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HEALTH AND HUMAN DEVELOPMENT**
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For some time I have thought of setting out my current ideas on development in general and the role health will play in it. This is a topic I have addressed before, but as my thinking, knowledge and responsibility have grown, so has my appreciation of the need to define how mere development is unsatisfactory for us as an unqualified term in the context of our responsibilities in health. I am now wedded firmly to the concept of human development and the need to define more clearly how health is related to it.

It is obvious that I cannot, and I doubt if any of us here could be defined as a specialist in all the aspects of human development, and that is good. I believe, as does Harland Cleveland, that those good managers who truly develop in the intellectual sense pass through three phases. At first we are generalists in that we have fairly vague knowledge about a few areas. Then we become specialists in that we deepen our knowledge and expertise in a very few limited areas and our capacities for analysis and critical thought are sharpened. Then, if we truly develop, we become another kind of generalist in that we bring this sharpened capacity to bear on wider and perhaps more basic issues. These issues are often complex and involve the kind of systemic thinking that sometimes escapes the specialist. This is the case with human development.

I will also take a quasi historical approach because by nature I try to avoid the arrogance of pretending to develop entirely new knowledge. All major events have a historical context. If we do not appreciate that there are currents rather than pools of thought we lose much of our ability to grow. If we do not know where the currents that bear us come from, we will not appreciate where we are and can never entertain any vision of where we are going or where we should go.

I embrace the current thinking that human development is the basic aim of all of us who are engaged in work that improves any aspect of human life. As I have said before, human development is about enlarging peoples choices - it is about expansion of possibilities and to use the concept of Goulet[1], it is a means to the human ascent. But it was not always so, although I like to think that in some ways we have come full circle in our thinking.

The post-war period saw the burgeoning of development almost as a growth industry and the main focus was on the increase in availability of material goods. I am always interested to read ancient writings which looked at material goods with much more emphasis on distribution rather

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** **Workshop on Technical Cooperation and Health Deadership**

than acquisition. Many early economists were largely concerned with the ends to which material goods were put and, there was a distinct teleological focus to the discourse[2]. I am often pleased to remind my economist friends not only that one of the fathers of the discipline, William Petty, was a physician but also that Adam Smith was a professor of moral philosophy before he wrote his seminal work and I have seen his famous "invisible hand" interpreted to mean the hand of providence and less so that of the market[1].

The concept of development in terms of physical resources is of course as old as man himself, and the idea that there was a discipline and theories related to enhancing material progress is also centuries old. But I accept the view that the concern with a national or international responsibility for improving the lot of a large number of the world's people is a relatively recent phenomenon - one that is essentially post-war[3]. For several reasons, not all altruistic, there was enthusiasm for raising the standard of living of the newly emergent nations and such improvement translated into enhancing some measure of economic growth. Very subtly, but very definitely, economic growth became virtually coterminous with development[4]. The great goal was to increase the per capita income of the underdeveloped countries.

We must remember that the categorization of countries as developed, or more euphemistically developing, emanated essentially from the old industrialized nations. The orthodox paradigm elaborated by Rostow[5] was that there was a progression from underdeveloped to developed, and given certain conditions a country would pass from one stage to another. Given that the touchstone of this development was increase in per capita income, and the thesis that people would act rationally to improve their state, considerable attention was paid to those conditions that impeded this natural passage. Poor or inefficient government that stifled market forces was the culprit most often cited. Underdevelopment had its origin in local behaviour which could be changed over time to allow development to take place.

The success of countries that moved from underdevelopment seemed to be based primarily on a high rate of investment from internal savings and emphasis on a well trained labour force. The concept of human capital evolved as related to the need for this training and competence of the labour force. I will cite the opening passage from the classical paper of the economist who is credited with formalizing the concept[6]. Schultz wrote

> *Although it is obvious that people acquire useful skills and knowledge, it is not obvious that these skills and knowledge are a form of capital, that this capital is in substantial part a product of deliberate investment... Direct expenditures on education, health and internal migration to take advantage of better job opportunities are clear examples.*

But in the late 1960's and early 1970's a strong movement began to develop that addressed the obvious poor social conditions that seemed to resist development planners. As the famous Swedish economist Gunnar Myrdal admits[7]

> *... on the whole, before the Second World War, economists had not shown much interest in the problems of poverty and inequality of peoples in the "backward regions."*

The movement in a sense was a return to the teleological bent of the early philosophers in that it put emphasis on the ends rather than the means. Perhaps it was fitting that much of the early disquiet about the poverty and inequality that resisted development came out of the United Nations and is attributed to Singer who claimed that development was about growth and changes in the social and cultural conditions of countries. We then saw attention paid to "growth with equity" and definition of what constituted the basic needs of a society and its people. Dudley Seers was among the first to question the effect of the previous development strategies[8], but some of the most compelling statements that I find on this issue came from Robert McNamara when he was President of the World Bank. I like particularly not only his emphasis on the differences between rich developed and poor underdeveloped nations, but also his angst about the internal poverty. In his presidential address in 1977 he concluded[9]

> *Current development programs are seriously inadequate. They are inadequate because they are failing to achieve development's most fundamental goal: ending the inhuman deprivation in hundreds of millions of individual lives throughout the developing world.*

And in 1973 he continued in the same vein

> *Absolute human degradation when it reaches the proportions of 30 to 40 percent of an entire citizenry cannot be ignored, cannot be suppressed, and cannot be tolerated for too long by any government hoping to preserve civil order.*

Although it now became standard dogma to look for improvement in social conditions as a goal of development and the human state was seen as being all important, it was the landmark UNDP publication of its Human Development Report in 1990 which brought together much of this thinking. An early paragraph of the overview of the report bears repetition[10]

> *Human development is a process of enlarging people's choices. The most critical of these wide-ranging choices are to live a long and healthy life, to be educated and to have access to resources needed for a decent standard of living. Additional choices include political freedom, guaranteed human rights and personal self-respect.*

I have simplified or adapted these concepts as they most fittingly apply to PAHO, and will posit that there are five major components of this human development that are intricately intertwined. These are health, education, economic growth, a safe and healthy environment and a range of people freedoms that include such things as democracy and human rights. I have heard sometimes doubts expressed about the validity of this concept because of difficulty in measuring it. And parenthetically, I have some doubts myself about the utility of a development index that does not measure absolute progress but does no more than establish nations in some sort of league table of development. Some of the aspects of human development are fairly easily quantified and some are not subject to quantitative measurement. This must not disturb us - many of the aspects of the humanly better life will never be subject to ready quantification, and will only be gauged by very proxy measurements. It has been common practice to use loosely the terms economic development or socioeconomic development in describing certain changes in society. Indeed several adjectives can quite properly be used to qualify development. It is futile to believe that the concept of human

development will displace forever the use of terms such as socioeconomic development but I ask that we accept as put by Goulet that[1]

> *"Economic," "social," and "political" development are simply methodological constructs adopted within specific disciplines to study aspects of a change process which they "abstract" from a total reality which comprises, beyond facts, meanings and symbols.*

I will now address very briefly the treatment of these ideas in PAHO. If we go back to our Sanitary Code[11], it is clear that our founding fathers appreciated in 1924 that disease and its spread would influence international trade and commerce and by extension the possibility of economic growth of the countries. I can find little evidence of serious treatment of the role of health in relation to economics until after the development of the Alliance for Progress, and in establishing a place for the health sector in this movement, the role of health and of PAHO was emphasized principally in the context of the relationship between health and development construed mainly in economic terms[12]. In the 1980's, PAHO paid considerable attention to the effect of the economic crisis on health, and the important formal documents that addressed the relationship between health and development were essentially focussed on the importance of economic growth for health and vice versa[13]. Dr. Macedo in many of his presentations showed a considerable conceptual advance in thinking about the issue, as he questioned frequently the kind of development our countries should seek during and as they emerged from the economic crisis and sought a new form of development[14].

Given the concepts of human development and the crude taxonomy I have presented, let me now analyze what our working hypotheses and practice should be. As in any complex situation such as this, it is the systemic approach that is most appropriate and we have to consider how health is related to various components of human development and how synergically they can contribute to that development.

I will begin with the more traditional concept that has been dealt with extensively here and elsewhere[15, 16, 17] - the relation between health and economic status. The association between economic status and health is well accepted both at the national and the individual level. The rich tend to live longer and be healthier than the poor and this has been shown by numerous studies. I was interested recently in a novel approach to the topic taken by researchers who examined the relationship between the height of the obelisks in a graveyard and the ages at death. Those persons who had the bigger gravestones and presumably were richer, had lived longer[18].

There is no doubt about the association, the real question is the underlying mechanism. The explanations range from the simple, such as the rich have better nutrition and hence are healthier, to the more complex such as, the rich are better able to utilize the information available to enable them to make those life choices that result in lower mortality and morbidity. Perhaps the most compelling explanation is that economic status is another of the determinants or expressions of social class and the evidence is now unequivocal that health outcomes are firmly linked to social class.

This relationship is important for us as regards the policies about allocation of resources and energy for health improvement. The best exposition of the nature of the determinants of health and the possibility of health improvement is to be found in the book *Why Are Some People Healthy And*

Others Not? by Evans, Barer and Marmor[19], which I encourage you strongly to read. They put forward the view that a focus exclusively on poverty may block our understanding of many of the basic mechanisms that underlie the relationship between economic status and health. There is some basic process that leads to a gradient in health outcomes which is seen even although there is improved access to health services. It is probable that there are biological mechanisms that are associated with social gradients which then are manifest in differential possibilities of being affected by disease. The authors show that health outcome gradients are constant over time even though the causes of death change and even though the general health status of the population is improved. But this is not the place to describe their arguments on the physiological changes or adaptations associated with social status that can affect health outcomes. One of the very important aspects of their work is the extension of the concepts of the Lalonde health fields and a close examination of the relationship of care services to health status. A general conclusion is that it will never be possible for any country to satisfy the health care demands of its population.

It is important for us to note that the relationships within a population are plastic in the sense that there is no essential genetic or fixed characteristic inherent to poverty that determines ill health. It is even more important to appreciate that although it is true that the rich are healthier, at the level of populations, the distribution of income is a more important determinant of health outcomes than the average income[20]. In other words, health outcomes are one reflection of equality or resource availability.

While it is well accepted that economic status contributes to health outcomes, it is less well documented that health contributes to economic status at the population level. It has always been taken almost as an item of faith that a healthy population produces more, and disease elimination enhances the possibility of economic growth. There are good studies on improving the nutrition of workers who then produced more. What is less well documented and is of importance at the policy level, is that national investment in health enhances the possibility of economic growth. It is now being shown that there may indeed be a causal relationship between investing in health and other social goods and a country's future economic growth[21]. In an Inter-American Development Bank's report on human resources Behrman claims that "... for very poor areas where there has not been rapid technological change, the returns from investing in health and nutrition appear larger than those for increasing schooling"[22].

As indicated above, it is not only the extent of poverty that affects health outcomes, but income inequality is equally or more important. It is no cause for pride that Latin America has a very high degree of income inequality - and it is proposed that the persistence or aggravation of this phenomenon is not inherently structural, but derives from the evolution and maldevelopment of human capital. The case is made with data for the possible impact of education on reducing this inequality[23], and by extension I would theorize that health investment would have the same, as well as a complementary effect. I hope to see the same studies done for health as for education.

We sometimes forget that health expenditure in all countries consumes a significant fraction of the national wealth and we must be constantly aware of the opportunity costs of such expenditures. Health status of the population and the perception of the health of the locale are important economical assets particularly to those countries that depend on tourism as a prime source of revenue. The economic aspects of the trade in health services is just coming to the fore[24].

The relationship between health and education has always been assumed and there are good data on the impact of health on nutritional status, past and present and on the capacity of children to learn. One might also argue that improvement of health status that leads to a lengthening of productive life would decrease the rate of depreciation of the investment in education[25].

I will not discuss the relationship between health and a safe environment - this is too obvious. I would only refer to the fact that it is the behaviour of the micro-environment that has most direct bearing on human health. It is the safety of the air, water and soil, and the quality of housing that affect us most. It is not that we should ignore the concern about the large global commons, but at the operational level we whose concern is human health and the possibility of corrective action in that area, have to focus on the immediate environment and act locally.

Perhaps the most difficult concept to grasp is that there is a linkage between health and forms of societal organization or various aspects of people's rights and freedoms. The idea that health may be better in a democracy is not new - it was said very clearly 150 years ago by Virchow[26]. At the most elementary level there is the possibility, and some data to show that indicators such as life expectancy fell or did not rise recently at the same rate as in those countries of the world that were non-democratic and authoritarian[27].

The more intriguing possibility is that attention to health at the individual and collective level may favour human development through involvement and improvement of people. The perception of underdevelopment, as I have stated above, usually comes from the observer and as others have noted, the changes necessary for any aspect of human development are often painful. One first step to such change, however, is the recognition by people not only that the current state of affairs is aberrant and changeable, but also that they can change it. There must be a consciousness that life might be different. I would propose that health status might be the kind of trigger that awakens people to the possibility of a better life. They may begin to see that their children do not have to die needlessly and that mothers do not have to die in childbirth. It may well be that we do not use sufficiently health as a change agent that may influence people to begin to play positive roles in society. There are many advantages to health. It is, as you have heard many times, one of the "noble" areas around which it is fairly easy to achieve dialogue. The experience in war torn Central America and the recent successful efforts of President Carter in the Sudan to broker a peace in order to put health services in place are examples of the powerful influence of health. Similarly, I believe - again without empirical evidence -that the practice of genuine participatory democracy enhances the possibility of community action that can lead to better health.

There are other political aspects of health that I could mention. The democratic societies are just as sensitive as others to their national security and as I have pointed out recently, health or the possibility of disease elsewhere must be a consideration. Internal domestic stability is essential for national security and dissatisfaction over social conditions like poor living and ill health can provoke threats to such internal stability[28].

If you have followed my arguments about the relevance and centrality of human development and accept the systemic approach to such development, and if health shares the spotlight with those other areas that contribute to improving the human condition, then you might agree that there can be

no single development agency and no simple recipe. Those agencies concerned with health and those with education are by definition also development agencies, and it is in this light that I now wish to address what should be the role of PAHO and of its managers in a development agency concerned primarily with health.

I have not thought it necessary to explore here any definition of health. The classic definition of health as adopted and promulgated by the World Health Organization is a general expression of a desirable state. In practice we have to accept that there is some general continuum between that definition and the measurement on a population basis of health by using some indicators of illness or disease. What I do not wish, is to have the polemics of arriving at a precise definition impede us from establishing the claims that the health of the people is an important aspect of their development.

The first responsibility is to appreciate the importance of health and human development as a strategic and programmatic orientation. You must be able to articulate clearly why a health agency must be concerned with human development and be able, at the national and international level, to put the case for health in these terms.

In the division of PAHO that must occupy itself with this strategic orientation we have located the program that deals with one group of people - women - whose health is important in development terms. Also you will see, I hope with increasing clarity, that except for the aspect of health and the environment, we will consider under this heading the relationship among health and the other facets of human development. That division will have prime responsibility for our technical cooperation in relation to the interaction between health and economic growth and to a lesser extent on the economics of care, important though that may be.

I have discussed many factors that affect health and it may be felt that the health sector should not have to be justifying attention to it, since attention to the health of people is a moral imperative. I wish to be clear that I do not dispute the moral and ethical considerations with regard to health, but I continue to say that these are not enough: there must be additional justification for investing in health. To make our case more compelling we need to have data and transform it into information. There is no doubt in my mind that one of your critical responsibilities as managers is not only to advocate for attention to health, but to cooperate and collaborate in providing our countries with the information that shows where the inequalities in health lie and the efficacy and effectiveness of the interventions to reduce them. This is the main reason for the programmatic location of the Program on Health Situation Analysis in the Division of Health and Human Development. To continue to defend the need to improve the human condition without promoting the measurement of those aspects that lie within our competence, is an abrogation of an important responsibility.

It is not enough for PAHO to be aware of the general positions I have outlined above, it is necessary for us to seek to sow the seeds of understanding in our countries and equally important in our partners, some of whom for one or other reason may persist in the reductionist approach which I hope we have abandoned. The possibility for meaningful intersectoral activity which we continue to espouse, can be made real if there is this understanding. We are working to get this understanding at the highest levels of government.

The need for increased understanding of the issues is, for several reasons even greater now. First, there is a cry for health sector reform in almost every country of this Region. Much of the concern is with the cost of care and the extent to which the system should be reformed such that it is more equitable and so that its financing should no longer be an excessive call on the public purse[29]. It is important in discussing reform not to lose sight of the fact that important though they may be, the care services are not the major determinants of health status. Care must also be taken to ensure that there is understanding that there are certain health services - those with high positive externality content for which the State must assume responsibility. We cannot lose the focus on the population health and reducing the inequality and inequity that exist with respect to health.

Second, there is the determination of the multilateral funding agencies to invest in the health sector and PAHO must be ready to assist governments and especially Ministries of Health in determining, along with the lending institutions, the most effective allocation of funds. Even though the available funds are a small fraction of total government investment, they have tremendous leverage and may shape practices for many years to come.

Third, we must understand that in this Region there is an almost inexorable drive or shift towards a liberal market-driven economy. It is pointless arguing against it or repeating endlessly that the strength of the market does not lie in its distributive capability. It is our responsibility to point out those segments of the population that are left out and help to design strategies that at least address the deficiencies in health that occur in them.

Fourth, we must understand the importance of health and human development because it will be a matter for our technical cooperation. I believe that all of you know well my perception of the basic approaches of technical cooperation, but I have discussed less often some of the ideology of the cooperation with our countries. As originally conceived, technical cooperation had two main components. First the transfer of knowledge allowed the recipient to master the technology which could ensure change. But the other component that is often less discussed is that of the power relationships between the two parties. When the developed countries transferred technological know-how they never dreamt of the power sharing that might result from the development of others. We are in a unique position because we can facilitate the enhancement of capacity without being concerned with power relationships, and even when we promote cooperation among countries it is on the basis of equals. We must use this non-threatening position to the maximum to promote the understanding of human development and the improvement of health as one of its components.

I have mentioned some of the internal programmatic responsibilities for some aspects of the technical cooperation and some of the reasons for your understanding the linkages and concepts. But I hope it is clear that all parts of PAHO must share in the understanding of what is meant by and done in human development. For example, the importance of nutrition as a component of the health to which I have alluded is obvious, as well as the relationship of disease control to many of the other components of human development. Once again I insist on the systemic view.

But there is yet another important reason for our dealing with this issue here. PAHO is engaged with its Member States in an effort to renew the enthusiasm and interest that characterized Health for All of the post Alma Ata years. I believe that this initial impetus waned for several reasons. The economic crisis of the 1980's caused attention to be turned away from many social

issues; some of the moral force of the leaders appeared to be dissipated in other things; and, perhaps of equal importance, there was not enough effort placed into the preparation and careful follow up of the plans that were necessary to ensure that the basic primary health care strategy was implemented and evaluated.

But perhaps the most important reason may be that health was seen in purely sectoral terms and there was little genuine basis for the intersectoral action that was so critical. The dominant thinking did not accord to health the same importance in programmatic and operational terms as was accorded other aspects of social endeavour. The rhetoric and moral justification, though necessary, were not sufficient to engage public interest in health as important for human development.

The essential goal of Health for All is that there should be social equity - there should be fairness and that fairness could be expressed in health if the primary care strategy were implemented and if there were equality of access to those goods that are important for caring and even curing. If there is to be renewed enthusiasm for Health for All as a noble goal, it is essential that there be an appreciation of the real aspiration behind it and that health occupy a different place in the public agenda. The public support necessary for the transformation of the health systems, the community participation and the intersectoral work will not be forthcoming unless the connection of health with other areas is clear. The quest for Health for All will be made easier if and when we agree to seek human development as the ongoing process which I have described.

There is one final responsibility I would give you. Perhaps because of the history of medicine and the instinct of health workers for care and perhaps because much attention is paid to care as a determinant of health status, priority is often given to the individual human condition.

We must never denigrate this genuine concern for the individual, but at the same time must promote vigorously the attention to groups, as the preservation of health is both an individual as well as a collective enterprise. It is in the collectivity of action at the national and particularly at the international level that this Organization should have its strength. We were created for this purpose - the promotion of Pan American thinking and action and that is one responsibility we must never abjure.

This collectivity of action in the Secretariat was well shown recently as you all worked together to craft the mission statement that will guide our work. I am pleased with it and am sure everyone of you can and will identify with what you helped to create. Let me read it

> *The Pan American Sanitary Bureau is the Secretariat of the Pan American Health Organization (PAHO), an international agency specializing in health. Its mission is to cooperate technically with the Member Countries and to stimulate cooperation among them in order that, while maintaining a healthy environment and charting a course to sustainable development, the peoples of the Americas may achieve Health for All and by All.*

Thank you.

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