The enduring links between land and power, and between landlessness and poverty, ill health, and low life-expectancy, [are] strikingly visible. ... In 1952 the Arbenz government introduced a modest agrarian reform programme that affected some (unused) land owned by the giant US multinational United Fruit Company. Arbenz was overthrown in a CIA-backed coup and harsh military rule returned.

In Chile Allende's socialist government was overthrown in 1973 in a coup supported overtly by the government of the USA, the CIA, and ITT with appalling consequences for employment and health, as Navarro[28] wrote:

> Allende's policies, which had a substantial impact in expanding and optimizing socioeconomic rights of large sectors of the population, were considered by ... international institutions (like the World Bank and the Latin American Development Bank) to be in conflict with the sacred and ubiquitous right of private capital accumulation. … [A]fter the coup the Junta denationalized most of the public property and once again made Chile safe for multinational corporations ... The Junta [made] cuts in public expenditure for health services …
>
> [I]n 1976, a quarter of the population had no income at all, unemployment was estimated at 22 percent – during Allende's [presidency] it was 3.3 percent – and a phenomenon of mass hunger and starvation existed unknown in the recent history of Chile.

In Nicaragua the socialist government of Daniel Ortego which implemented agrarian reforms as well as successful community-based medical services [some of which now ironically serve as models for New York's tuberculosis control programme] was cruelly aborted by USA-directed political and economic blockades and by its covert military support of the right-wing contra rebels who even targeted health workers.

In Eastern Europe efforts to sustain the communist revolution against capitalist intervention permeated and corrupted every aspect of life. In the Soviet Union the intervention started even before the end of the World War I. It was exacerbated by World War II and continued, there and in Eastern Europe, to undermine the achievements of the revolutions by slow attrition, by the cold war, and by the rearmament's race until these interventions eventually succeeded in thwarting the already tarnished experiment in communism. Now, within a few years, these so-called liberated people are suffering the horrors of a capitalist take-over with an increase in the number of abandoned children, the elderly, and other vulnerable groups, an increase in all forms of crime, deteriorating living standards, medical services, and health status, and in many places horrendous racist wars.

Yelstin's crushing in October 1993 of the opposition to his market reforms was described in the New York Times as a "democratic coup". But John Pilger wrote[36] more realistically that:

> What has happened in Russia is a vivid example of the war against democracy being waged all over the world in the name of the "global economy" and "development": the euphemisms for market imperialism. It has brought about what has been described as an "economic holocaust" in the poorest countries, which are 61 per cent more in debt than they were a decade ago and where, according to UNICEF, half a million children die every year as a result of a peonage imposed by IMF "structural adjustment" programmes.

The economic changes that have taken place in China since the late 1970s have affected medical services and health. As Victor Sidel[37] wrote:

> As part of these changes, the communes have been dissolved. Because the organization and financing of rural health care was largely dependent on the commune system, rural health care services changed substantially.

He concluded:

> [C]hina's current ideology of unrestrained d free-market entrepreneurialism ... has destroyed the economic and social bases for equitable rural services.

Ordinary people in developing countries have been most affected but nowhere have they been spared. In 1976 a British Labour government was forced to abandon its commitment to public spending and social welfare by submitting to

the demands of the IMF to devaluate its currency.[38] The current spirited defence by French farmers of their economic independence and cultural survival is directed against the attempted take-over by USA's agribusiness and the hard bargaining stand taken by their government at the General Agreement on Tariffs and Trade (GATT) talks.

In the face of extensive well-documented evidence on, and public awareness of, the deleterious effect of monopoly capital on the economies of people and countries especially in the developing world, how is it that multinationals and their surrogates have not only survived but have actually prospered? Bribery and corruption of the ruling elites in donor and recipient countries alike, the convergence of interests between the power brokers, and a perverted value system predicated on capitalist control of the media and the advertising agencies (Vance Packard's Hidden Persuaders) have contributed to this sorry state of affairs. As Navarro[28] wrote:

> The main cause of underdevelopment is control of the economy by a small percentage of the population, … [the] lumpen-bourgeoisie (their economic, social, and political power is dependent on the power of the bourgeoisie of the metropolis), which has strong connections with international capital and close affinity to the values, tastes, and forms of consumption typical in the developed countries. It is this group which establishes and determines the pattern of production and consumption in under-developed societies, and which moulds a pattern of production and consumption that is not conducive to, nor is it aimed at, the overall development of those societies.

Seabrook[32] compared international financial institutions and their surrogates with religious fundamentalism. But there are some differences as he explained:

> The west does not issue *fatwas* against individuals. We prefer sentences of mass death, to be executed by the impersonal forces of "economic necessity".

The story of clothing high-lights the issue. In South Africa, for example, the clothing industry is being snuffed out at many levels. Cotton and wool (an important export commodity in the past) have been supplemented and even replaced by synthetic fibres. Locally produced material and finished products can also not complete with the cheap goods produced in Asian sweat-shops by exploited, contracted, cheap labour often from subsidised GM-ed cotton crops grown in the United States of America, nor with the second-hand clothes from the developed world that flood the markets. People who have already lost their land to commercial farming, now lose their jobs and without jobs there is no

money, and without money there is now no food, and without food there is no health. and without health there is no life.

iv peace, individual rights and social justice

Weapons are meant to kill and maim and they do. Their manufacture and distribution deprive a country of resources for economic development and social health. On the other hand social, economic, civil, and political rights, social justice, and measures to promote and maintain health could flourish under conditions of peaceful coexistence within and between countries. Peace, personal rights, and social justice are interdependent as Tawney quoted by Navarro[28] indicated:

> [P]olitical rights afford a safeguard and significance to civil rights ... [and] economic and social rights provide means essential to the exercise of political rights.

Why are there wars? The USA and other neo-colonial powers have been overtly and covertly involved in savage civil wars on behalf of the profits of multinational corporations and cheap fuel following which friendly client regimes are installed. As Ray Elling[33] wrote:

> When the "natives" have on occasion become restless about such [multinational] exploitation and extraction, military force has always been available in the background. Where abortive uprisings and revolutions have occurred and direct military or other intervention has followed, a repressive police state has been established.

In some of these wars the United Nation's Organisation and the North Atlantic Treaty organisation front for international capitalism.

During the cold war era military offensives were also predicated on capitalism's perceived need to contain communism. This and the connections between capitalist governments, multinationals, and war are described in a 1972 report of the National Emergency Civil Liberties Committee (in the USA) as quoted by Ray Elling[33]:

> In mid-May ITT's president, Harold Geneen, admitted at a stockbrokers meeting to $350,000 sent to rightist forces in Chile for use against the Allende regime, with the encouragement of the CIA. He explained that the purpose was "to preserve a major investment of the company amounting to $135 million for the stockholders which the company did recover". This,

> of course, is not the sole explanation, but in Guatemala, Iran, Brazil, as in Chile, the close relations between the CIA and specific US business interests determined to maintain domination of local economies have been quite clear. An examination of the record, including the Pentagon Papers, demonstrates that control by American interests of the "rich natural resources" of Southeast Asia was no minor goal in our initial intervention in Indochina. But the people could not be told this. Hence the myths of the cold war were used as cover for the initial secret operations of the CIA, and the later open military expansion when this was not enough to bend the Vietnamese to our will.

It's the ordinary people everywhere who pay the bills for the military equipment, who suffer the opportunity costs to their economy, health, and life, and who fight the wars while the trans-national corporations get stinking rich from the trade in armaments. The financial considerations that influence policy are seldom openly admitted and the source and the means of supply of military equipment are usually secret. This was the case when just before the first gulf war Britain provided Iraq with strategic supplies as Jolyon Jenkins and Robin Ballantyne[39] reported in a British magazine:

> "Arms-to-Iraq" is a misnomer: we have been witnessing a "technology-to-Iraq" scandal. Matrix Churchill did not make weapons, but the machine tools used to manufacture them. And its goods represented only a tiny part ... of the enormous quantity of equipment supplied by Britain to Iraq at the time there was supposedly an embargo in force on exports of "lethal equipment".
>
> The great majority of this equipment was also not actual weaponry, but it was similarly hi-tech. It included communications equipment, satellite spares, and uranium. All of it had a clear military use, but some was sufficiently detached from the actual mechanics of killing people to allow civil servants and ministers to pretend it was non-lethal.

A United Nations General Assembly resolution to ban landmines, proposed by the European Community of which Britain is a member, was privately opposed by Britain for private commercial reasons according to an official within the United States government. As John Pilger[40] wrote:

> [T]he British have told the Clinton administration that they will vigorously oppose any worldwide ban on landmines, regardless of a law which is about to pass through Congress banning the export of American mines for three years. Indeed, so adamant are the British that the Americans are said to be having second thoughts. According to a State Department source, "The

> British position is commercial. They have a big deal coming up, selling landmines to a Middle East country. There's a lot of money involved."

Wars, civil unrest, and easy access to weapons for private use are generally very good for business, as long as not too much killing and destruction take place in the businessman's backyard. The cut in defence spending since the end of the cold war is not unrelated to the current world-wide recession. Control of private use gun purchasing in the USA, now hopefully a bit closer, is badly timed for the arms industry. Despite overwhelming popular support the enabling legislation is after seven years of campaigning not yet enacted. Peter Fabricius[41] explained why:

> [There was] opposition from the notoriously powerful National Rifle Association ... [a]nd behind them the big money of the gun manufacturers who contribute such large amounts to congressional election campaigns.

Fortunately (or deliberately) for international capitalism there are still some wars being fought, situations that can be conflagrated into wars, and if these were to end, recalcitrant liberation movements that need to be suppressed. As Michel Chossudovsky[42] wrote:

> With regard to arms sales while much of the weaponry provided by the United States to client Third World military regimes is theoretically intended "to help countries defend themselves against external attacks" an examination of US exports suggests that a large portion is in fact designed for internal repression.
>
> US government records show that US agencies and corporations are providing arms, equipment, training, and technical support to the police and paramilitary forces more directly involved in torture, assassination, and incarceration of civilian dissidents ... The United States stands at the supply end of a pipeline of repressive technology extending to many of the Third World authoritarian governments.

The United States and the United Kingdom are not the only governments that front for multinational weapons' manufacturers. Even socialist Sweden is involved. Not only did Sweden sell arms to India but it allegedly also bribed Rajid Ghandi's government while doing so. The command economy countries of Eastern Europe also sustain their economies on the export of weapons. And now South Africa is entering the market. Armscor is being privatised and is promoting its products on world markets and fairs.

In many countries defence uses up a very large fraction of the national budget as well as money that should be devoted to social programmes, to lower the tax burden, and to pay off national debts. The developed world is said to spend nearly $150 billion a year on weapons.[43] It is no coincidence that Sweden and Switzerland, and since the end of World War II, Germany and Japan, countries that do not have standing armies, have high standards of living and health.

Countries where fighting takes place are laid waste in every way and the people suffer grievously. We now also have and use horrendous new weapons such as napalm, white phosphorus, and agent orange (dioxin), bullets and rocket tips made from nuclear waste, and land and anti-personnel mines. Their targets (not admitted but nevertheless real, so-called collateral damage) are civilians, and the dying and disablement continues long after the wars are officially over. As Eric Hoskins[44] wrote:

> Radioactive bullets made from American nuclear waste and used by coalition forces during the Gulf war may be the cause of mysterious new illnesses that are showing up in Iraqi children. ... This suspected linkage, as well as the likelihood of serious environmental contamination of soil and water, has alarmed international medical experts.

And as Pilger[40] wrote:

> [In Cambodia landmines have] killed more people than any other weapon. ... Doctors and paramedics perform up to 500 amputations every month; and for every victim who reaches an ill-equipped hospital, another will die without treatment.

The socioeconomic ravages of all forms of war are almost always associated with political repression. As Susan George[29] wrote of FLICs so too of conventional wars fought by military means, and not only in Africa:

> Under pressure of debt, debt service, and IMF programmes political repression is flowering and multiplying in Africa ... Claude Ake says that political repression is the "greatest single obstacle to development" and he is quite right, but behind political repression lies the financial burden. International agencies and their insistence on delivery of pounds of flesh help to provide a convenient alibi for the abuse of power.

And as Navarro[28] wrote:

> A picture of hunger, starvation, torture, harm, desperation, and death is the result of the orthodox politics perpetuated by the centers of international economic order, and they require a most brutal political repression to sustain and maintain them. Chile has clearly shown what Brazil and many other countries had already shown, that the interests of International Capital and the international and national political institutions that sustain it are incompatible with the realization of human rights ....
>
> [P]olitical repression in those regimes is required and needed to sustain an economic system whereby the few (including US corporate interests) control much, and the many (the masses of those countries) control very little.

We in South Africa still face the economic and human fall-out from recent civil resistance and its often fatal repression, our military interventions in neighbouring countries, and the ideological antagonisms, distrust, associated brain-washing, double-talk and propaganda as well as the implications for peace, civil rights, social justice, and health of the ruling African National Congress' sell-out of its socialist principles. Lessons need to be learned and the chains of causality need to be unravelled.

v healthy living and working conditions

People cannot be healthy without proper shelter, easy and affordable access to safe water and healthy food, the separation of water and sewerage, safe refuse disposal, access to a safe and clean source of fuel and transport, industrial safety, job satisfaction (for those who are fortunate to have jobs), and the control of disease vectors, micro and macro environmental pollution, anti-social and criminal activity and ecological degradation, inter alia. Several of these considerations have in some countries been incorporated into a set of basic human rights. Technology-driven changes in living, working and communicating must now be added to the list of factors that impinge negatively on health. The list is interactive and almost endless; it includes transport, recreation, social-networking, and what, how and when we eat,.

Ubiquitous advertising by multinationals and smaller commercial and industrial enterprises is a powerful influence on the way we live. The unbridled promotion of alcohol, tobacco, cleaning, cosmetic, and food products, whose manufacture, use and disposal may directly and indirectly affect animal and plant life and which contribute significantly to the escalating pandemics of, and premature mortality from, cancers, auto-immune diseases, mental illness, cronic liver and

lung disease, and the rapidly expanding list of diseases collectively known as the metabolic syndrome. The management of these diseases fill the coffers of commerce and industry and when treatment fails, the coffers of commercial-scale coffin manufacturers.

HIV/AIDS although caused by a virus thrives in socially-disrupted societies, migrant groups, and in war, famine, and poverty ravaged communities where living and working conditions are often totally inhumane and where (un-protected) promiscuity, alcoholism and drug abuse are often the only escape from horror. This epidemic while financially benefiting the pharmaceutical industry has severely strained medical services in the worst afflicted countries

As the Gluckman Commission on Health and Medical services in South Africa[19] reported in 1944:

> First and foremost among the causes of ill health are the economic poverty and social backwardness of the greater part of the Union's population. Vast numbers of people in this country do not earn enough to purchase the minimum of food, shelter, and clothing to maintain themselves in health.

As stated in the introduction to a monograph[45] on supplying water to villages in Nicaragua, "Water is life, and the quality of water means quality of life". The same can almost be said of housing and fuel and of the other social determinants of health and disease. Cedric de Beer[46] writing on the very rapid spread of tuberculosis (TB) among African mine workers and other Africans in the early part of this century concluded that:

> [T]he spread of the disease is not random. ... It is the poor, the underfed, those who live in overcrowded conditions and work at hard jobs who get TB. These are the people who hold the lowest positions in the economy, and do not have the political power to improve their situation. ... All the drugs in the world will prove almost powerless in the face of poverty, unemployment, and social misery.
>
> The conditions for the epidemic were created by the massive social upheavals which resulted from the development of large scale industry, beginning with the mines. These changes were accompanied by the development of the migrant labour system, the creation of the bantustans and the destruction of the rural subsistence economy: all factors which hastened the spread of the disease.

The migrant labour system which was a lucrative and cheap deployment of the mine industry's work-force is another important facet of living and working which contributed not only to distress, disease, disability, and death (particularly tuberculosis, HIV/AIDS, and venereal diseases) among the migrants themselves but also among their families, whom they leave behind and to whom they return periodically. As Cedric de Beer also wrote:

> Pass laws were developed to ensure that Africans were in "white" areas only to work. When the migrant worker had completed his contract, or if he was found to have developed TB, he had to return to the reserve area. ...
>
> Surveys in the Transkei, Ciskei and Basutoland around 1930 showed that between 69% and 88% of men aged about 20 were infected with TB and 72% of black workers applying for jobs on the mines were infected.

To the migrant labour force should now be added other oscillatory migrants such as truck and train drivers and their co-workers even if they are only away from home for a few days, refugees and other displaced people.

vi food security and the food industry

Rural people are no longer self-sufficient in food. Where they have not yet been forced off the land, they are producing not food for local consumption but cotton, coffee, tea, and other raw commodities for the market. When prices drop, as they seem inevitably to do, they borrow money for food and fuel. They may be forced to sell their land to pay their debts, and then they are hungry, starve, get sick and die (even by suicide as in India) or follow some milder and protracted path to disaster, as Susan George[29] wrote:

> Favouring cash crops has two major, far-reaching effects, neither very helpful for feeding people. The first is obvious: less food is planted. The second is more pernicious. Smallholders get more cash when they sell their tea or coffee ... so normally they should be able to buy food for their own consumption even if the government has to import it, as it has increasingly done (in Kenya) in recent years. The rub is that while families might get a higher cash income, they don't necessarily spend it on food. This is because men control the money from cash crop sales. ... When women have money they spend it on family welfare – first of all on feeding their offspring.

Ray Elling[33] documented a variation. He wrote:

> MNC [multinational corporate] agribusinesses exploit vast sections of the best land for the export of a single cash crop ... turning farmers into low wage earners who have to import food simply to keep themselves alive. Gradually, a whole country is shifted from a position of relative self-sufficiency to one of extreme dependence and poor nutritional levels.

In today's global economy, no man or country is an island. Food has become an important mechanism used by trans-national corporations for exerting influence and control as Susan George[29] noted:

> Morocco, a cereals exporter in the 1960s, today satisfies only a fifth of its own wheat needs. Food imports rose by an average 17 per cent between 1970 and 1983 – a stunning 220 per cent. This was not accident but policy.

Agribusiness – commercial farming usually of mono-crops, and in the USA not infrequently GM-ed and CAFO-based (Concentrated Animal Feeding Operations) life-stock “factories” processing thousands of confined animals with their polluting methane-spewing earth-warming manure lagoons and with the incubation and spread through vast transport networks of animal infections and diseases – which displaced small farms in the developed world is a variation of the dispossession by market-oriented imperialism seen in the developing world with similar impacts on the health and lives of the farmers and their families.

The changes in farming made possible industrial food processing and vice versa. The use of compounds extracted from plants and animals or synthesized de novo to titillate and seduce consumer palates has altered and adulterated the stuff sold in shops as food. There is evidence that much of this stuff often mass-produced by very large trans-national food conglomerates is causally related to the pandemics of non-communicable diseases, the treatment of which is providing the medical industrial complex with huge profits. A lucrative sham health food industry has also developed in reaction to “industrial” food.

vii civic morality, family and social solidarity

What we are, how we live, what we think, how we act are determined by the work that we do, by how we earn our keep. Today the capitalist mode of production dominates the value systems as well as family, social, and civic behaviour in those countries which it controls, and it undermines/d that of the rest. The effect is like a cultural hegemony, defined by Gramsci as quoted by Navarro[28] as:

> [a set-up] in which a certain way of living and thought is dominant, in which one concept of reality is diffused throughout society in all its institutional and private manifestations, informing with its spirit all taste, morality, customs, religious and political principles, and all social relations, particularly in their intellectual and moral connotations.

Family and community networks have been disrupted; social capital has been reduced. An aggressive, acquisitive, greedy, consumerist, materialist ethos has replaced traditional supportive and sharing social and personal practices. Societies are plagued by social anomie, alcohol and drug abuse and violence. People prostitute themselves in every way in order to survive or to live like the Jonesses and the advert models.

In the cities of the third world the squalor of squatter life and life on the streets is totally incompatible with a healthy family life. In the developed world things are not so good either especially in poor inner city areas. As Peter Townsend[30] wrote of the United States of America:

> [T]he US has by far the largest percentage of children in poverty among nine rich countries ... [T]he life expectancy of males in Harlem is now lower than of males in Bangladesh. Stereotyped references to this fact often include the homicide rate and high levels of drug addiction, but these are superficial and insufficient explanations.
>
> Homelessness is a far bigger problem in New York than in London or any other city in Europe. The gap between rich and poor is very wide and is growing remorselessly. ....
>
> According to a report issued by the Los Angeles district attorney there are 150,000 members of gangs in the city. About half the blacks in the population are said to be members. Gang killings average 25 a week, and other murders account for a similar number. ....

It's no use blaming the victims as authorities tend to do; the causes, one of which is undoubtedly poverty, lie in the system. He explained:

> In the inner cities poverty arises directly and indirectly from the world-wide restructuring of companies and jobs, depressing wages and eliminating jobs, and encouraging transient work by migrants. A substantial number of people become dependent on jobs and profits

> related to the international drugs trade ... This underground economy also creates their misery as much as internecine violence.

In the third world urban poverty and homelessness result in the same social diseases. Farmers who have been forced off their land or who can no longer support their families in the rural areas, swell the ranks of the urban poor. Rural families are broken up because the husband/father usually leaves without the family. Unless he joins a "homeboys" network he is stranded and alone in an alien urban environment. If his original family does not join him he may establish other liaisons and families. Where the rural family remains intact, social patterns are disrupted when food production is replaced by cash-crop production. Susan George's remarks on Kenya[29] probably apply throughout the developing world:

> Whereas African women have power over decisions relating to food and food crops, they have precious little say over the disposal of household money. This is the husband's province. Men may further appropriate their wives' labour in order to earn more cash (most of which they spend on beer). Women then have even less time for producing food, not to mention childcare duties.

She also quotes from a UNICEF report and comments on what happens when there is a reallocation of labour towards the production of cash crops.

- Cooking practices change. Quick, easy to prepare meals, usually of nutritionally poorer staples, are produced once a day or in bulk, and vitamins are destroyed by food simmering in the pot.

- Intra-family distribution of food is affected. Women have no time to prepare special infant foods and cannot supervise the distribution of food during the day. Children are asleep before the daily meal is eaten.

- House-cleaning ... tends to decline.

- Fuel and water collection is constrained by time.

- Care of children is relegated to other siblings or elderly grandparents.

> What's more ... when older brothers and sisters feed the little ones, the little ones get smaller portions. ... Studies ... show that growth and development may be deeply affected by who feeds the children.

Urban squatting (due to rapid and uncontrolled urbanisation, itself a consequence of rural dispossession and poverty), unemployment, population displacements as a result of natural and man-made disasters, internal conflicts, and war, migrant labour, disintegrated communities, disrupted personal, domestic, and community networks, poor housing, urban decay, violence, criminality, alcohol and other substance abuse, early sexual activity, teenage pregnancies, sexual promiscuity, prostitution, the commercial sex industry, and other forms of transactional sexual activity and risky sexual behaviour are causally interconnected and are important determinants of the current widespread and escalating epidemic of AIDS , other sexually transmitted diseases and much distress, disease, disability, and death besides. Unfortunately as Anthony Zwi[47] wrote of AIDS, but of general relevance:

> AIDS prevention campaigns ... rarely take account of the cultural, social, and economic constraints on less risky behaviour.

Kark recognised the destructive impact of migrant labour on family and social mores and the important relationship between a stable family life within an intact social group/community and syphilis, a serious and debilitating sexually transmitted disease from which in 1938/9 23% of Africans in South Africa suffered. The same now applies to HIV/AIDS. In 1949 Kark[48] wrote:

> Urbanisation in South Africa [and increasingly elsewhere in the developing world] has taken a particularly disturbing direction ... as it has developed mainly on the basis of migratory labour... [T]his has lead to instability and pathology in family relations.
>
> Prostitution and alcoholism are well-established immediate causes of syphilis ... [T]he temporary nature of the sojourn of [migrant labourers] in urban areas is not conducive to the development of a moral social code, which might influence behaviour as it would be in the case of a stable community.
>
> [The new urban code was transferred] to the rural areas ... producing great changes in Bantu social customs, breaking down a system of rigid moral standards, destroying the old concepts of right and wrong, cheapening relations between men and women and bringing with it syphilis.
>
> [A]ttempts to inculcate a reorientation towards a healthy sexual and family life cannot succeed in any but a few cases. The first line of treatment must be to remedy the unhealthy social relationships which

> have emerged as the inevitable result of masses of men leaving their homes every year.

The French government[49] is campaigning to keep films and television programmes out of GATT in order to prevent cultural swamping and Coca-Colonisation. There are similar concerns in other parts of the world about the potentially disastrous consequences for local culture and traditions from television programmes beamed from satellites controlled by international multimillionaire media moguls, and about the effects on local food preferences – and attendant disease risks – of the invasion by corporate purveyors of United States-style dietary practices and junk food.

And then there are the refugee camps …

viii education

There should be affordable and appropriate education to prepare the youth for healthy, responsible, and productive living. There should be programmes for adult literacy, skills training, and further education.

In today's world a formal education opens doors to social and economic advancement. But informal education, what we learn from our parents, grandparents, friends and relations, the media, the street, from life in general, makes us what we are. Francis Bacon[50] did not differentiate between formal and informal education. He is quoted by EP Thompson to have written:

> Since custom is the principal magistrate of man's life, let men, by all means endeavour to obtain good customs ... This we call education ...

Informal education rooted in people's history and personal experience should not be disregarded nor disparaged; it should be encouraged, supported and integrated into the development of the individual and of society. But there is a danger here. Societies and people who have been dispossessed, who are disturbed or damaged, who are frustrated, aggressive, and alienated may have lost their customs, their traditions, and their culture; in effect the informal education curriculum may have been lost, stolen or usurped by market forces and by the imperatives of the global economy, as Seabrook[51] wrote:

> An alien set of values is implanted into the lives of the people, precisely through their children; alien, not merely in the sense of foreign, but alien to humanity: a commerciogenic identity is formed. At first it was partly resisted, but with time it became more and more acceptable, until it has now become

> a major determination of the lives of the young, displacing all earlier forms of acculturation. This process of forgetting beyond reclamation is a form of colonialism far more effective than that which held so much of the west in thrall.
>
> There is something infinitely malleable, mobile, inventive about this nimble colonialism ... in the seductive guise of an iconography of luxury projected electronically across the world, its dispossessing core is dissimulated in the exotic paraphernalia of consumption and enjoyment.

Education should empower people, give them a sense of identity. It should be socially relevant as Julius Nyerere an educationalist as well as a statesman and socialist proposed. Hendrik Verwoerd when he introduced the so-called Bantu Education Bill in the South African House of Parliament with his infamous reference to fitting Blacks to be hewers of wood and carriers of water, argued similarly for relevance. He, like Bernard Mandeville centuries before him, wanted to use education to subjugate the underprivileged and the poor. Mandeville is quoted by EP Thompson[50] to have written:

> To make society happy and people easy under the meanest circumstances, it is requisite that great numbers of them should be ignorant as well as poor. Knowledge both enlarges and multiplies our desires. ... The welfare and felicity therefore of every state and kingdom require that the knowledge of the working poor should be confined within the verge of their occupations and never extended ... beyond what relates to their calling.

Theoretically people should have the right, the opportunity, and the freedom to decide what type of education they want for themselves and for their children. They unfortunately cannot always take decisions conducive to their personal and group advantage because they operate in a value-laden environment built and maintained by those in power. All of education has become what Thompson[50] called formal education, “an engine of cultural acceleration and estrangement". Illich[52] was more critical. He wrote:

> Many students, especially those who are poor, intuitively know what the schools do for them. They school them to confuse process with substance ... The pupil is thereby schooled to confuse teaching with learning, grade advancement with education, a diploma with competence, and fluency with the ability to say something new. His imagination is schooled to accept service in place of value. Medical treatment is mistaken for health care, social work for the improvement of community life, police protection for

> safety, military poise for national security, the rat race for productive work. Health, learning dignity, independence, and creative endeavour are defined as little more than the performance of the institutions which claim to serve these ends, and their improvement is made to depend on allocating more resources to the management of hospitals, schools, and other agencies in question.

And if you do get a matriculation certificate, or even a university degree, you may still be unable to get a job. All this formal education and effort – for whom/what? Perhaps teachers, the education industry/establishment, paper mills, monopoly capital, trans-national corporations benefit; ordinary people seem not to.

Female literacy and formal education are claimed to be very relevant to mother and child health. Much money has been spent/wasted on research to support the female literacy-health hypothesis. Female literacy may help to improve utilisation of, and response to, medical services by facilitating women's interaction with the medical establishment. A similar, or greater, effect could possibly be obtained if health professionals/workers were less arrogant, if they communicated sympathetically with their patients, understood their history and identified with or shared their culture. Education may be a marker of socioeconomic status, it may be associated with better job opportunities and it may be one of many ways to empower women and others to assert their rights; it is no more and often not even this.

Even with a perfect syllabus and with adequate and appropriate teachers, books and facilities (an impossible dream in South Africa?), education on its own can flop badly. Students need time to study, food in their stomachs, a place to sleep well, easy access to books and places of learning, a light to see by. When would a poor woman go to school or prepare her lessons? After work, after preparing food for the family and feeding the children, after cleaning the house, collecting water and fuel, and after satisfying her husband's "sex" needs? How can a child (girl or boy) learn on an empty stomach, after a poor night's sleep in an overcrowded shack or damp hut, with inadequate heating or ventilation, disturbed by buzzing, biting mosquitoes or other insects, drunken brawling or warring, gun-toting gangs, or ”third forces”, after attending to younger siblings, domestic chores or cattle in child-based households or rural homesteads, and after a long walk over steep, dusty, rocky paths?

Universal female (and male) literacy is only possible when socioeconomic conditions are good. Then it will probably be these conditions, and not the literacy, that will make the difference in health status. The emphasis placed on

female literacy as a tool to improve health is another diversion preventing people from understanding and acting on the root causes of their poor health.

ix political will and revolutionary change

The above measures are predicated on political will. According to the Conclusions of the Inter-Regional Seminar[18] China had achieved a successful transformation in health status due in no small part to political will and socioeconomic change. It was noted that:

> China has demonstrated a tremendous political commitment to the task of changing the quality of life of all its people. ... This political commitment permeates all levels of government and all social and mass organizations ensuring sustained popular support.

Specific legislation was promulgated and enforced in the UK in 1945 when the National Health Service was introduced and in Finland in 1972 when there was a move supported by community participation from the biomedical model to preventive medicine. In France pregnant women are paid by the state to attend antenatal clinics. In Japan which has the lowest infant mortality rate in the world (4.6 per 1000 live births in 1992) national law requires that all expectant mothers receive a handbook on maternal and child health published by the Ministry of Health and Welfare[53] as reported:

> As soon as a woman knows she's pregnant, she reports this to the local ... health authority, and they provide a local paediatrician and a copy of the ... handbook ... A compendium of health statistics and medical advice on pregnancy, delivery, and all aspects of child care, the handbook is also the child's medical and immunization record. ... Along with an extensive program of "new mother's classes" it has been the key to the success of the Japanese maternal and child health program.

In South Africa the recommendations of the Gluckman Commission on Health were accepted with two reservations. It is the second, "that the government would introduce the services ... in a series of measures, not as a single step", which concerns us here. Cedric de Beer's comments[46] on this demonstrates the negative effect of a lack of political will. He wrote:

> [I]n emphasising the need to move slowly, the government signalled that it was unwilling, or unable to engage in the massive mobilisation of resources necessary to implement the commission's plans. The state remained inert. The health tax was never introduced. The finances required to train sufficient

> medical personnel and to build enough health centres were never made available. There was no real attempt to implement the proposal that doctors should become state employees providing a special service to the whole population. ....
>
> The proposed National Health Service was stillborn. After 1948 (when the Nationalist party came to power) the few small attempts to implement some of the commission's proposals were hastened to their end.

Mervyn Susser[54] in his keynote address to the 7th Annual National Conference of NAMDA (National Medical and Dental Association) tentatively implied that popular mass action of a political nature was needed in addition to political will on the part of the state, when he said:

> The Cuban experience shows that [there should be] an intense population directed effort with a strong public health component. This effort must be directed not only at the community but together with it.

In his analysis of the British data Susser noted that there was a class-based lack of improvement in health equity in Britain following the introduction of a national health service (NHS). He said that:

> [I]n the face of a marked decline in mortality overall, the mortality gap between the classes had in fact widened.
>
> The British do not fare better and are in fact in some respects worse off when compared with Europe as a whole. The disadvantage in health status of the poor was not redressed by a free and effective medical service. Susser said:
>
> What the NHS did in terms of free services for all, then, was not enough in itself to alter the British health profile and to achieve equity in health states.

He concluded:

> [T]he key to the British inequities lies in public health and social change .... [E]quitable services alone is insufficient to bring about equity in health status; in the face of enduring social, economic, and educational disparities, more is required.

Susser reiterated this when he wrote[32] that:

> [O]ne cannot be sure from the Cuban example alone that revolutionary change is not required in addition.

Navarro[3] was more emphatic. He stressed people's lack of resource control

> [T]he major cause of death and disease in the poor parts of the world today in which the majority of the human race lives is not a scarcity of resources, nor the process of industrialization, nor even the much heralded population explosion, but, rather, a pattern of control over the resources of those countries in which the majority of the population has no control over their resources.

He positioned the achievement of equity within resource control[55].

> [I]t would be unhistorical to expect that changes towards equity can occur in the present distribution of resources within or outside the health sector, without changing the economic and cultural dependency and the control by the defined social classes of the mechanisms of control and distribution of those resources.

And both equity and resource control were dependent on changes in the social, economic, and political system. He wrote[13]:

> [T]he greatest potential for improving the health of our citizens is … primarily through changes in the patterns of control, structures, and behavior of our economic and political system.

These changes will not be easy to achieve. Monopoly capital will fight hard to protect its domination and the attendant advantages. As Aidoo wrote[56] with reference to rural Ghana:

> [T]he problem is that the achievement of this goal [to provide adequate and appropriate health care for all] as the Chinese experience shows, requires a revolutionary transformation of contemporary ... society, a transformation with probable unacceptable implications for both the political incumbents and westernised medical practitioners and social scientists.

x a non-medical multi-sectoral paradigm

Implicit in the foregoing is the realisation that only when the concerted, coordinated, cooperative, and integrated action of all sectors in society is directed at changing the socioeconomic reality (with or without a political revolution) will everybody be able to enjoy a good quality of life. If this is achieved the battle for equity in health status can be won. And from the perspective of medical services, fewer people would get ill and the need for medical services would be less, more affordable, and probably also more efficient.

Health professionals/workers however tend only to pay lip service to the role of socioeconomic, cultural, and political factors in health and disease. Almost invariably therefore whenever definitive programmes and interventions are planned only the medical model is proposed. However as James Grant, the Executive Director of UNICEF said[18] at the Inter-Regional Seminar:

> It is worth remembering that in China health is not simply a "sector" but an explicit goal to be achieved through all sectors.

But things may be changing. Since the official launch of the Healthy Cities project in 1986 its comprehensive, multi-sectoral, and community-centred approach has successfully promoted a reorientation in thinking and action on health. In a recent editorial in the South African Medical Journal Yasmin von Schrinding and Nicky Padayachee[57] suggested that the Healthy Cities concept should be applied in the cities in South Africa. The multi-sectoral approach found successful expression in rural China as stressed in the Conclusions[18] of the Inter-Regional Seminar:

> Separate independent organisations concerned with health alone should <u>not</u> be developed [their emphasis].

Practical recommendations[18] were made for the integration of local administrative sectors:

> The health [read medical services] team within each community should be administered by the local organization responsible for the management of the socioeconomic development of that community. In this way health work becomes part of development, contributing to it as well as benefiting from other development activities, particularly in the fields of housing, provision of safe water, food production and supply, and education.

xi preventive medicine and medical care – medical services

Accessible (without financial and geographic barriers), affordable, appropriate, effective, efficient, participatory, people-centred, equitable, comprehensive, internally integrated medical services organically fused into the life of people would/could help to achieve and maintain a high level of health.

The influence of the pharmaceutical industry and other components of the medical industrial complex with their penchant for directing medical services towards impersonal and technical interventions, iatrogenesis and new diagnoses for new drugs, should be guarded against.

xii the role of health professionals/workers

Health professionals/workers should not restrict their action to medical services but should act at all levels of social medicine. Lowry[12] quotes from a BMA book on deprivation and ill health that:

> Doctors are responsible for promoting health as well as treating illness, and doctors share with other disciplines a responsibility to suggest social policies which might prevent avoidable illness.

Schaefer[8] expressed similar sentiments:

> The key to a more relevant paradigm of health protection and promotion may lie in returning to a basic truth that oriented public health in earlier days: the recognition that the health of populations is not the sole territory of health workers but a major goal of human social organisation – governments, institutions, informal associations. …
>
> Once we acknowledge that health is everybody's business, it follows that public health's critical role goes beyond giving services and guiding individual behaviors. We [doctors] must be able to influence social choices that impinge on health at every level and in all relevant sectors. To become able we must reconsider our insights, our science, our political skills and our capacities for advocacy and leadership.

Health professionals/workers are technically trained to render particular services in health protection and promotion, in disease prevention, cure, control, and in rehabilitation and palliation (tender, loving care). Because of their training and experience they can also be expert consultants and resource persons and as

members of society and of their own specific communities, they should join in local health-related initiatives.

In the Conclusions of the Inter-Regional Seminar[18] a pro-active role was proposed for doctors in connection with national administrative policies that are relevant to social medicine, such as decentralisation:

> Where decentralisation policies in health care are not consistent with national administrative policies, the health sector should take a lead in encouraging governments to adopt decentralisation policies in the context of socioeconomic development, if necessary, by initiating the process in the health sector itself.

However doctors and other health professionals as well as non-professional health workers (counsellors, community health workers ...) usually have more power in policy formulation, decision-making and service delivery than the people they serve. They may also have a vested interest in preserving their own privileges and power and that of the dominant class into which many have been born or co-opted. Here-in lies a conflict of interest. As Navarro[13] wrote:

> [T]he opposition of the medical profession to Allende was not because Allende reduced the amount of technology available to it, but because, in encouraging the democratization of the health institutions, he was a threat to the perpetuation of its social class as well as professional privileges.

Where income, living conditions and standards, access to resources, traditions, culture, language, and pattern of disease are widely divergent as in South Africa, a centrally decreed, one-size fits all medical manpower structure would be inappropriate. Manpower should be trained and deployed according to local needs. As a WHO Study Group on health systems research reported[58] in connection with the private medical service sector obviously applies equally in the public sector:

> Every aspect of the physical and social environment has a bearing on the … health system. ... The general organization of health systems depends on the overall structure of the administration in a country, as well as on the dynamics of the private market for goods and services.

Coverage (number of health professionals/workers per population) should take precedence over technological considerations (academic qualifications, high-tech facilities, non-essential drugs and equipment, laboratory investigations, etc).

Low-tech coverage is safe and cost-effective when a proper referral system between all levels of care is in place, especially within a decentralised framework. This is no less relevant in affluent, well-endowed communities as in deprived ones. As reported[18] in the Conclusions of the Inter-Regional Seminar:

> Priority should be given to developing the health manpower required to provide health care to all people at all levels.
>
> Health manpower development must follow the same decentralization process as the health care system. This may require the sacrifice of national uniformity and rigid technical standards in the interests of improved coverage and local control.

And, always and everywhere arrangements should be made for continuing training programmes and opportunities to upgrade knowledge and skills.

Students in basic and post-basic courses and programmes should be exposed to issues in sociology, economics, history, and politics and should receive training in epidemiology and management, as pertained in the Institute of Family and Community Health in Durban directed by Sidney and Emily Kark more than thirty years ago. As Mervyn Susser wrote[59] in one of a series of articles celebrating Sidney and Emily Kark's contribution to social medicine:

> Multidisciplinary curricula built on the basis of epidemiology and the psychosocial sciences as well as on the substantial research programme (mostly operational), were designed and used to give a comprehensive education in all aspects of primary care and community health.

The Inter-Regional Seminar came to similar conclusions[18] with an added stress on training in management skills:

> The managerial aspects of health care should be emphasized from the outset of training and further developed throughout the whole process of continuing education.

The relationship between health professionals/workers and the community affects communication, trust, compliance with recommendations and prescriptions, and service efficiency and effectiveness. Measures to improve patient-carer interaction include the commitment of the health professionals/workers to the places where, and the people among whom, they work. Health professionals/workers should preferably live where or close to where they work. The Conclusions[18] of the Inter-Regional Seminar refer to this:

> Community health workers, neighbourhood and occupational health workers, and others engaged in health-related work in a community should be from that community ... and accountable to [that community].

In 1985 Cuba developed a family doctor programme with full administrative and academic support. These doctors live in the communities where they work.[60]

xiii referral systems within an integrated whole

Within a multi-level medical service the peripheral services should be supported and supervised by the centre and there should be an effective and integrated two-way referral system within a mutually-supportive strategy. As was pointed out in the Conclusions[18] of the Inter-Regional Seminar:

> The ... system requires the peripheral services to be actively supported by intermediate ones; the front-line hospital has a particularly important role to play in this regard. Support must include technical supervision and guidance, programmes for continuing training, and the provision of necessary supplies and equipment. Of paramount importance ... is the availability of a system of referral ensuring access to more highly trained staff capable of dealing with a progressively wider range of specialised health interventions that require more sophisticated technology than can be provided at the community level. Ease of access to the higher levels enhances the value to the community of the health care locally available.

The corollary to upward referral is also important: the higher levels should be supported by the peripheral services. Patients who do not require high-tech care at all, or anymore, should be referred to the periphery for continuing care. This arrangement allows highly trained professionals to use their skills and training effectively and to obtain personal job satisfaction and respect. It is a rational way to manage ubiquitously scarce personnel and other resources. But beware: this may threaten trans-national corporate profits as the peripheral services may be cheaper to run and are likely to generate less profit than the central services!

The different levels within the medical sector should be integrated at all stages of development and operation. In South Africa the high cost of current relatively more high-tech services, and political alienation from, and disillusion with, medical care in both the private and the public sector has prompted some policy makers to opt for primary health care as a solution almost as a stand-alone service. This would be wrong as the Inter-Regional Seminar[18] concluded:

> Primary health care should not be planned and implemented as a vertical programme in parallel with, and independent of, the rest of the health care system [their emphasis].

xiv surveillance

As Susser[80] indicated in his address to the NAMDA conference a national, equitable, comprehensive, universally accessible, integrated, efficient, and participatory medical service did not ensure an improved health status for everybody in Britain.

> [T]his joint effort has to be sensitive to the dynamic nature of health and disease through time. The antecedents of disease are shadowy enemies ... To overcome these enemies, or at least to contain them, requires the constant exercise of an epidemiological capacity to measure and monitor both the performance of health services and the state of health of the society. Beyond that the war against disease requires the ability to respond flexibly to what is learned from such constant surveillance.

A good surveillance system is not essential but very useful. China was successful by 1982 in significantly raising the health status of the rural population despite not having a good surveillance service.

A surveillance system requires a critical epidemiological methodology and is subsumed within a systems analysis methodology.

xv systems analysis methodology

This implies a continuous data driven approach consisting of:

1. status quo and needs analysis
2. priority setting and planning
3. implementation
4. process and outcome review
5. back to 1.

The data should be relevant, essential (as opposed to interesting or nice to have), accessible, easily retrievable, and timely. The information should be collected and analysed by the people who use it. Priority setting depends on needs (perceived and real), resources (available and required), on the chances of a successful outcome and on cost-benefit. Monitoring and evaluation, audit, and peer review are subsumed under item 4.

xvi grass-roots participation, decentralisation and power

All people as individuals and as members of communities, trade unions, neighbourhood associations, places of work, political organisations and parties, and youth, religious, self-help, cultural, and other groups should participate in action on health. People should be mobilised, empowered, and politicised by their action so as to maintain commitment and the momentum of change as stated in the Conclusions of the Inter-Regional Seminar[18].:

> Perhaps the most important factor in the development of the health care system has been the participation of the people in the provision of health services, in the management of the system, and in mass campaigns. The people have contributed to the integration and better coordination of health programmes and to inter-sectoral collaboration at all levels.

And in reference to the role of primary health care:

> Only through individual and community involvement in the planning, organisation, operation, financing and control of health care will primary health care become a "way of life" and will "health for all by the year 2000" be accepted as a goal for all sectors concerned with socioeconomic development.

Participation does not just happen because we want it to happen or because it is thought to be a good thing. Nor is participation just help with building some sort of medical station (as seems to pass for participation in many parts of this country). As reported in the Conclusions of the Inter-Regional Seminar:

> [T]he participation of the people is not simply the contribution of community resources to a health system managed by professionals; nor is primary health care a matter of providing for community health workers with inadequate training, isolated from the rest of the health care system, unsupported and unremunerated by the people they serve

Participation is associated with real power at a decentralised grass-roots level to be exercised through cooperation, mutual transparency, accountability, mandates, joint data collection and handling, and two-way reports. As stated in the Conclusions of the Inter-Regional Seminar:

> For people to be involved in the planning, organization, operation, financing and control of health care, they must have political and economic power.

> The process of decentralizing the health care system must accordingly be accompanied by a shift of power to the social periphery, leading to increased local control of resources.

Decentralisation focuses attention on local problems and local solutions. It enables local goal-directed financing and promotes equity. Decentralisation facilitates locally relevant surveillance and systems analysis and helps to ensure that service providers have a locus for support, training, accountability and where needed redress. As in the Conclusion to the Inter-Regional Seminar:

> So that the health care system can mobilise local resources and ensure that they are being used in a manner consistent with local problems and priorities, there is a need for effective decentralisation of political and economic power.

Medical services should be a local provision within the jurisdiction of a decentralised representative authority or unit. This authority should be elected by, and accountable to, a geographically-defined population. The authority could be a town or village. In metropolitan areas with large populations smaller units managed by suburban councils, supported by civic or rate payers' associations could be appropriate. In rural areas a district or a “chief's” domain may constitute a suitable unit. The units should share common features. They should be culturally cohesive and economically sustainable. It is not meaningful to put numerical boundaries onto such units.

Multi-sectoral integration and popular participation at the operational level are linked to meaningful decentralisation and changes in administration infrastructure. The decentralised administrative body should be responsible for all matters of local government. In this way all the issues subsumed within social well-being and public health would be managed by one authority and all the components of social medicine would be locally integrated. This pertained in China according to the Conclusions of the Inter-Regional Seminar.

> The reorganization of the country's economic and social structure, and in particular the high level of decentralization, has permitted the integration of the health sector with all aspects of economic and social development and has facilitated the people's involvement in the financing as well as the management of health care.

xvii government support

The central government authority should determine guidelines, principles, policies and standards for the whole country as summarised in the Conclusions of the Inter-Regional Seminar:

> Governments need to develop long-term strategies incorporating certain essential features:
>
> (a) a strong and unequivocal commitment to health care [read medical services] … by political leaders at every level;
>
> (b) as part of this commitment, full acceptance of the principle that health is an overriding social goal of all sectors and not simply the concern of the health sector;
>
> (c) acceptance by governments of responsibility for supporting industrial, social, political, and production-related organizations in the pursuit of this goal;
>
> (d) the development, where people's organizations are weak, of strategies that can be used by all sectors to strengthen existing organizations and facilitate the free self-development of new ones in association with the decentralization process.

The Inter-Regional Seminar recommended that a regional authority should facilitate coordination and cooperation within the health sector and between the health sector and other regional sectors as reported in the Conclusions:

> To provide support for primary health care, programmes under the responsibility of the health care system should be properly coordinated at the central level. Nearer the periphery coordination should turn into integration. At the community level all programmes should be integrated as part of the community's programme of socioeconomic development.

The regional authority should be involved in region-wide campaigns and through selective financing should encourage and support what may from time to time be considered to be national and regional priorities.

The Inter-Regional Seminar also recommended that the state should promote cost-containment. Motivation and reward for health promotive and disease preventive practices are part of the package. The report stated:

> [G]overnments, as part of their strategies for implementing [an effective health care system], should establish mechanisms to:
>
> (a) increase awareness ... of the true cost of health care;
>
> (b) encourage behavior leading to a reduction in unnecessary expenditure; and
>
> (c) reward communities that are able to achieve better health at lower cost.

xviii vertical mass medical interventions

In countries such as China and Cuba and also in some developing countries like Costa Rica and Sri Lanka where comprehensive socialist reconstruction programmes were not implemented but where decentralised primary medical services were combined with separate, vertical public health campaigns targeted to specific outcomes significant improvement in health status occurred. Mass vertical campaigns in other settings were often less successful, difficult to organise and more costly. Their comparative value and cost-effectiveness is however not established.

xix mobilising popular support

Successful programmes raising the level of health of populations highlight the importance of socioeconomic and political mobilisation and the role of pressure groups, associations, clubs, and other organisations. In China the communist party, other civil structures and community organisations, including inter alia women and youth, contributed significantly to achieving and protecting advances in social reconstruction and health. According to the Conclusions of the Inter-Regional Seminar:

> Under the leadership and guidance of local, social, political, and production-related organizations following delegation of effective political and economic power the contribution of the people to health could take many forms, involving different members of the community in different situations, for example:
>
> (a) taking part in development activities aimed at improving the quality and standard of life through more adequate food, better housing, cleaner water, improved sanitation, etc.;

(b) complementing the human resources of the health system by providing basic preventive and curative services;

(c) undertaking group action to mobilize the community for mass campaigns leading to better conditions, protection and awareness.

In Cuba there were the Committees for the Defence of the Revolution. In Allende's Chile there were similar bodies, as Navarro[61] wrote:

> Industrial Strife Committees were established to coordinate the management of all factories located within a vicinity or community and to set up committees within each factory in charge of production, distribution, defence and mobilization. Also, these committees stimulated the creation at the community level of the Neighbourhood Commands, broadly based community committees in charge of the coordination of the community social services, including health, and the mobilization of the population.
>
> Another example of community participation was the Councils for Distribution of Food and Price Controls, neighbourhood committees created by communities to avoid speculation and oversee the distribution of popular items to consumers.

xx funding

It really does not matter who funds medical services – where the money comes from. Funds can be allocated by the central, regional and/or local authority or obtained from targeted taxes, rates, and fees, the sale of medical services, donations or loans from any source, insurance or investment funds, or from customised economic enterprises preferably health-related.

What is critically important, however, is how the money is used and how its use is controlled. There should not be a separately funded hierarchical sector responsible only for preventive medicine, medical care, research or surveillance. The money should be channelled through a representative and accountable local authority. This would ensure that funding is goal-directed and meets local needs. There should be no historical funding. All the components of social medicine including, by definition, all public sectors should be funded from a single integrated budget. Not only will what is done in other sectors affect what happens in the medical sector, but the other way round will also apply as concluded at the Inter-Regional Seminar:

> The method used to finance health care can be an important instrument of policy by facilitating the objectives of decentralisation, involvement of the people, and self-reliance within a health care system. It affects:
>
> (a) the distribution of resources;
>
> (b) the social acceptability and economic efficiency of the services offered;
>
> (c) the ease of administering services;
>
> (d) the capacity of the health care system to finance its growth.

Policy and decision-making are predicated on power. Power flows through financial control, accountability, and performance monitoring at every level. Decentralisation facilitates these processes. Local control should be guaranteed by statute and effectively supported by government, as noted in the Conclusions:

> [Decentralisation] has to be initiated by national policies, supported by the necessary legislation or equivalent instruments and implemented by strategies that:
>
> (a) ensure that resources generated locally are used to build up and maintain, to the maximum degree possible, local health services
>
> (b) allocate government resources to subsidise local health services when the communities concerned lack sufficient resources, thus putting social solidarity into practice by overcoming gross regional and local disparities.

All people should have equal access without financial or other restrictions to every component of social medicine that society can afford bearing in mind that "financial burdens on a poor man's resources are a social crime".

A predominantly publicly funded first contact medical service programme under local control is envisaged. Private first contact practice is not precluded but could in time be phased out. Secondary and tertiary care which includes all specialist services and in-patient care could be structured and financed through non-profit quasi-autonomous non-governmental organisations (QANGOs). These QANGOs would be licensed, supervised and subsidised where necessary by regional government. Access to secondary and tertiary care could be bought by the peripheral units on behalf of their constituents or by private individuals for themselves.

Academic institutions for health professional/worker training should fall within the financial jurisdiction of regional government, while the setting and supervision of practice standards and financial control should reside in the central government. Central government should also finance and supervise the licensing and control of medicines and medical equipment.

xxi the role of development and aid agencies

Development and ostensibly philanthropic agencies such as the United States Agency for International Development (USAID) and the Rockefeller Foundation have agendas more in keeping with the interests of trans-national corporations than with those of the recipients of their largesse. The testimony[62] of the Deputy Administrator of the USAID in 1964 from an official United States of America government document, entitled "Winning the Cold War: The US Ideological Offensive" kind-of lets the cat out the bag:

> Our basic broadest goal is a long range political one. It is not development for the sake of sheer development. ... An important objective is to open up the maximum opportunity for domestic private initiative and to ensure that foreign private investment, particularly from the US, is welcomed and well treated. ... The AID program planning process recognizes that the program is an instrument of US foreign policy.

The same applies in the UK and in other donor countries. They can also act as a fifth column. So beware of international do-gooder agencies. Also watch the so-called social responsibility programmes of local and multinational corporations. Where do they get their money from? Whom do they represent? What's in it for them? Who is likely to benefit? As Michael Taussig[5] wrote:

> [T]he health sciences can be recruited for these political goals in a large number of complicated and interacting ways. The basic allure of health care ... is that it might take the political edge off some of the outstanding social problems that the system as a whole produces, without necessitating deep changes to the system itself – changes such as occurred in China or Cuba. Also, medicine is a specially privileged tool in that its humanitarian image allows for the penetration of forces that might otherwise be unacceptable.

Donors seem averse to funding service in South Africa now. Many, if not most, loans and grants preferably go to new programmes and research. While funders pay impressive lip-service to responding to the needs of the recipients, they nevertheless usually set up only the programmes that they want. The recipients are then often expected to maintain these programmes at their own expense and

often in conflict with their own needs. But because funding applications are usually made, especially by the medical establishment, with the donor's known interests in mind, research is in effect donor-driven and hence readily financed.

Increasingly medicines are being tested in poor countries before applying for their registration by control bodies like the MCC (Medicines Control Council) in South Africa and the FDA (Food and Drug Administration) in the USA. The pharmaceutical firms, most of whom are among the largest and most powerful multinationals in the world, benefit from testing new drugs among the poor because it is cheaper and there are fewer restrictions and controls.

Pharmaceutical firms also sponsor clinical research, but almost all of it relates to their own products. Money is seldom given for endeavours unrelated to profit. The published results advertise their products. The reputations and careers of the researchers are advanced and their opportunities for funded travel, ostensibly to conferences/jamborees to report on their research, are increased. Grants for research and for organising and attending conferences are tax-rebated to the benefit of both the donor and the recipient. The medical establishment is coopted and possibly also corrupted. The ordinary tax payer in effect funds the medical industrial complex. The free use/abuse of local state facilities for this so-called research has only recently been restricted.

Currently sponsored research directed at documenting the status quo in health status is popular and lavishly funded. The information is supposed to be used to assist in framing national health policy.[63] I am not against this type of research, but we must get our priorities right. There are many questions being asked to which the answers are blatantly obvious. Ask almost anybody anywhere in this country – health professionals/workers or lay persons – what the commonest diseases and their causes are and they will give you a fairly accurate answer. The published findings have usually confirmed what was known all along. The usual conclusion of this research is self-serving; “more data are needed” or something similar. Perhaps the state security apparatus appreciates the gratuitous detailed data base. It is of little benefit to the people and the planners.

The local interest in HIV/AIDS education is a particularly suspect area. The only benefactors of the vast amount of money spent on this seem to be the paper, rubber and advertising industries, and the new breed of AIDS researchers. Population-control among blacks might have been part of the hoped-for spin-off from the programme: if AIDS does not kill them, condom use will cut down on their breeding! But since 1994 the leit-motive is different. The real challenge of HIV/AIDS, the elimination of poverty and its associated homelessness, family disruption, inhumanity, and alienation, is ignored. Thabo Mbeki when president

of South Africa was vilified when he argued for a social cause of the epidemic. Unfortunately he positioned his case as an emotional and irrational rejection of the viral hypothesis and autocratically prevented access to drug treatment.

Support for medical education, another area favoured by donors, is also fraught with hidden agendas. Peter Donaldson[64] studied the role of the Rockefeller Foundation in Thailand and wrote:

> Two social structural conditions seem to explain the role of foreign agencies in the evolution of the professions in the developing world, and in particular the international diffusion of Western professional role models. These conditions are:
>
> (a) values shared between the foreigners who intervene and the ruling class of the developing country in which they intervene, and
>
> (b) the competitive advantage foreigners have in the marketing of professional models ....
>
> [T]he usual situation is one in which foreign agencies and their personnel apply considerable pressure on Third World countries to develop and maintain professionals patterned after Western Models.

According to Joshua Horn as quoted by Michael Taussig[5] the Rockefeller Foundation's motives at the Peking Union Medical College in pre-revolutionary China were similar. He wrote:

> On the surface, it seemed to many, including Chinese students and staff members, to be a purely philanthropic undertaking. In fact, it trained a generation of willing henchmen who helped America dominate China ... Responsible American officials themselves admitted that this type of penetration was cheaper and more effective than other forms.

The history of medical education in South Africa confirms the Thai experience. Initially we imported the British model and then the industrialised cities exported this model to the poor rural hinterland. Nowhere and never was the model relevant. It is still with us today, as inappropriate as ever. But doctors, nurses and other medical service personnel educated at great expense in South Africa can be and are readily poached by the developed world saving themselves the cost of training. South African professionals are highly regarded in the developed Anglo-Saxon world whose curriculum we follow. Poaching also happens to trained health professionals in other developing countries

The in-roads into multinational profits from costly high-tech medical services have precipitated some re-thinking. Ironically medical care among the employed and in emergencies among the uninsured and the low-paid is subsidised in the United States of America by the multinationals themselves. This helps to explain Kellogg's (a food multinational) current interest in supporting local research into cheap, nurse-based medical services. Parallel research is taking place in the deprived rural areas in the United States and in Mexico. Peter Donaldson's conclusion[65] applies here and now too. He wrote:

> The Rockefeller Foundation's experience ... is typical of what happens in most large scale assistance programs involving substantial foreign intervention in professional development. The shortcoming of these programs is not that they create inequality associated with professional services throughout the developing world but that they so neatly serve those who maintain ... [the programs].

Summary

Not only should the imbalances and mal-distributions of power and opportunity be corrected by social, economic, and political transformations, but people should also have sufficient power to safeguard their achievements and their health against inroads from trans-national corporations and their proxies while implementing appropriate medical service programmes.

This is unfortunately only a dream; it is not attainable. It is nevertheless hoped that awareness and understanding of the interacting factors critical to health may motivate people to make changes in the determining factors and their over-arching power structures. And, if by revolution, may their idealism-inspired achievements not be sold out – if, that is, society survives the upheaval!

Postscript 2011

This chapter was written in the late 1990s. Minor punctuation and lay-out changes were made now.

The argument holds. The determinants of health and disease have become starker, health status has deteriorated further, medical services are increasingly ineffective, and the contradictions have intensified.

The role-back malaria insecticide-treated bed-net debacle that resulted in mosquito insecticide-resistance and increased malaria incidence in immune-reduced older children and adults[65, 66] is a good example of a programme that benefits the bed-net and insecticide industry and not health. Malaria can be and has been eliminated by vector control with netted (without insecticide) homes (not make-shift temporary shelters) and vector breeding site elimination, personal protection by covering clothing and the use of insect-repellent skin applications (including traditional, indigenous, plant-based substances), and effective case management (by low-level workers or community members if necessary). Such a programme needs political will, peace or at least the absence of war, and people empowerment. It does not need top-down insecticide-treated nets or indoor residual spraying with resultant vector resistance and changed biting pattern (from in-door to out-door), celebrity and charity-funded, locally unaffordable, difficult to use bed-nets, genetically modified sterile male mosquitoes, nor parasite resistance to effective drugs (chloroquine and now also artemisinin) from their prophylactic use in low doses by the tourist trade.

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