The Historical Failures and Accomplishments of theWestern Medical Model in the Third World

CHAPTER 2

The evolution of health policies and different approaches to health care occurs within the larger context of social and economic development. Changing perspectives of development strongly influence prevailing models of medical and health services and affect who benefits most and who benefits least or is harmed in some way. We discuss the processes of development and underdevelopment in detail in Part 4, but here provide a brief summary as background to the discussion on changing approaches to health care.

The Development Debate

Since colonial times, the "development" of the so-called "undeveloped," "less developed," or "developing" colonized lands in the South has been defined and directed by the more powerful nations of the North. The net transfer of wealth from the South to the North has always been the bottom-line of the development process. As we will explore further in Part 3, the persistent high incidence of illness, death, and developmental delay in the world's children is inseparably linked to the increasingly globalized forces of under-development—carried out in the name of development. (For this reason, we usually use the term "underdeveloped" rather than "developing" countries.)

In the course of the twentieth century, the concept of development has become synonymous with *economic growth*. To this end, during the 1950s development planners urged Third World governments to invest in (and accept giant loans for) large-scale agribusiness and industrialization. Although the planners recognized that this model of *growth-oriented development* would concentrate wealth in the hands of a small, more affluent sector of the population, they maintained that the benefits would eventually trickle down to the poor. In the subsequent two decades, however, it became increasingly clear that this trickle down theory did not work. Overall economic growth was frequently accompanied by expanding poverty.

As poverty and consequent social unrest became more acute during the late 1960s and early 1970s, development planners came to emphasize—at least in their rhetoric—the importance of eliminating poverty through measures such as increasing employment and promoting fairer income distribution. This led to the concept of providing *basic services* in response to *basic needs*, which became dominant in health and development thinking.

However, this progressive trend was reversed by the economic crisis that began in the late 1970s. Combined with a political shift to the conservative right in a number of major industrialized countries, this caused a drastic regression in mainstream development policy that prevails today. In response to their huge foreign debt burden, debtor countries of the Third World were forced to accept Structural Adjustment Programs (SAPs) imposed by the World Bank and International Monetary Fund (IMF) as a condition for receiving bailout loans. These adjustment policies—which lowered real wages, reduced food subsidies, and slashed budgets for public health and education— harmed, rather than benefited, the poorest people. (See chapter 11.)

Thus, during the 1980s policies for providing poor people with more adequate incomes and services were deprioritized. As wages fell and unemployment rose, the basic needs of a large and growing sector of humanity remained unmet. At the time they were needed most the social programs designed to serve as a safety net for the poor were systematically cut back. Development strategies in the 1990s have begun to show gaping contradictions which undermine their credibility. Despite the World Bank's pledge to prioritize the elimination of poverty, its big-business promoting policies remain firmly in place, and the gulf between rich and poor continues to widen. These macro-economic trends—which we will look at in more detail in Part 3—have a profound influence on changing patterns of both health systems and health.

The Evolution of Third World Health Policies: Western Medicine as a Tool of Colonial Domination

Throughout the Third World, traditional healers (shamans, herbalists, witch doctors, bonesetters, etc.) have for centuries been the major providers of health care. Even

today, in many countries they still offer an alternative to Western medicine, often serving as the principal care-givers for the majority of people in rural and poor urban areas.

Prior to the nineteenth century, colonial medical services—provided by Western doctors linked to trading companies—served their European employees almost exclusively. Throughout the colonial period, public health activities were initiated either to combat diseases that affected the European populations (e.g., malaria and sleeping sickness) or as attempts to maintain a healthier work-force and so ensure healthy profits.[3] For example, the Colonial Development Advisory Committee of Britain in 1939 noted that:

> If the productivity of the East African territories is to be fully developed, and with it, the potential capacity of those territories to absorb manufactured goods from the United Kingdom, it is essential that the standard of life of the native should be raised and to this end the eradication of disease is one of the most important measures.[4]

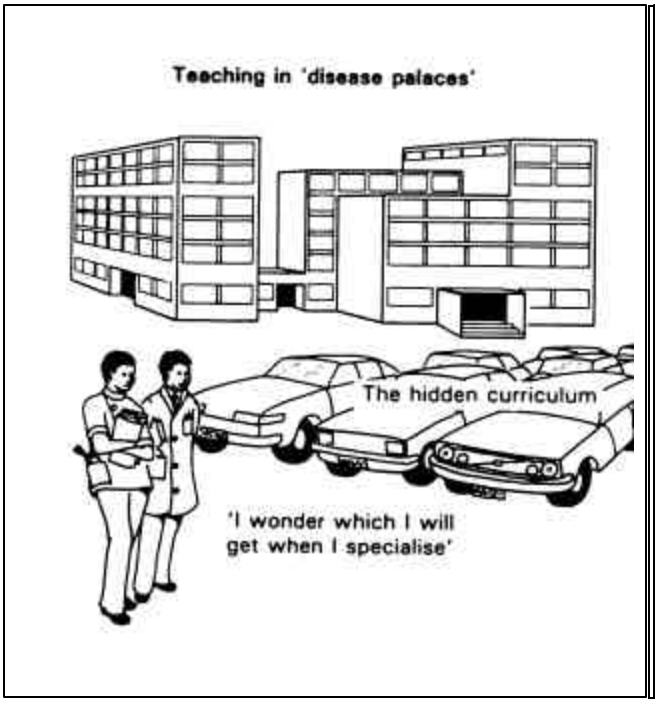
By the end of the colonial period, the pattern of health care which had developed in most of the Third World was largely modeled on the system in the industrialized countries. It emphasized expensive high-technology and urban-based curative care in large hospitals, with Western-trained care-providers. Its services were almost wholly confined to the larger towns and, to a lesser extent, to plantations and mines.

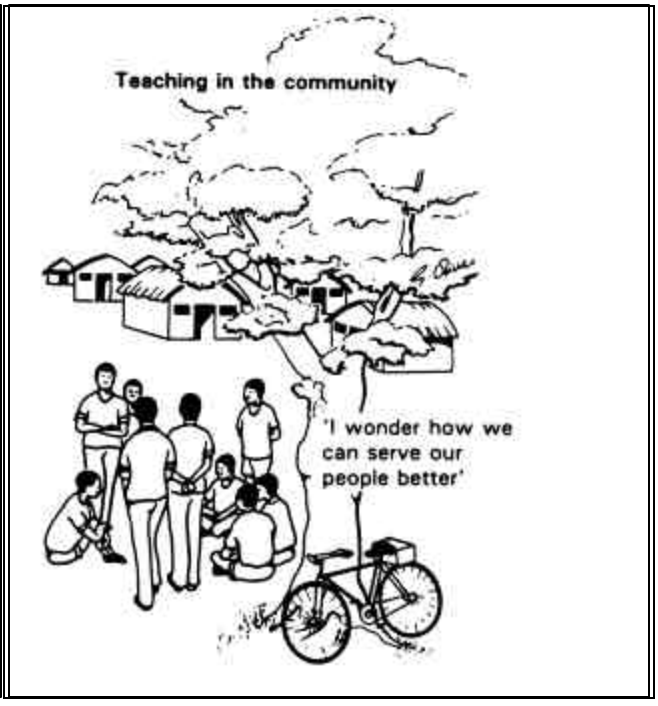
The few public health services that existed were rudimentary and urban-based. The needs of people living in rural areas and urban slums were largely neglected. This situation continued with little change until the middle of the twentieth century.

Attempts to reform the Western medical model

The 1950s and 1960s saw most of Asia and Africa win independence from colonial rule. Most of the newly independent states drew up plans to expand adequate health services into underserved areas. Although on paper these plans often emphasized prevention and gave priority to rural areas, most government and international funding continued to go to curative, urban services. Some poor countries spent over half their national health budgets maintaining one or two huge, urban, tertiary care hospitals.

These "Disease Palaces"* were equipped with the latest, most expensive, imported medical equipment. Their





* This term was coined by David Morley, public health pioneer and author of *Paediatric Priorities in the Developing World* and *See How They Grow*. During the 1950s and 1960s, Morley, Maurice King (author of *Medical Care in Developing Countries*) and other researchers advocated the redesign of medical services to meet the needs of the poor.

western-trained specialists and researchers focused their attention on the diseases of the affluent while neglecting those of the poor majority. For example, Imelda Marcos built The Lung Center of the Philippines at great cost but the Center would not take tuberculosis patients because it did not want to deal with infectious diseases.

Tuberculosis, at the time the Lung Center was built, was the third leading cause of death in the country. (It is, today, still the fourth leading cause of death.) For many years, the Lung Center's operations had to be heavily subsidized. Meanwhile the Quezon Institute, an older establishment for tuberculosis patients, had its budget slashed each year.[5]

The public health campaigns during this time tended to be quite narrow. They were designed to eradicate specific diseases such as yaws, smallpox, or malaria. These campaigns were often "vertical" (specific to a single disease): each had its own administration and budget and operated autonomously, rather than being integrated into the larger health care system. Often these narrow campaigns absorbed more resources than did all the rest of the country's rural health services. As we shall see, international promotion of narrow, vertical campaigns has continued to this day, despite attempts to introduce more comprehensive health strategies.

Probably the most significant development of the 1950s and 1960s was the creation of the *rural health center* staffed by paramedical workers or auxiliaries, called *medical assistants* and *health assistants*. This approach—promoted by the Indian Bhore Commission and later outlined in Maurice King's book *Medical Care in Developing Countries*—has come to be known as the *basic health services* approach.[6] Although it did improve coverage somewhat, the approach was still very service-oriented and medicalized, with little community involvement.

During the late 1960s and early 1970s health and development planners became more aware of the social and economic dimensions of poor health. A growing social consciousness that health—and health care—was a basic human right led to international support for a *basic needs approach* to national health services. Rethinking their priorities in the light of this budding social ethic of basic health services for the entire population, some major funding agencies began shifting their funding emphasis from huge urban hospitals to community health programs. They calculated that the funds spent on a single teaching hospital could maintain hundreds of health centers or clinics staffed by auxiliary health workers, and could provide basic services to many times the number of people.[7]

By the mid1970s, although access to health care for many people in rural parts of underdeveloped countries had been improved through the use of auxiliaries, their expected potential was still far from fully realized. This was partly because medical assistants and other auxiliaries, like their professional mentors (doctors and nurses), had little attachment or accountability to the communities they served. Frequently, they either migrated upwards in the medical hierarchy or dropped out altogether.

The negative effects of the Western medical model

The most serious shortcoming of the Western health care model—which even today remains the dominant model in the Third World—is the way it almost entirely ignores the underlying socio-economic and political causes of health problems. The health professions have helped spread the idea that the ill health of people living in poor countries is largely due to ignorance and overpopulation, rather than to the systematic underdevelopment of the Third World by the First World.

The transfer of Western medicine to the Third World has had other negative effects. In poor countries, as in rich, most physicians come from the higher social classes. Frequently they ally themselves with local and international business interests, particularly medical ones. Invoking the principle of "professional autonomy," doctors insist on their unlimited right to acquire and use sophisticated, costly technology and to prescribe expensive, often ineffective and/or dangerous drugs. Above all, most insist on their right to private practice. Their vested interests have often led them to resist social change, whether at the national or international level. For example, in Chile during the presidency of Salvador Allende, many doctors obstructed efforts to democratize health care institutions. Similar professional opposition occurred in Nicaragua following the overthrow of the colonial regime in that country.

The germs of reform

The disappointing performance of auxiliaries, coupled with growing interest in the *basic needs approach* during the 1970s, led to growing critique and rethinking of Third World health care strategy. This was spurred by the remarkable progress in health attained in China, as well as by the achievements of many small grassroots initiatives in Third World countries, undertaken mostly by nongovernmental organizations.

From these alternative approaches emerged the concept of *community-based health care*. Key to this concept

were *community health workers* or *health promoters:* persons selected from and by their own communities and given brief courses showing them how to help their neighbors meet their most important health needs. Self-reliance and the use of low-cost, local resources were encouraged. Emphasis was placed on preventive measures, health education, and involvement and leadership by members of the community.

Throughout the 1960s and 1970s concerned groups of health workers and community organizers began to pioneer what became known as "Community-Based Health Programs," or CBHP. These participatory, awareness-raising grassroots initiatives arose in a number of regions, including Nicaragua, Costa Rica, Guatemala, Honduras, Mexico, South Africa, India, Bangladesh, and the Philippines.

Most of these programs started as a humanitarian response to enormous unmet needs, with a humanitarian rather than a political agenda. But institutionalized exploitation and routine violation of poor people's basic rights so clearly contributed to ill health and high death rates (especially of children) that many of these community-based programs evolved strong sociopolitical components. In some regions (the Philippines, Central America, and South Africa) a wide diversity of small, isolated, community-based health programs began to form loose alliances which gradually grew into broad-based movements, linking health, social justice, and basic human rights.

In Nicaragua (under Anastasio Somoza), the Philippines (under Ferdinand Marcos), and South Africa (under apartheid rule), enormous social inequities and systematic violations of human rights contributed to the abysmal health status of a marginalized majority. And in each of these countries, a strong community-based health movement played a crucial role in "awareness raising" and the development of problem-solving and organizing which enabled people to finally stand up and oust the despotic regimes.

Community-based health initiatives in different parts of the world developed different methods for helping health workers, mothers groups, farm workers, and others learn to analyze their health needs and take organized action. In Latin America, the awareness-raising methods of Paulo Freire's renowned adult literacy program in Brazil (out of which grew his classic book *Pedagogy of the Oppressed)* were adapted to health education. (See page 132.) A "Discovery-Based Learning" model was developed in Central America and Mexico and described in David Werner and Bill Bower's *Helping Health Workers Learn.*[8] At the same time in the Philippines, a group process of "situational analysis" or "structural analysis" was like wise used to help people diagnose the underlying causes of poor health. These methodologies for empowerment became important tools in helping groups of disadvantaged people conduct a "community diagnosis" of their health problems, analyze the multiplicity of causes, and plan strategic remedial actions in innovative and creative ways.

The biggest and probably most highly acclaimed community-based health initiative was the barefoot doctors program in China. This grew out of a national liberation movement and was subsequently incorporated into the national health system of the victorious People's Republic. As an integral part of a revolutionary development process it sought to ensure that the people's basic health needs were met. To this end the campaign was remarkable in that it promoted a decentralized process in a country that has always had a strongly centralized government. Each barefoot doctor was accountable to members of the community, although the central government was backing the program. In this way the local community acquired more influence in the nature and quality of the health service provided; millions of people were mobilized to become involved. In addition, the campaign was unique in its commitment to ensuring comprehensive improvements in food, housing, and environmental sanitation. As a result, a number of diseases were virtually eliminated, while child mortality dropped significantly. (China's achievement of "Good Health at Low Cost" is further discussed in Chapter 17.)

Adapting Community-Based Approaches to National Health Systems

In the mid 1970s, a number of top scholars and development planners—observing the failure of the imposed Western model of health care to improve health statistics in many Third World countries—decided to look closely at models that appeared more successful.

The impressive health gains in China and by community-based health programs in the Philippines and elsewhere stood out in stark contrast to the disappointing results of most western-oriented national health programs. Despite criticisms dismissing them as "non professional" or "second rate," health planners began to examine the potential of using the principles of CBHP for national health services. This would entail a revolutionary shift from the existing medical establishment to strong community participation, with emphases on prevention, prioritization of rural areas, and an approach which put disease in its social context. This meant literally turning the system upside down, from a top-down system to a bottom-up approach.

Nonetheless, reforms proceeded cautiously, due in part to increasing tensions over social issues affecting health. Large top-down governments began to co-opt some of the new ideas while prestigious Western academic institutions began to use the rhetoric of bottom-up alternative approaches. Terms like "self determination" and "community participation" entered the vocabulary of professors and graduates under the new doctrine of "Health by the People."

At last, in 1978 in Alma Ata, Kazakhstan (then the Soviet Union), a grand meeting of health ministers from around the world led to the formulation of a plan whereby basic health services would be available to all people. In the next chapter, we look at the Alma Ata Declaration, an unusually progressive document with far-reaching structural and economic implications. If fully implemented, it could have substantial benefits for poor and disadvantaged people the world over.