

Changing International Health Policy and Changing International Development Goals

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The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

- WHO Constitution

Introduction

The World Health Organisation (WHO) was founded in 1948 with a remit to promote public health around the world. The WHO's constitution sets out its objective as 'the attainment by all peoples of the highest possible level of health' (WHO, 1948). How does the WHO define health? The WHO defines health in wide terms as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1948).

The paper raises broad questions over the aspirations and practice of international health policy in its international political and development context. The paper explores how international health policy has been informed by evolving international development strategies, from the earlier modernisation approaches to the sustainable development approaches of recent decades. The final part considers international health policy today in a world of continuing international inequalities.

International health policy and modernisation strategies

International health policy in the first two decades after the Second World War was ambitious and linked to the national development of the newly independent states. International support for ambitious health goals reflected Cold War rivalry between the Western and Soviet blocs for political influence in the Third World. Developing countries enjoyed a high degree of legitimacy internationally following successful anti-colonial struggles. The aspirations of developing countries were represented in the Non-Aligned Movement whose voice internationally belied the relative weakness of its members. The elevated status of developing countries within the UN organisations in this period was important for setting the high ambitions of international development and international health. Western policy-makers supported Western models of modernisation, hoping that the convergence of living standards through industrial development would lead to the convergence of cultural and political values. Western policy-makers hoped too that the adoption of modern urban life styles and the nuclear family would reduce population growth in developing countries. Population growth was a major Western preoccupation, informed by

security concerns, which equated demography with national power (Furedi, 1997). Accordingly much Western international health funding related to family planning programmes (Sorkin, 1976, p. 120).

International health policy in this Cold War political climate was planned on the assumption that non-Western states would be industrialised and reach the same levels of development as Western industrialised states. The WHO's Constitution reflects these ambitions stating that, 'Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger' (WHO Constitution, 1948). The goals of international health policy were nothing less than the eradication of disease and the establishment of modern medicine and modern hospitals with medically trained staff. The motto of international health policy in this period may be summed up as: eradicate and cure.

Eradicate and cure

The Malaria Eradication Programme (MEP), a central plank of the WHO's approach in the 1950s and 1960s, symbolised the high ambitions of international health policy in the first two decades of international development. The high ambitions were informed by great optimism in science and possibilities of modern medicine. They also involved expectations of equality between countries including expectations that populations in developing countries should enjoy the levels of physical health and absence of disease experienced by populations in developed countries. The MEP gained some early successes in rolling back the spread of malaria, essentially through the use of pesticides to control malaria-carrying mosquitoes, but began to experience difficulties as resistance developed to the pesticides used, including DDT.

If MEP was ultimately unsuccessful, the eradication of smallpox represented an unprecedented international effort to eradicate disease. Eradicating smallpox was technically easier because it was transmitted by human to human contact and was not an insect-borne disease. In turn since the interventions required were simpler and effective, countries were enthused at all levels of society to implement the smallpox eradication programme by the speed of results witnessed in the countries initially targeted.

Rising health expectations and development

Health was not simply seen as important in its own right, but as important in promoting development. First disease eradication was seen as vital to promote a healthier workforce when many workers, or potential workers, were debilitated by malaria and other diseases. Second disease eradication was seen as important in facilitating development programmes by freeing up land plagued by malaria, sleeping sickness, river blindness and other diseases for cultivation and development. Third health improvements were seen as promoting new values among populations conducive to development. Repeatedly the international health literature made a link between raising health expectations and raising the horizon of expectations among populations more broadly. Fatalism and risk aversion were seen as major cultural obstacles to development, which health improvements could tackle. From this perspective, health programmes helped foster entrepreneurialism. The economist Wilfred Malenbaum observed that:

Health inputs in physical facilities have a high demonstration effect on the power of man to influence his own destiny. For the bulk of the poor, and especially the poor peasant, the happenings of life tend to be accepted as pre-ordered, however harsh their influence. Health programs may serve to challenge the inevitability of this sequence. Since the consequences of new health facilities are highly visible, the peasant's own decisions on other measures, and especially on his everyday work activities, may begin to alter the formerly pre-ordered prospects (Malenbaum in Sorkin, 1976, p. 49).

Health programmes required acceptance by communities to work. A major concern of international policy-makers was how to encourage people to follow health programmes. Cultural anthropologists like Margaret Mead were consulted by the WHO. Mead quotes one 1950s' health education initiative, which asked how:

How can you influence people living in rural areas to get water from safe sources? How can you overcome the resistance of people to modern medicines? How can we educate the public that sanitary hygiene plays a big part in the prevention of leprosy and other contagious diseases? How can we influence people to change their present unsatisfactory village sites to more healthy ones? (in Mead, 1966, p. 86).

Public compliance with health education lessons could not be treated in isolation from their general expectations. Health messages succeeded where people had raised expectations about their lives. Mead cites Egyptian researchers who observed:

in many rural areas people lived in an environment offering many hazards and few resources. In their present struggle for existence their greatest need was to be able to look forward to a better level of living. An appeal to them to change their food and health habits generally fell on deaf ears, because they were so well aware of their own insecurities and so used to them that they had in the past made all the adjustments that seemed possible. Hence they appeared uncertain and sceptical about new proposals to alter their way of living. Yet suggestions about new uses of their existing resources, and particularly evidence of some small successes, might make them aware of the possibility of escape from the ceaseless effort to achieve a bare existence (Mead, 1966, p. 89).

Initially there were concerns that people would need to be encouraged to use modern medicine, but these concerns were soon superseded by concerns over the over-use of modern hospitals and medicine. Mead's own study is ambivalent about the benefits of modernisation for well-being, as will be discussed below. From the late 1960s the ambitions of international health policy began to be tempered.

Retreat from eradicate and cure

The lessons for international health policy became the failures of malaria eradication, not the successful eradication of smallpox. Certainly malaria eradication presented more difficulties than smallpox eradication and the MEP had run into serious problems over pesticide resistance. However the MEP was not simply abandoned

because of technical difficulties, but the withdrawal of political and financial support from major donor states, notably the United States. The withdrawal of support was related to international political and domestic cultural concerns. Not least the value the MEP placed on DDT and other pesticides to control malaria fell foul of the nascent environmental thinking in the West, encapsulated in Rachel Carson's *Silent Spring*. Carson blamed her own cancer on chemical pesticides and her passionate attack against DDT and other chemical pesticides poisoning the planet gained a wide hearing in Western countries.

More broadly the ideas behind the MEP were out of step with the changing international development strategies which were moving away from modernisation towards sustainable development. The shift was led by fears that modernisation strategies were fostering social and political problems. Dudley Seers, director of the influential Institute of Development Studies, University of Sussex, alerted in the late 1960s that 'it looks as if economic growth not merely may fail to solve social and political difficulties; certain types of growth can actually cause them' (Seers, 1979, p. 9). Uneven development and sharp inequalities within developing countries questioned modernisation strategies. Fears over existing strategies were brought home to Western officials by the experience of political assassinations and civil riots domestically, and the Vietnam War and the 1973 Oil Crisis internationally, which rekindled Malthusian fears over resources and suggested that developing countries could hold Western states to ransom over raw materials. Meanwhile Third World nationalism was on the wane and developing countries exercised waning influence on international development strategies including international health policy.

The sustainable development model was codified from the 1970s and 1980s in documents such as the Brandt report *North-South: A Programme for Survival* (1980). Sustainable development policy-makers challenged the idea that 'the whole world should copy the models of highly industrialized countries' (Brandt, 1980, p. 24). Industrial development as the goal of international development was replaced by basic needs policies pioneered by bodies such as the International Labour Organization (ILO, 1969, 1976; Seers, 1979). Investment in low or medium technology, not industrialisation, and more small-scale rural development projects was considered appropriate for developing countries (Schumacher, 1973). The policy implied continued reliance on self-generated income activities and subsistence farming for the vast majority of developing countries' populations.

The changing international development strategies revised international health policy goals from the ambitious disease eradication and cure model to a more modest disease management and prevention model and from modern high-tech medical care to basic health needs. The shift in goals also revised expectations of international equality of health and health provision between people in developing world and developed world, as health services were expected to orientate themselves around basic needs provision. A primary health care approach, discussed below, was adopted in an international climate more pessimistic about the possibilities and efficacy of progress.

From urban medicine to rural health

Modernisation policies with their emphasis on modern hospitals and medicines encouraged an urban bias in health service spending concentrated on the larger cities.

As a consequence, the provision of health care was spread unevenly with more spent on urban areas than rural areas. This urban bias was noted, but was not necessarily condemned. Indeed prioritising provision for urban professionals and industrial workers was deemed an acceptable transitional measure under modernisation approaches as part of fostering a stable nation state and an amenable industrial workforce whose activities were furthering national development for the long-term benefit of the whole population. However the state national health spending on high-tech hospitals and treatments, which only a tiny percentage of the population had any prospect of accessing, became increasingly criticised as inequitable and wasteful as modernisation approaches themselves were attacked. A 1967 Tanzanian social and policy document, recognising the inequities of the existing health approach, declared:

We must not forget that people who live in towns can possibly become exploiters of those who live in rural areas. All our big hospitals are in towns and they benefit only a small section of the people of Tanzania; it is the overseas sale of the peasants' produce which provides the foreign exchange of payment. Those who do not get the benefit of the hospitals thus carry the major responsibility for paying them (Arusha Declaration 1967 quoted in Chagula and Tarimo, 1975, p. 151).

Modern urban hospitals took a large proportion of national health budgets, while public health concerns were not adequately addressed with the over-stretched infrastructure of many cities in developing countries. Housing, sanitation and public services were not keeping pace with the growth of cities with serious health consequences.

Criticism of the urban bias grew in Western official circles along with criticisms of modernisation strategies. Modernisation strategies hoped urbanisation would lead to urbanism, understood as civic norms of behaviour and values. Instead urban expansion was becoming associated with social problems, epitomised by the vast squatter settlements developing around cities. On the health side, there was alarm that industrial development was not necessarily improving the health of populations, but was spreading disease and creating new socially-related health problems. Reports on health in developing countries repeatedly warned against the effects of rapid urbanisation. Urban areas were associated with improved mortality rates, but they were also linked to socially-related health problems such as alcoholism, which posed broader concerns for societies. The negative consequences of urbanisation for health have been a recurring theme of last four decades and have been central to sustainable development thinking. In this vein, a collection of essays under the title *Health and Development* published a decade ago cautions that, 'urbanization does not automatically equate with better health but it may equate with different health and health problems' (Phillips and Verhasselt, 1994, p. 10).

These social concerns lead back to the WHO's broad definition of health encompassing social well-being and people's capacity to adapt to change. If health is understood as social well-being, then urban social alienation and political unrest have suggested in official development thinking the need to shift away from urbanisation policies.

A negative view of industrialisation and urbanisation is a central theme in the sustainable development literature. The antecedents to sustainable development thinking may be traced back to the Romantic reaction against industrialisation, colonial development policies and anthropological research notably that of the Culture and Personality School. Many anthropologists were preoccupied with the destabilising effects of modernisation on the communities they were observing. Mead's international health study suggested that societies based on tradition were more harmonious and stable:

people live in accordance with century old-custom, and are emotionally balanced and free from nervous tension because their way of living is closely adapted to the surrounding conditions, into which they were born and in which they will remain all their lives (Mead, 1966, p. 4).

Mead's study also suggested the resilience of small-scale traditional rural societies and people's ability to secure their basic needs for food, shelter and health and to adapt to their harsh circumstances (Mead, 1966, p. 4).

The negative perceptions of urbanization led to attacks on the urban bias of international development and preference for rural development to help maintain rural communities and discourage the flight of rural populations to the cities. Sustainable development policies have sought to stabilise communities and promote local solutions, rather than raise people's expectations and encourage social mobility. If sustainable development legitimises different expectations for developing countries than industrialised countries, it does so from a culturally relative perspective, which challenges the earlier development assumptions that developing countries should aspire to become like the advanced industrial societies.

How did the shift from modernisation to sustainable development influence the goals of international health policy? The next section looks at the primary health care movement.

Primary health care movement

International health policy became centred round the primary health movement whose ideas were inspired by the evolving sustainable development thinking. Ken Newell, Director of the Division for Strengthening of Health Services at the WHO headquarters from 1971 to 1977, was a key figure. Newell's report *Health by the People* (1975) together with the earlier WHO/UNICEF *Study of Alternative Approaches to Meeting Basic Health Needs of Populations in Developing Countries* (1974) set out the new direction of international health policy. A holistic view of development is reflected in Newell's holistic view of health to include sustaining communities and communal feelings:

The wider issues presented include: productivity and sufficient resources to enable people to eat and be educated; a sense of community responsibility and involvement; a functioning community organization; self-sufficiency in all important matters and a reliance on outside resources only for emergencies; an understanding of the uniqueness of each community couples with the individual and group pride and dignity associated with it; and lastly, the

feeling that people have of a true unity between their land, their work, and their household (Newell, 1975, p. 192).

The WHO formally adopted the primary health care approach in 1975. This was followed up by an International Conference on Primary Health Care sponsored by the WHO and UNICEF in 1978. The new international health policy wanted countries to move away from expensive high-tech urban hospital-based curative interventions. Instead of concentrating health services in urban areas, the primary health approach wanted to bring services to people in rural areas. The primary health care movement was influenced by China's use of so-called barefoot doctors, non-professional health staff, who promoted simple health methods in communities through the workplace and other spaces. Newell described the primary health philosophy as being about more than the delivery of cheap services and aspiring to move from top-down development and promote grassroots community development giving ordinary people more of a role. Newell summarised its ideals thus:

health services were not purely a way of delivering health care interventions to people but were something important to individuals and groups in their own right. Key changes of this idea called primary health care were linked to qualities such as power, ownership, equity and dignity (Newell, 1988).

The primary health care movement's emphasis on local solutions encouraged the role of non-governmental organisations (NGOs) in community health. Major Western relief organisations such as Oxfam re-orientated their activities from Europe to developing countries in the postwar period and incorporated development work into their activities. Their needs-based and people-focused relief work has lent itself to sustainable development thinking and they have been well-placed vehicles to carry forward sustainable development ideas. Many NGO staff, like their anthropological predecessors, have partly been inspired to work in the developing world because of their doubts over the character of Western industrial societies.

The NGO development philosophy has defined itself against industrial development and embodied local small-scale, technologically simple, community-based development. Their sustainable development philosophy is exemplified in NGO health programmes such as high profile campaigns against baby-milk formula in favour of breast feeding impassioned by concerns over commercial exploitation by foreign companies. At the same time, public health in NGO development thinking has become attached to environmental concerns where populations in developing countries are constructed as part of nature and protecting their well-being equated with protecting nature. So whereas reference in the older international public health literature to the environment referred to matters such as large-scale public works to improve the infrastructure of cities or clean air legislation, the present reference to the environment is bound up with environmentalist concerns. NGOs, for example, have typically promoted village wells projects and opposed large dam building projects. The links between international health policy and environmental thinking is important in international organisations too, for example, the WHO's Commission on Health and Environment and its report *Our Planet, Our Health* (WHO, 1992).

Promotion of traditional medicine

The primary health care movement also took a new interest in traditional medicine along with its holistic health approach seeking to respect communities. The changed international health policy involved a shift in the cultural norms considered desirable to foster. If earlier modernisation and health strategies were associated with promoting ambitious risk-takers seeking to master nature, the new ideal was associated with enhancing respect for existing cultural identities and harmony with nature. The new interest in traditional medicine reversed the position of earlier international health policy, which saw itself as championing modern scientific medicine against older irrational prejudices, linked to development strategies raising people's horizons beyond their communities.

The 1978 Conference on Primary Health Care and a number of WHO reports including *The Promotion and Development of Traditional Medicine* of the same year endorsed incorporating traditional medicine. The endorsement of traditional medicine was immediately facilitated by the attention given to China's system of primary health and how Chinese health policy integrated both modern and tradition medicine. Receptivity to traditional medicine was encouraged by the inadequate coverage of modern health care services, and further by the revival of interest in traditional medicine among the middle classes in the West and India (Leslie, 1976). The celebration of traditional medicine's integration into primary health care may have romanticised the effective abandonment of universal modern medical health care, but its endorsement was genuine in that it reflected cultural disenchantment with modernity within developed countries and interest in non-industrial cultures as more authentic, ethical ways of life. Traditional medicine compliments notions of sustainable development, appropriate technology and holism. Sustainable development writing characteristically affirms traditional medicine and rejects the idea that traditional medicine is inferior to modern scientifically-based medicine. Traditional medicine is generally treated as unproblematic, although occasional concern is voiced that it may impact negatively on the uptake of immunisation programmes.

The next two sections consider radical thinking on international development and health and their contributions to the evolving international health strategies. The first section considers underdevelopment critiques of modernisation and health inequalities. The second section considers counter-culture critiques of modernisation and modern medicine.

Underdevelopment theories and health inequalities

Underdevelopment and dependency theories were the dominant critiques of modernisation in development studies. These influential theories inspired by Marxist and anti-colonial ideas, targeted capitalism and imperialism, rather than industrialisation itself, as perpetuating international inequalities. An underdevelopment theory approach to international health problems is encapsulated in an edited collection of essays entitled *Imperialism, Health and Medicine* (Navarro, 1982). The editor Vicente Navarro explains the underdevelopment theory understanding of international health problems:

the 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, not 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 (Navarro, 1982, p. 7).

In summary, his analysis blamed ‘the underdevelopment of health’ on ‘the sickness of imperialism’ (Navarro, 1982, p. 9). Underdevelopment and dependency theories proposed alternative autonomous development models for developing countries outside the world economy dominated by Western states, and were interested in the paths of countries such as Cuba or Chile under Salvador Allende. The desire to break the dependency of developing countries led underdevelopment critiques to merge with anti-industrialisation critiques. Industrialisation strategies in developing countries were criticised for being reliant on foreign investment and their industrial sectors being subject to foreign domination, ownership and exploitation. Consequently non-industrial economic activities came to be stressed as less dependent. Underdevelopment health thinking sought to break the dependence of developing countries on foreign medical technology and drugs. Underdevelopment thinkers held up Chile’s attempt under Allende to move away from national health policies relying on imports of expensive foreign drugs and hospital equipment as exemplary.

Underdevelopment theories were already becoming superseded by anti-industrialisation critiques by the time that the *Imperialism, Health and Medicine* collection of essays was published. The next section discusses the rise of radical anti-industrialisation critiques.

Counter-culture critiques of modern medicine

Official international development thinking became critical of industrialisation as a goal for developing countries and its associated health strategies. Radical international development thinking also adopted anti-industrialisation ideas, although coming from different concerns. Earlier Marxist-inspired accounts had assumed that the industrial proletariat was the agent of social revolution. However doubts had grown over the political potential of industrial workers following the failures of radical political movements in the late 1960s to bring about fundamental social changes. Counter-culture works such as Herbert Marcuse’s *One Dimensional Man* or Paulo Freire’s *The Pedagogy of the Oppressed* suggested that the hope of radical politics lay with those outside industrial production. A new interest was taken in the role of peasants, particularly following the Vietnamese defeat of the United States in the Vietnam War. Counter-culture ideas mingled with environmental concerns over population growth, resources and the impact of industrialised societies on the planet.

Counter-culture ideas influenced radical thinking on international health. Ivan Illich’s works such as *Limits to Medicine, Medical Nemesis* (1976) applied anti-modernisation ideas to the health field. Illich, a Catholic priest who lived in Latin America, argued that industrial development was creating frustration, not well-being, and the expansion of wage labour which accompanied industrialisation was undermining autonomy and altruistic relationships (Illich, 1976, pp. 215-216). Illich proposed an alternative spiritual view of development and underdevelopment as a

state of mind and suggested that domestic or community modes of production as opposed to the wage labour of industrialisation was conducive to altruistic relationships, of relevance to the care of the sick. His work attacked limited health budgets being spent on technologically advanced hospitals and medicines, whose costs were exacerbated by the fact that developing countries had to rely on imports of technology and drugs. He observed that expensive medical training did not necessarily benefit developing countries because trained medical staff could emigrate and find better paid work in developed countries (Illich, 1976, p. 56).

Such criticisms echoed criticisms voiced elsewhere. However Illich's attacks on modernisation and modern medicine were more fundamental. Illich's *Limits to Medicine* proposed that many modern diseases were socially, culturally and professionally constructed, in short, 'man-made' (Illich, 1976, p. 107, note 222). Illich argued for a more holistic concept of health, instead of the modern scientific medical model. Illich wrote of health as freedom, anticipating Amartya Sen's discussion of development as freedom (1999). Illich was preoccupied with how health intervention smothered 'health-as-freedom' even with equitable provision (Illich, 1976, p. 242), although he acknowledged a role for sanitation, inoculation, and vector control (Illich, 1976, p. 220). Illich criticised the development of technologically-orientated health services for impeding people's self-reliance and therefore undermining people's health, health being defined in terms of autonomy (Illich, 1976, p. 275). Furthermore he feared that the development of anaesthetics would anaesthetise people against reality, encouraging passivity and discouraging feelings of compassion:

An advanced industrial society is sick-making because it disables people from coping with their environment and, when they break down, from substituting a "clinical" prosthesis for the broken relationships. People would rebel against such an environment if medicine did not explain their biological disorientation as a defect in their health, rather than as a defect in the way of life which is imposed on them or which they impose on themselves. The assurance of personal political innocence that a diagnosis offers the patient serves as a hygienic mask that justifies further subjection to production and consumption (Illich, 1976, p. 169).

Illich's views may be contrasted to the earlier belief attached to international health policy that medical advances would attack fatalism and raise people's belief in their ability to change their circumstances. Conversely Illich sees pain as a corrective to humanity's hubris and fears if humans can be anaesthetised against pain, they will have no sense of limits, 'The pain inflicted on individuals had a limiting effect on the abuses of man by man' (Illich, 1976, p. 135). Modern medicine therefore undermined social and moral well-being. Illich's radical rejection of modern medicine was not adopted in international health policy, but his critique of medicalisation helped to legitimise the shift away from the policies aspiring to develop universal modern health services and consolidate the shift to basic health needs for developing countries.

Selective health care strategy

The primary health care ideals of grassroots development were overtaken by economic crisis in the developing world in the 1980s, commonly referred to as a 'lost

decade' for development. The imposition of structural adjustment programmes in the wake of the debt crisis in developing countries following the recall of Western loans led to serious cutbacks in public services, along with the loss of subsidies on staple foods and the wide imposition of charges, which had implications for the health of populations in the developing world.

NGO activities took on new significance in the 1980s with the international debt crisis and the setbacks in national development. NGOs made trenchant attacks on impact of structural adjustment programmes on welfare in developing countries in the last and sought ways of limiting their effects. Their debt relief recommendations have sought conditions involving the external regulation of national budgets in developing countries to ensure basic welfare spending including health. Their hopes in external regulation may be contrasted with the earlier dependency theories which were suspicious of outside intervention in developing countries, discussed above.

Unsurprisingly the decade witnessed serious reversals in the health gains of the previous decades. Against this backdrop, the primary health care approach was modified into a selective primary health care approach. The selective primary health approach was pioneered by UNICEF and became part of its attempt to facilitate 'adjustment with a human face' and ameliorate the social impact of austerity measures on children. Its GOBI programme identified four simple, cheap and effective health interventions, which could help child survival against the background of the erosion of the already inadequate health services. The programme focused on growth monitoring, oral rehydration to counter diarrhoea, breastfeeding and immunisation against six diseases: tuberculosis, poliomyelitis, diphtheria, tetanus, whooping cough and measles (Black, 1996, pp. 18-19).

The GOBI programme demonstrated real successes in reducing child mortality in an otherwise very depressing decade for international development. Consequently the programme's approach was looked to by other international organisations. The Millennium Development Goals, set out two decades later, is essentially based on UNICEF's approach in the GOBI programme. Indeed Goal Four of the Millennium Development Goals to reduce child mortality incorporates the GOBI programme's strategies with some additions. UNICEF itself expanded the GOBI programme to include 3 FFFs: food supplements, family planning, female education (Black, 1996, p. 19). Again this expanded programme had some impact, but the expansion into health education areas of family planning was more controversial and less effective than the original GOBI priorities (Black, 1996, pp. 189-191). The GOBI programme deserves praise for saving lives in the midst of crisis. Good emergency practice is based on the principle of triage prioritising treatments that save as many lives as possible given insufficient resources in a crisis. However a selective child survival programme is very far from WHO's objective of 'the attainment by all peoples of the highest possible level of health' (WHO, 1948). Tellingly primary health care advocates in the 1980s were concerned that a selective health care strategy should not displace a comprehensive primary health care strategy, and criticised its wider adoption as undermining the ideals of the primary health care movement:

The advocates of highly selected and specific health interventions plus the managerial processes to implement them have ignored, or put on one side, the

ideas which are at the core of what could be described as the primary health care revolution. They are in this sense counter revolutionaries (Newell, 1988).

These criticisms are interesting given the centrality of the UN Millennium Development Goals in international development planning and campaigning today. If the 1980s were a lost decade for development, and the 1990s were preoccupied with humanitarian work and deprioritised development issues, the new millennium is often presented as re-invigorating development and advancing an exciting innovative and inclusive agenda. Yet the Millennium Development health goals effectively constitute a selective health care strategy. As such the Millennium Development health goals repackage the 1980s' survival strategies as international development goals. The Millennium Development Goals initiative therefore puts forward a rather demoralised vision for the developing world. So how has present development thinking become reconciled to selective health care strategies?

Voices of the Poor

The sustainable development approach has defined itself against the earlier modernisation model based on industrialisation and the trickle-down effect and proposed a bottom-up approach to development. The needs-based approach has evolved into a rights-based approach which has sought to both to codify basic needs as a right and to empower the most vulnerable sections of society to realise these rights. So while the earlier sustainable development projects were more focused on practical provision and skills, projects in the last fifteen years have become more interested in social empowerment. To name just two influential figures in international development, the economist Amartya Sen has written on *Development as Freedom* (1999), while the aid practitioner John Clark, formerly of Oxfam and more recently adviser to the World Bank has written on *Democratising Development* (Clark, 1990). The idea of rights-based development has gained acceptance in the World Bank, not just among international social organisations such as the UNDP, WHO and UNICEF.

The empowerment approach to development is encapsulated in the World Bank's seminal *Voices of the Poor* report, officially endorsed by Britain's Department for International Development among other major donors, which has adopted a holistic view of development and sought to take the expressed needs of the poor as the starting point for development work (Narayan et al, 2000). Thus if the 1980s abandoned primary health care movement concerns over 'power, ownership, equity and dignity' (Newell, 1988), the 1990s saw a revival of interest in these concerns.

The World Bank's *Voices of the Poor* report (Narayan et al, 2000) focuses on individuals at the bottom of society and their personal aspirations, experiences and relationships and sees fulfilment of their modest aspirations as international development priorities. At first glance re-orientating development policies around the expressed needs of the poor seems very progressive. Yet international development advisers in the past were concerned with the poor's fatalistic acceptance of their condition and felt they needed to raise populations' expectations. Indeed low expectations are highlighted in the report, which states how its participants 'hope for moderate, not extravagant, improvements' (Narayan et al, 2000, p. 24). But orientating policies around people with low expectations leads to minimalist goals. So

the report may be accused of disingenuously using the poor's low expectations to legitimise low development goals. The report's authors deny this charge arguing that the importance of small changes to the poor reinforces the requirement to prioritise their needs. Yet the empowerment approach has been analysed as legitimising the retreat from state health services and attempting to ensure poor households can improve their own health (Abrahamsen, 2000). The contemporary understanding of well-being also questions the need for significant material transformation to improve the lives and health of populations in developing countries, as the next section discusses. This is another aspect of the *Voices of the Poor* report (Narayan et al, 2000).

Well-being not wealth

The *Voices of the Poor* report champions the idea that the goal of development should be not wealth but well-being. Its concept of wellbeing involves 'material wellbeing, physical wellbeing, social wellbeing, security, and freedom of choice and action' contributing to 'states of mind as well as body, in personal psychological experiences of wellbeing' (Narayan et al, 2000, p. 22). Indeed the report suggests that wealth and well-being are not necessarily compatible (Narayan et al, 2000, p. 30). Repeatedly the report downplays the significance of material prosperity by highlighting the nonmaterial aspects of well-being.

International development thinking originally emphasised the correlation between a state's wealth, the population's health and health expenditure. But development strategies of the last decade have wanted to counter the idea that a country's wealth necessarily determines the health of the population. Thus the editors of *Health and Development* argued, 'It is by no means clear that health status automatically improves with rising levels of development in any given country, and this certainly cannot be said for all inhabitants' (Phillips and Verhasselt, 1994, p. xiv).

The idea underpins the UNDP's annual human development index and reports, which compare the welfare of populations in different countries, highlighting examples where countries with lower national wealth are providing better welfare than those with higher national wealth. The theme is very popular in international development reports today. Favourite examples are Cuba and Kerala province in India. It is often highlighted that Cuba's infant mortality rates compare favourably with the United States of America although Cuba is far less wealthy.

These examples are interesting to study to see if their approaches can be applied elsewhere. Nevertheless a broad correlation remains between a country's wealth and its population's health, although this correlation is downplayed in international development circles today. Sub-Saharan Africa is one of the poorest regions of the world with some of the lowest growth rates and predictably has some of the worst health problems.

Psychological well-being

The elevation of well-being over wealth evidently suggests new possibilities for international health issues to be taken more seriously because the concept of well-being is bound up with health. 'Ill-health is both a cause and a consequence of

'poverty' is a statement that appears in WHO, World Bank and other international health reports. The World Bank has observed that 'for many poor people, the body is their main asset' and that they 'regard accessible, effective and affordable health treatment as a priority when ranking institutions of local importance' (Narayan et al, 2000, p. 100).

The concept of well-being also implies a particular perception of health and health priorities and approaches which is more than the absence of disease. The goal of well-being gives greater emphasis to the psychological aspects of ill-being and well-being, including the psychological aspects of poverty. Unsurprisingly mental health problems have come to the fore. The *Voices of the Poor* report highlighted mental health as a key issue (Narayan et al, 2000). Mental illness has been made a priority area by the WHO, so too international aid organisations. Indeed the past decade witnessed pointed examples where psychological well-being was prioritised and physical problems downplayed over other health problems in international interventions. Notably the subject of trauma in the 1990s displaced the Western media's previous focus on famine as the prism through developing countries were portrayed. Psychosocial programmes were a high profile feature of international responses to humanitarian emergencies in the 1990s (Pupavac, 2005).

Well-being is bound up with health, but without significant material improvement, populations in developing countries will have to continue to endure many diseases and illnesses that have been eradicated or whose effects are minimised or cured in developed countries through access to modern hospitals and medicines. Yet international development strategies effectively conceptualise the well-being of populations in the developing world as having to accept diseases that fall outside its selective health strategies. As such international development strategies are logically seeking to promote well-being in the presence of disease, not its absence.

Health education strategies

The psychological non-materialist emphasis in international development thinking emphasises solutions at the level of the individual focused primarily on self-help and behaviour modification, rather than the macro level and the eradication of diseases. Health education remains a prime focus of international health policy and is reflected in the recommendations of the World Bank. The report singles out moving from '*From illness and incapability to health, information and education*' (Narayan et al, 2000, p. 263), although the report itself acknowledges that the poor emphasise their need for curative medicine. The strategies of the Millennium Goals emphasise education and prevention through behaviour modification rather than cure. The Millennium Development Goals 2004 report on its HIV/AIDS strategy states that, 'For the foreseeable future, education will remain the only "vaccine" against HIV' highlighting condom use and behavioural change (p. 9).

Health education programmes have become the staple response of international aid organisations, but there are questions over the extent of their effectiveness. Health education work has had some success over the decades, but has difficulties achieving universal coverage and universal uptake. Health education programmes tend to overlook the hidden costs of participation in programmes for individuals, such as the burden of time and travel costs to centres. Moreover health education work, including

Millennium Development Goals initiatives, often confuses problems of knowledge, acceptance and behaviour changes. Research on the effectiveness of health education has long highlighted the importance of distinguishing knowledge, attitudes and behaviour change. Even if people are informed about risks, there may be difficulty persuading people to follow precautionary health messages when people's lives are inherently insecure. Communities may have developed traditional risk avoidance strategies following traditional patterns. However there are few incentives to adopt new patterns of behaviour based on modern risk avoidance if one does not expect one's life to be significantly transformed. Mead's study on *Culture, Health and Disease* forty years ago understood this problem (Mead, 1966). Yet such experience is repeatedly overlooked.

Future directions

The new emphasis on global health draws attention to how health threats transcend borders, but these borders remain as relevant today as before in determining the health of populations. Too often disproportionate attention in global health is given to potential risks posed by diseases in the developing countries to Western countries as opposed to the daily experience of disease and ill-health in developing countries. Moreover some of the diseases such as ebola that have received much publicity as global health threats in recent years appear to reflect irrational panics rather than realistic threats. So while international development policies emphasise the problem of inequalities, the emphasis is on inequalities within developing countries, between rural and urban, gender inequalities within families, but have surprisingly little to say on international inequalities nor do they express an aspiration for developing countries to have the same standard of health as those in developed countries.

International health advocacy, for all the reference to being part of a global village, have not challenged the unspoken assumption of international health inequalities that populations in developing countries cannot expect to have modern health systems based on the latest medical developments. The well-being of populations in developing countries, it seems, is to be based on their stoical acceptance of a materially simple life. The empowerment of the poor does not encompass adoption of the same standards of living and expectations of populations in developed countries. Indicatively participants in a workshop on human rights led by British lawyers in Bosnia were instructed that the right to health concerned the right to basic health, not advanced cancer treatment.

Recently there has been more international advocacy around patenting and the availability of cheap generic medicines taken up by NGOs such as MSF and Oxfam. Again the problem of developing countries losing health workers to Western health systems, for example, is currently receiving concern. Renewed attention is also being given to the major diseases of malaria and tuberculosis. However international advocacy remains informed by different development and health expectations for developing countries. Although these differences are based on cultural relativist arguments, rather than elitist arguments, they are nevertheless legitimising unequal health outcomes.

Exceptionally the Bill and Melinda Gates Foundation, founded by the billionaire Microsoft entrepreneur Bill Gates, states an aspiration for health expectation in developing countries to be same:

The mission of our Global Health program is to ensure that people in the developing world have the same chance for good health as people in the developed world (Bill and Melinda Gates Foundation, <http://www.gatesfoundation.org>).

Strikingly this aspiration for equality in health between developing and developed countries has come from an organisation outside of international development circles which have inculcated low expectations. The high aspirations for health in developing countries represent a breath of fresh air, shaking up international health debates, and are also backed by real resources, which however small relative to the problems, might result in some scientific breakthroughs that could help cure and eradicate diseases and inspire more official action. The audacity of the ideas invokes the earlier spirit of international health planning. The announcement of Gates that his foundation was going to put resources into seeking a cure for malaria and a method of eradicating malaria-carrying mosquitoes resurrect some of the ambitions around the MEP of half a century ago. International NGOs have welcomed the new initiatives, but there is some ambivalence. In key respects, Gates' approach is antithetical to contemporary international development and international health thinking. Notably research into developing disease resistant crops with enhanced nutrients involving genetic modification, or genetically modifying mosquitoes to eradicate malaria-carrying mosquitoes, or developing new insecticides goes against sustainable development thinking. Such ambitions invoke the spectre of humanity's hubris, which has haunted development thinking for the last three decades.

Meanwhile the presence of disease and sickness is the reality for populations in developing countries. Most of the world's population remain without access to both adequate primary health care and medically advanced interventions. The vast majority of health problems suffered by people in developing countries are unaddressed. The 'attainment by all peoples of the highest possible level of health' (WHO, 1948) does not appear to be an objective any longer, let alone a reality.

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