People's Health Movement

Celebrating David Sanders

And the Struggle for People's Health

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Edited by
T. Sundararaman | Bridget Lloyd | Fran Baum

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Eds. T. Sundararaman | Bridget Lloyd | Fran Baum

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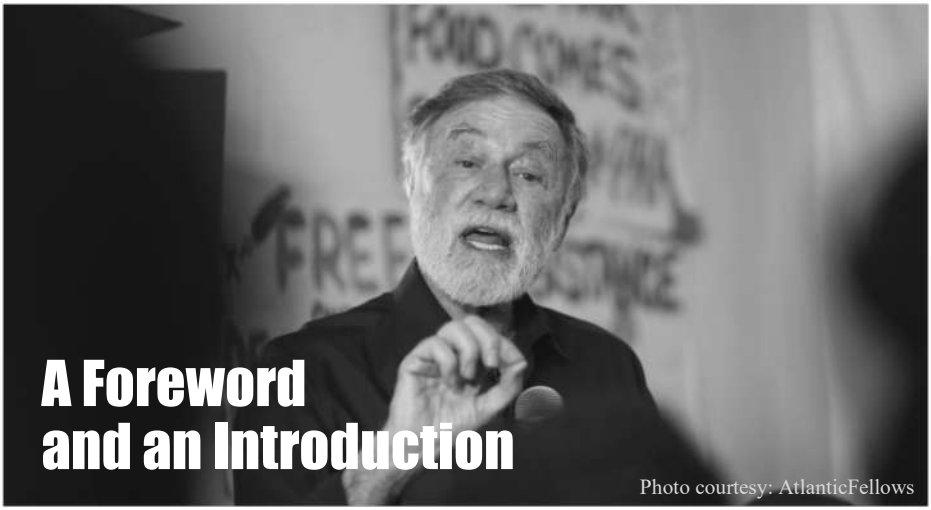
This small token of tribute to our beloved David could be possible only with the help of a number of comrades and friends. Thanks are due to all those who have contributed to the resource material for this book in the form of permission to use the articles/papers and photographs.
Special and sincere thanks to
Sue Fawcus and Louis Reynolds.



A Foreword and an Introduction

Photo courtesy: AtlanticFellows

On August 30th, 2019, at the age of 74, David Sanders passed away. Very few persons had, or will ever have, such a huge impact on the struggle for health rights and health equity as David.

This book is a small celebration of his life's work and legacy. David made a great contribution to shaping the discipline of public health. He also leaves behind him a social movement that he was completely dedicated to and which he played a significant role in founding, guiding and inspiring. His third legacy is in the human resources he created - as teacher, mentor and guide - but even more important as an inspiration that could reinforce their commitment to dedicating their lives to the betterment of people's lives - even during the darkest of times. There have been many obituaries and articles published in his memory and we begin this book with a sample of this - the tribute from the People's Health Movement, to their mentor and leader published in the Lancet. But most such tributes can only draw attention to a few highlights of his career and personality. We hope that the collection of articles published in this book allow the younger generation and generations to come, to get a better glimpse of the variety of his achievements and the significance of these - so that they can also get inspired, as we did once, for the challenges ahead.

David was born in South Africa (August 5th, 1945) but grew up in Zimbabwe where he qualified as a medical doctor. During the 1970s he lived in the United Kingdom, where he specialised in paediatrics and public health. During his time there, David was actively involved in political movements associated with de-colonisation and the struggle for a just and humane socialist future. He returned to newly independent Zimbabwe in 1980 and worked at the University of Zimbabwe's Medical School. In this period he put to work many of the political principles that he had imbibed – when he established the first rural placement for

medical students and helped the government to initiate a rural health programme built around health promotion and prevention by community health workers. In the second article in this collection, Roger Etkind, his close friend and comrade, recounts these formative years - emphasising David's own descriptions of himself - as a champion of reforms, but never a reformist. He also shows how David learns and practices - the strong "*thread of democracy* that runs through David's politics… the democracy of mass organisations and the democracy of the political organisation itself."

One very important facet of David was his total conviction that anyone interested in furthering the cause of public health and health equity had to participate in social movements for the same. We would like the reader to refer to David's interview with Antony Costello on "How to be a Social Activist for health" where he sets out, why though one may contribute as a teacher and researcher, engagement with and participation in social movements is one of the most important requirement for bringing about change. David was conscious that when his time amongst us came to an end, the People's Health Movement, that he helped create and provided leadership for throughout his life would be his most important legacy. In chapter 3 therefore, we publish a recent article of David, which he co-authored with Fran Baum and Ravi Narayan, where he presents a lucid understanding of the People's Health Movement, that would introduce this movement to any young person interested in public health and the struggle for health rights and health equity.

In the early 1990s David returned to South Africa to work, initially in the University of KwaZulu-Natal and then from 1993 onwards in University of Western Cape in Cape Town. Here he established the Public Health Programme (subsequently known as the School of Public Health) and became its founding director. He led the school until 2009. During his years there he developed a world -renowned distance-learning Masters in Public Health that graduated students from all over Africa. His writings during this period and even during his time in Zimbabwe shaped the discipline of public health, in a significant way.

One important aspect of what he brought to the discipline of public health was an active interrogation of global health policies. In chapter 4 we reproduce a critique of the Universal Health Coverage discourse and the Astana resolution, published in the Lancet, just two weeks before his untimely death.

Another key focus of his work was on the social determinants of health. Representative of this, we have selected in chapter 5 a relatively recent co-authored paper of David's on the "Paradox of Under-nutrition and Obesity in South Africa". This paper is reflective of the way he used political economy to critically analyse and discuss the social determinants of the major public health problems of the day. It is also part of the large body of work that he produced on different health issues of Africa.

Finally, in chapter 6, we publish a long extract from the iconic work that has influenced a whole generation of scholars and activists – "The Struggle for Health". Published first in 1985 and then going through many editions since, this book remains a pivotal reading for health professionals and activists and a great example of the political economy approach to understanding health and health care. In a world where health economics is grounded almost exclusively in neo-classical economics, this book still represents an altogether different conceptual framework for undertaking the study of health systems.

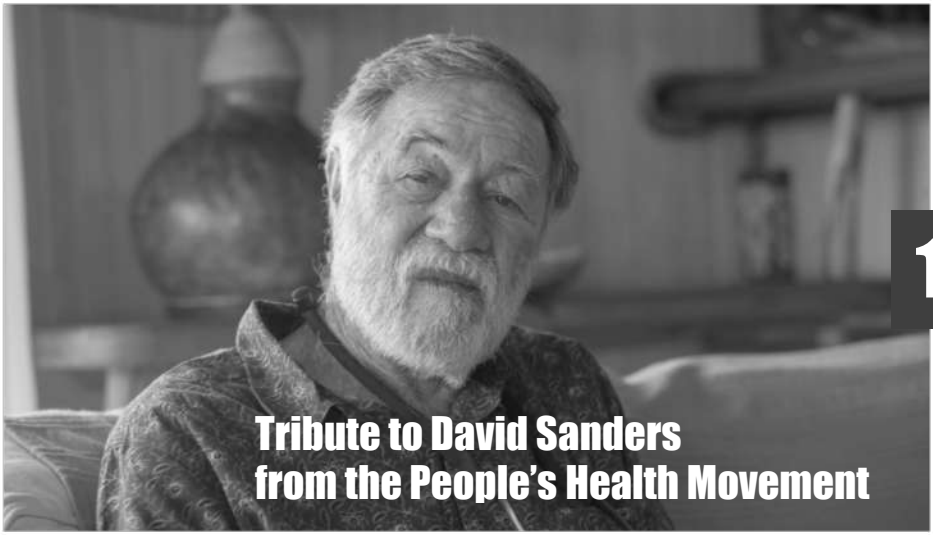
There are many other areas of academic and activist contributions by which David Sanders is known. This would include such important areas as community health workers, the strategies of primary healthcare and many more. Unable to do justice to all of his work in any one book, we present a few samples of his writings in many such areas in the last chapter of this volume. We caution that this list represents only a small proportion of his publications - and is provided here merely to stimulate readers who are interested, to search further and learn more of his work.

What the printed word cannot do is capture the warmth and friendliness that radiated from him, his love and ability to share knowledge and mentor younger people, his quick anger at injustice anywhere in the world, or the tirelessness and intensity with which he could travel and work. Perhaps the photographs we publish here, will help us reflect back on this. Those in our movement who knew David will remember engaging with him deeply in discussions and debates on different aspects of the struggle for health as also relaxing and enjoying his quick wit and humour while debriefing on the political events of our respective nations as also the progress of our personal careers and life-style choices. Paying tribute to David is also paying tribute to the tremendous support his family (Sue, Ben, Lisa and Oscar) has provided him, especially the long partnership he had with his wife and comrade - Sue Fawcus, herself a health professional who has made immense contributions to the struggle for health in her own way. We also express our gratitude to the many friends, comrades and colleagues who shared in his work and struggles when he was alive, and who have contributed to sustaining and building on his legacy, now that he is no more with us.

David, you lived a full and committed life and your legacy will live on through those you inspired and through your words, some of which are represented in this volume.

T. Sundararaman | Bridget Lloyd | Fran Baum
On Behalf of People's Health Movement

Amandla! Ngawethu!



1

Tribute to David Sanders from the People's Health Movement

Fran E Baum, Hani Serag, Bridget Lloyd

On behalf of the People's Health Movement, we would like to pay tribute to David Sanders.

David Sanders' sudden death on Aug 30, 2019, led to an avalanche of tributes to his passion, commitment, ability to inspire, and intelligent use of evidence in the struggle for social justice and to improve the health of the world's poorest people.[1] His contribution was summed up by the South African Minister of Health Zweli Mkhize when he said David "was a fierce critic of the impact of neoliberalism on the health of people. He was not only an accomplished researcher, academic and mentor to many but also a leader of social movements, including the Peoples' Health Movement".[1]

What marked out David's life was that he managed to bridge the often-divided worlds of academia and activism. He had a great intellect and used this to pursue research in the service of health justice. He always insisted on having the best evidence possible for improving health equity. Camila Giugliani of People's Health Movement Brazil noted in her tribute that David was "an example of an activist who has had the courage to fight injustices, always, and of a professor who has made the best use of his knowledge and academic achievements to bring light to the struggle for health for all".

Globally, David made a massive impact through the People's Health Movement. He was a driving force behind the First People's Health Assembly, which led to formation of the People's Health Movement. When things needed to be challenged, he did so directly, with all the facts at hand, and he was respected and heard, even by those who didn't want to hear.[1] People's Health Movement comrade Wim De Ceukelaire, Executive Director of Viva Salud, wrote in his tribute "Whenever he took the floor and grabbed a microphone, you knew people in high places became uncomfortable".

David was a warrior for global health justice—always deeply insightful in his analysis of the global political economy and fearless in speaking truth to power.

David's experience was deeply rooted in Africa where he was born and lived most of his life. As a young paediatrician in Zimbabwe, he witnessed the impact of poverty and underdevelopment on children's lives. His crowning achievement for African public health was founding and leading the School of Public Health at the University of the Western Cape (UWC) in South Africa, which enabled a generation of Africans to be trained in socially aware public health. Uta Lehmann, School of Public Health, University of the Western Cape, said "Inspired by and under his energetic, and at times demanding leadership we built the formidable School of Public Health at UWC, offering transformative public health education to students from the entire continent, conducting research and developing interventions for health systems and health programmes, always informed by a focus on the social determinants of health and issues of social justice".[1]

Throughout his career David showed political and moral passion and cour-age. With his seminal book The Struggle for Health: Medicine and the Politics of Underdevelopment,[2] published in 1985, David inspired a generation of young doctors to see their work as more than providing care and that it extends to the social determinants of health. The ideology driving David's analysis and action was deeply rooted in Marxist philosophy and a critique of the dominant capitalist system especially under the current neo-liberal regime. His book was prescient in naming the commercial determinants of health in the chapter on medicine, business and the state. He saw that the expansion of western health systems into low and middle income was part of the broader expansion of capitalism.

Concern with this trend continued throughout his life. He championed comprehensive primary health care and community health workers as a solution. Just the week before he died, The Lancet published a Comment[3] in which David pointed out that universal health coverage without primary health care was likely to benefit commercial interests rather than people's health.

David influenced an extraordinary number of people's lives through his work and activism. His close friend Louis Reynolds of People's Health Movement South Africa notes in his tribute that "few people who had meaningful encounters with David came out unchanged. They saw themselves and the world, and their place in it, in a new light. They understood that they have power, and that they could use that power to change things, especially if they encouraged and mobilised others to join them. Many of them went on to do great things and to change the lives of others".

Mary T Bassett, Harvard TH Chan School of Public Health, summed up the feeling of so many of David's colleagues when she noted in her tribute that "we don't get people like David Sanders very often: a fearless public intellectual and a good friend. The best way to honor him is to carry on his commitment to the struggle for health."

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2

David Sanders

The Democratic Revolutionary: The Formative Years

By Roger Etkind

I met David in London around 1978-79. I met him through politics, the politics of an organisation that we both separately joined called the International Marxist Group (IMG). This was the British section of an organisation called the Fourth International, which was the Trotskyist International set up in 1938. The most famous member of the IMG was neither I nor David. It was Tariq Ali, who is the one you may probably have heard of.

Democracy and the United Front

At that time, the IMG was probably at its peak – approximately 1,000 members; 1,000 cadres you could call them. It was not the biggest left organisation in Britain; the biggest was the Socialist Workers' Party. Even they were probably only around 3,000 members. So it's interesting that both I and David decided to join the IMG and not the SWP. Why didn't we join the bigger organisation? I think there were a number of reasons for that.

The most important one was the orientation of the organisation towards the United Front and towards mass organisations. I think what distinguished that particular tendency of politics in Britain at that time was that its cadres went into mass organisations. We built and respected the democracy of those organisations. We didn't try and take them over. We didn't try and set up our own mass organisations. We understood that it is only through those self-motivated, self-organised organisations of the working class and the poor that socialism will

come. It's not going to come from little political organisations running around doing their own thing. I think that attitude towards the United Front remained with David through his life, and it was a key element of his politics.

And these were interesting times in the UK . One of the mass organisations that had grown up during the 1970s was a very powerful socialist feminist movement. Classical Marxist organisations such as the IMG had to wrestle with feminism, with gender politics. What is the relationship between class politics and gender politics? There were many such big debates and it was a very interesting time to be around.

Democracy and Political Organisations

Another important aspect of the IMG was that it was an organisation that believed in the internal democracy of political organisations, unlike what is experienced in many of the political organisations that all of us have known. So, there was the right to build up, groupings around particular political positions, to form tendencies, and and then to fight for those positions in the organisation, especially in the reasonably frequent congresses of the organisation. That was another crucial aspect of democracy.

So there is a *thread of democracy* that runs through David's politics and the politics of that grouping, - the democracy of mass organisations and the democracy of the political organisation itself.

Internationalism

And then we all know about David's global footprint- about the contributions that he made and the engagement he had with democratic movements and struggles for health across so many different nations. This came from his internationalism. And his internationalism was not an accident. It was very deeply rooted in the same politics. It's a politics which understands that there is no socialism in one country. We saw what happened to those who tried to build socialism in one country. It became a repressive state and ultimately collapsed. There is no future for socialism in one country. The only future is an internationalist future.

Class Politics and Transitional Demands

When David was in the UK, he immersed himself in British class politics. Because class politics are actually international politics, he was able to develop in that direction.

Probably the most important element in that politics was what we called transitional demands. This approach arose in opposition to the sterile, falsely polarised view that, on the one hand, there are reforms that we struggle for today, and on the other hand there is the maximum programme for revolution that we

will struggle for in the future. We'll get to that maximum sometime, or sometime never, but meanwhile we will concentrate on reforms.

The idea of transitional demands is that revolutionaries raises demands during the struggle that challenge and press against the limits of what capitalism can provide. In this way, we both relate to the real, immediate needs of working class and poor people, and at the same time we challenge capitalism. That's a fundamental thought and a fundamentally important aspect of political practice and I think it's something that we need to reflect on if we look at politics in South Africa today.

In South Africa today we see too many examples of those who come from the tradition of the communist party, who, on the one hand, struggle around daily issues in quite a reformist way. Then they jump on platforms and issue volleys of revolutionary slogans. And there is no apparent link between these two things. In fact, the most "revolutionary" trade unions are actually thoroughly reformist in practice and have a conservative trade union practice.

As David often said, he did struggle for reforms and he believed in struggling for reforms, but he was no reformist. And that's the challenge, to find that route forward.

An Inspiration

It is worth paying tribute also to a key inspiration for David as he came into Marxist politics in the 70s in the UK. The inspiration came from a famous and notable revolutionary of the Fourth International, Ernest Mandel. Ernest Mandel was an underground freedom fighter during the Second World War and then became a political economist and a theoretician as well as an activist. One of the things people remember about Mandel was during May '68 in Paris. He had been on a demonstration and when he got back to his car, there it was, in flames. His response was "Comme c'est beau; c'est la revolution" ("it's beautiful, it's the revolution").

Southern Africa

While David was in London, he worked also on Southern African politics. There was a grouping in the Fourth International, led by somebody who some of you know, Claude Gabriel. It worked on looking at issues, at strategies in relation to Southern African politics. He was also active in something called the Zimbabwe Information Group (ZIG) which produced a monthly bulletin. It had a network inside Zimbabwe. ZIG was not subservient to nationalisim. It was critical of it. It's a difficult line to steer, to remain in some way related to nationalist struggle whilst at the same time not being subservient to it. I had a similar experience with the Namibian Support Committee in the late '70s and early '80s.

Interestingly, when I was in London, I didn't really know a lot of what David did. He was quite secretive about it. I didn't even know his real name for a long period of time - for me, David's name was Simon which was his name in the IMG. He was quite justifiably very nervous that if he was an open Trotskyist at that time he would not be very well received by the incoming regime of the new Zimbabwe.

I next encountered him in '82 when I went to Harare to visit him and Sue. I'd been working in London. It was Thatcher at the helm; life was grim; the Falkland's/Malvinas war was rousing the people and those of us who opposed it were very small in number and rather embattled. So I escaped initially for a month to go to Zimbabwe. There he told me about what he had initially seen when he went back to Zimbabwe in 1980. At that time, he had travelled widely around the country, and what he saw was that in the liberated areas, the parts of the country that had been liberated in the late '70s, the beginnings of an organic democracy that had grown up there. In fact he saw in the Bondolfi mission, the beginnings precisely of the community health worker system which he did his best to build in Zimbabwe subsequently. It had grown through an organic process where community health workers were elected by their local community and were accountable to that local community.

There it is again, democracy, the thread that runs through David's life. The building of grassroots, accountable democracy is the *sine qua non* of revolutionary practice.

And what David saw in Zimbabwe, and often talked about was that the organic democracy that had grown up in the liberated areas was supplanted by the new government. It was destroyed and replaced by a top-down, standardised, bureaucratic democracy that was imposed on everybody. And that was the end of something which David spent a lot of his life working to recreate.

David's Humour

We've talked, many of us, in the last days, about that other aspect of David - his humour ; and in particular that rich vein of Jewish humour. So I want to finish with a joke that David told me many years ago. I remember very few jokes, but this is one, told in David's inimitable style, that has stuck.

It's about three old Jewish men trying to impress each other about how holy they are and how devoted to god they are. They are sitting together contemplating what will happen to their worldly goods when they die. Eventually, the first one says, 'You know when I die I'm going to take 10 per cent of my wealth and I will give it to god and the rest I will give to my family.'

The second one, he was not going to be outdone, 'Me, I am going to take 30 per cent of my wealth, 30 per cent I'm going to take and give to god and the rest I will

give to my family.'

The last one scratched his head, because he was a little bit nervous and torn between his holiness and his material possessions. Eventually he said, 'You know what I'm going to do, I am going to take all my wealth and I'm going to throw it up in the air. What god wants he will take. The rest… it's for my family.'

3

The Global People's Health Movement - A Short Introduction

Fran Baum, David Sanders and Ravi Narayan

What is the People's Health Movement?

'The struggle for health is a struggle for a fairer world' Dr. Amit Sengupta at the inaugural of the 4th People's Health Assembly, Savar, Bangladesh

The People's Health Movement (PHM) is a global network formed in 2000 which comprises grassroots health activists, civil society organizations, issue-based networks, academics, researchers and activists from low, middle and high-income countries. Its activity is conducted locally through country circles and globally through a range of campaigns.

> *"The struggle for health is a struggle for a fairer world"*
>
> *Dr. Amit Sengupta*
> *at the inaugural of the*
> *4th People's Health Assembly,*
> *Savar, Bangladesh*

Underpinning all its activities is a commitment to Health For All, as it was interpreted in the 1978 World Health Organization (WHO) and UNICEF Alma Ata Declaration on Primary Health Care (PHC)[1]. This Declaration presented a comprehensive vision for PHC in that it related health services to the broader organization of society, calling for a new international economic order that would benefit developing nations, empowering democratic participation in health, and calling for action on social and environmental contexts that increased disease risks. Health services were to be multi-disciplinary, attuned to local need, and emphasize disease prevention and health promotion. Reducing the inequities between groups within nations and between nations was seen as vital and recognized in the call of Health for All by the year 2000.

Resistance to this visionary view of health was rapid and one of the strategies that such push-back from global health institutions was the call for selective PHC that followed very soon after[2]. In the subsequent decades to 2000 neo-liberalism becomes the dominant driving force behind public policy[3] and as a manifestation of this structural adjustment of LMIC economies was strongly promoted by the World Bank and IMF[4]. These developments led to increasing disquiet among health activists. It became evident that Health for All would not be achieved by 2000 and that economic inequities were actually increasing[5]. Moreover, it had become apparent that the World Health Organization had retreated from the strong support for Primary Health Care (PHC) it had under the leadership of Dr Halfdan Mahler. Driven by a continuing decline in assessed financial contributions by Member States, the WHO indicated its intention to pursue Public-Private Partnerships[6] for funding its operations. Against this background and as a counterweight to disturbing trends in WHO and successive World Health Assemblies the first People's Health Assembly (PHA 1) was planned.

Origins of the Movement

Eight networks and organizations (described in Box 1) came together to plan the PHA 1. All of them had advocated for different aspects of Health for All and some had engaged with WHO to promote rational drug policy, comprehensive PHC, consumer rights in health care, sexual and reproductive health rights, regulate breast milk substitutes, and address social and economic determinants of health.

Box 1: Founding networks and organisations of the People's Health Movement

International People' Health Council (IPHC) which was a coalition of grassroot health movements that had evolved out of situations of popular struggle (including South Africa, Nicaragua, Palestine, Bangladesh).

Consumers International (CI) is a large network of 250 member organization in 120 countries which seeks to achieve changes in government policy and corporate behaviour while raising awareness of consumer rights and responsibilities.

Health Action International (HAI) lobbies governments and international bodies (such as WHO) to formulate codes, pass resolutions and develop policies to ensure that people who need them have access to safe, appropriate and affordable medicines and these are used rationally. It monitors unethical behavior of industry including the selling and promotional practices of drug companies.

Third World Network (TWN) is a transnational alternative policy group and international network of organizations that produce and disseminate analysis, proposals and information tools related to ecological sustainability, development and North – South relations[7].

Asian Community Health Action Network (ACHAN) is a network of community health initiatives and institutions that seek to spread a philosophy of community-based health care based on self-reliant human development for the oppressed poor[8].

Women's Global Network for Reproductive Rights (WGNRR) advocates for sexual and reproductive health and rights worldwide. Based in the global south, they work with rights, justice and feminist frameworks and have a consultative status with ECOSOC[9].

Dag Hammarskjold Foundation (DHF) was created in 1961 as the Swedish national memorial to the late Dr. Dag Hammarskjold, Secretary General of the UN. It plays a catalyst role in promoting innovative ideas, debates on development, security and democracy and supported the People's Health Assembly preparatory process and its organization[10].

Gonoshasthaya Kendra (GK) is a community health development program in Bangladesh, which began during the war for national independence. GK hosted the first global People Health Assembly on their rural campus at Savar, Bangladesh[11].

The announcement of a Peoples' Health Assembly clearly struck a chord with many, resulting in PHA 1 being attended by 1500 participants from over 90 countries. In the lead up to the Assembly, activists from various networks and countries drafted a People's Health Charter which was revised and then endorsed by the delegates at the Assembly.

Since PHA 1, three further Assemblies have been held. PHA 2 was heed in Cuenca, Ecuador in 2005 and PHA 3 was held in, Cape Town, South Africa in 2012 and the fourth and most recent Assembly- PHA 4 was held in Savar, Bangladesh in November 2018. (see https://www.youtube.com/watch?v=Kmm5Hj0HNWA for video describing the event and providing some background to PHM in the voices of PHM activists). These Assemblies are in effect the ultimate governing forum where the Movement's priorities and directions are refined and endorsed. They are inspiring events which motivate PHM's adherents.

In 2019 PHM has the following networks as affiliates:

- Medicus Mundi International Network – MMI
- VivaSalud, Belgium
- Third World Network – TWN
- Health Poverty Action – HPA, UK
- Latin American Association of Social Medicine – ALAMES
- Gonoshasthaya Kendra, GK – People's Health Centre, Bangladesh
- Health Action International – HAI
- HAI Asia Pacific
- International Baby Food Action Network – IBFAN
- Resource Group for Women and Health – SAMA
- Global Justice Now
- Brazilian Center for Health Studies - CEBES
- Community Working Group on Health, CWGH, Zimbabwe
- Public Services International

The ideology and vision of the People's Health Movement

The ideology and vision of PHM drew on those of the original networks and organizations. The People's Charter for Health (PCH), adopted in PHA 1 in December 2000, enshrines PHM's vision. Subsequently, the PCH has been refined and adapted to evolving circumstances and augmented by declarations that have resulted from subsequent People's Health Assemblies and statements in response to critical global health issues (see Box 2).

Box 2: Summary of the Ideology of the People's Health Movement

Global Health context – analysis of root causes of ill-health and inequality

The PHM analysis of the global context stresses that the current paradigm of development, which is characterized by individualism, anthropocentrism and neoliberal capitalism underpins growing health inequities. This analysis notes that governments in high-income countries, working closely with transnational corporations, are promoting neo-liberal policies to manage the contemporary crisis of globalized capitalism in the interests of the transnational capitalist class. With help from a set of one-sided 'trade and investment' agreements, these policies are either being accepted by or being forced on the governments

of low and middle-income countries and their populations as well as on the majority in high-income countries. The resulting national policies that include fiscal austerity and deregulation of economic activity are having far reaching consequences for the social conditions that shape people's health, and also for the approach to and funding of health care. PHM notes that such policies are worsening the fundamental determinants of health, and progressively crippling healthcare infrastructure and delivery of services. They are also encouraging national governments to abdicate their responsibility for public health, while ushering in privatization of public goods, including health services, often through introducing insurance regimes. PHM also points to the patriarchal, racist and homophobic nature of the currently dominant ideology which also serves to increase discrimination and so affect people's health. PHM notes the threats to human and planetary health posed by conflicts, mass forced migrations and a rapidly changing climate.

Box 3: The PHM Vision

The vision developed as part of the 2000 People's Health Charter[12] still guides the movement:

> Equity, ecologically - sustainable development and peace are at the heart of our vision of a better world - a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives. There are more than enough resources to achieve this vision.

The PHM sees health as a human right which prevails over economic and political concerns. The movement is based on an understanding that action on the broader social, economic, political, commercial and environmental determinants of health is key to health and equity. It promotes comprehensive primary health care as the basis of health systems.

The PHA4 declaration states:

"We want equitable public health systems that are universal, context-appropriate, integrated and comprehensive – not discriminatory, disempowering, private and for profit. Systems that provide a platform for appropriate action on the social determinants of health including a radical shift in existing power structures".

PHM promotes - as fundamental to a healthy society - democratic participation and transparent, accountable and gender-just decision-making processes through a strong people's organization and movement.

Source: People's Charter for Health (2000)[12], Cuenca Declaration (2005)[13], Cape Town Call to Action (2012)[14] The Struggle for Health is the Struggle for a More Equitable, Just and Caring World - Declaration of the Fourth People's Health Assembly (2019)[15]

One of the unique features of PHM is that its ideological positions are developed through a dialectic between scholarly analysis and reflection on lived experience. This is seen most clearly at the Assemblies where research and analysis of the contemporary political economy of health are presented alongside testimonies from people whose lives reflect its impact. For example, analysis may describe the impact of trade deals which privilege the needs of big agricultural trans-nationals and the testimonies might include those of small farmers undermined by the trade deals. A further example is that analysis might point to the growing influence of private medicine in a particular country and a testimony might describe the ways in which private medicine discriminates against the poor. Combining the knowledge from research and lived experience encourages political debate from which PHM positions are developed and then enshrined in declarations and statements.

An important aspect of PHM's work is acting as a bridge between the local and the global. PHM works on many global issues as described below but remains rooted in a concern with the health issues of local communities. Analysis and action undertaken locally are informed by an understanding of globalized neoliberal capitalism. PHM also takes local concerns to the global level such as to the World Health Assemblies. Much of the awareness and learning which is conducted through PHM is focused on encouraging understanding of how seemingly distant and removed global economic and political dynamics affect local health issues. As an example, this process could include analyzing how vertical health programs focused on particular diseases and funded by public-private initiatives that often include large philanthropic organisations such as the Gates Foundation have had the effect of de-skilling and weakening public health services because they offer better pay and reduce the pool of people available for employment by national health systems[16]. A further example is raising awareness in mining communities of how trans-national corporations are able to evade their responsibilities concerning the negative health impacts from environment they despoil through mining activity.

How PHM is Governed ?

A sustained effort at evolving a representative, democratic governance and decision making structure for this movement, which is primarily a network of networks, has been experimented with over the years.

PHM's ultimate decision making forum is the People's Health Assembly where consensus is strived for through debate. Between these gatherings PHM is governed by a Global Steering Council (GSC) with two co-Chairs. The GSC comprises regional representatives and representatives from some of the linked networks as well as a representative of the Advisory Council. The GSC is supported by a small secretariat, whose members receive modest salaries. In 2019 the secretariat was co-located in Cape Town, South Africa; New Delhi, India and Brussels, Belgium. The GSC has a Coordinating Commission (7 members) which meets monthly normally through Skype and makes most day-to-day decisions for PHM. PHM has also established an Advisory Council which comprises people who have given long service to the movement and are invited by the GSC to join.

The Global PHM has also established campaign groups to develop and mobilize around key cross-cutting global themes. The six campaign themes current in 2019, that were further developed and adopted at the 4th People's Health Assembly are:

- Gender Justice and Health
- Environment and ecosystem health
- Nutrition and Food Sovereignty
- Trade and Health
- Equitable Health Systems
- War and conflict, occupation and forced migration and Health

These themes frame the campaigns of PHM within country circles and globally. Within each theme there are issues that are relevant globally and that have local impacts. PHM brings together the knowledge from both perspectives. Additional campaigns and groups may evolve as new challenges and insights emerge. These themes do not exclude the development of campaigns within countries on pressing national health challenges.

Governance of each country circle is varied. At one extreme is South Africa where PHM is a registered organization, while in most other settings the circle is an informal network of individuals and like-minded organizations. Country circles vary in size from a handful of people in some countries to the massive PHM in India. The PHM in India (known in the local vernacular as *Jan Swasthya Abhiyan* - JSA) is a coalition of 22 national networks, alliances, movements, resource groups and federation of NGOs, which focus on health, development, science,

women's issues, health rights of children and people who are marginalized and environmental health issues. A JSA National Coordinating Committee with networks and state level representatives plan and organize different campaigns and initiatives on different aspects of health policy. Different states have evolved their own state level networks that focus on state level policy and health challenges while also promoting and participating in the national campaigns.

Country circles are clustered into regional groupings to encourage intra and inter regional coordination, and information sharing. In 2019, these regions are: South East Asia and Australia, South Asia; India (JSA); West and Central Africa; East and Southern Africa; Middle East including Northern Africa, Latin America which comprises three four sub-regions; North America; and Europe. These regions each nominate representatives to the GSC.

Major Global Campaigns of the Movement:

Globally, in addition to the six campaign themes listed above, PHM has a series of long standing initiatives designed to influence global health debates and actions.

Global Health Watch

The PHM in coordination with several other networks, produces a regular independent, 'alternative World Health Report' -the Global Health Watch (GHW). Five of these reports have been published and the sixth is planned for mid-2021. Each edition of the GHW is different and is a collaborative exercise of a large number of individuals, academic institutions and organizations "*who share a desire to improve the state of global health and to express their solidarity with the need to tackle the social and political injustice that lies behind poor health*"[11(xi)]. GHW 5[17] had contributions from over 120 individuals and 70 organizations globally. Each GHW contains sections that analyze the politico-economic context of global health, key social determinants, trends in health systems and also includes a section titled 'Watching' in which government, international aid agencies, health and development agencies and foundations are critically reviewed. In more recent Watches, a section titled 'Resistance' features inspiring and innovative campaigns and initiatives to strengthen the Health for All movement in different countries and globally.

WHO Watch

The formation of PHM was in significant part driven by a disappointment with the role of WHO in the years leading up to 2000. These disappointments were recorded in the People's Health Charter which demanded, "*a radical transformation of the World Health Organization (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures inter-sectoral work; involves peoples organisations in the World Health*

Assembly and ensures independence from corporate interests".[18]

PHM's frustrations continued and resulted in regular engagement with WHO. Initially a WHO Advocacy Circle included annual participation in the NGO Forum for Health session at the WHA and a technical briefing on PHM and the Charter in 2003. Later PHM established 'WHO Watch' through which selected members of PHM attend the WHO Executive Board meeting held in January each year and the World Health Assembly in May. The on-the-ground Watchers tend to be younger members and so the process is a great training ground and recruitment vehicle for PHM. The deep policy analysis is supported by experienced PHM members. Through their combined efforts, and supported by PHM members around the world, detailed, insightful and policy relevant critiques of resolutions and statements presented to the governance structures of WHO are available on-line. Feedback from a number of low and middle-income country policy actors suggests that the PHM commentaries are immensely helpful in assisting many LMIC governments in drafting their policy responses and one commented "We make use of the product of WHO watch very well"[19].

PHM also attends other WHO-convened events and provides commentary on the outputs. For example, a group of PHM members attended the WHO Conference on Health Promotion in Helsinki and published an alternative declaration to the official one (https://phmovement.org/phm-declaration-at-8th-global-conference-on-health-promotion-2013/). and also published an alternative declaration to the WHO World Conference on Social Determinants of Health held in Rio in 2011 (https://phmovement.org/alternative-civil-society-declaration-at-the-world-conference-on-the-social-determinants-of-health-2011/).

The International People's Health University

The International People's Health University (IPHU) is PHM's main education and cadre-building program. From 2005 IPHU has organized short courses in different regions of the world for young health activists and new contacts of PHM. These short courses (a few days to 2 weeks in duration) are held in different languages and are hosted by different country circles and sympathetic academic institutions. They are accredited by some universities for Master in Public Health programs. The faculty are drawn from more senior PHM members and activists who share their perspectives and life journeys and struggles to inspire the participants.

- The typical objectives of an IPHU course are to:

  Deepen understanding of -

| the links between the environment and health | globalisation and the political economy of health | gender relations in relation to health | social determinants of health

- Become acquainted with health services policy, including comprehensive primary health care and health systems with a critical perspective on 'health sector reforms'
- Acquire understanding of the application of a rights-based approach to health issues;
- Enable critical assessment of 'development assistance in health reform';
- Encourage exploration of the role of meaning and spirituality in activism and social change
- Develop practical skills and concepts which will enable activists to be more effective in the broad movement for health equity

(Source: www.iphu.org)[20]

Although evaluation of the IPHUs have established that most participants have found these courses inspiring they have been met with mixed success in inspiring the participants to become active in PHM in their home country. Although some do, it is clear that more follow up after the courses could increase the extent to which this happens[20].

Health for All Campaign:

This campaign is concerned with realizing the right to health nationally and globally. The PHM website says of the campaign that it is "a global organizing framework for different mobilization actions by civil society networks and social movements around the world and aims to inform and influence governments to address structural and systemic weaknesses in the health system". Practically, this usually translates into national circles developing or participating in actions to address key current health challenges, which are unique to each country. Such actions are as diverse as a recent campaign in Ghana for improved sanitation in the aftermath of a cholera epidemic, to an ongoing campaign for a 'Peoples National Health Insurance', spearheaded by PHM South Africa, an ongoing campaign in Australia to maintain and defined the national public health insurance system and a campaign in the UK to defend the National Health Service. In addition, the six campaign themes described above offer country circles additional possible foci for organizing.

PHM has been reflective about its activism to achieve Health for All. This has best been reflected in its recent research work funded by the Canadian International Development Research Council (IDRC). This involved PHM undertaking a large multi-centre study examining civil society engagement in the struggle for 'Health for All'. Over four years, 130 activist-researchers in 10 countries produced 50 research reports and an overarching final report as the conclusion of this work[19].

Getting Social Determinants of Health on the WHO agenda

PHM was one of the groups arguing for the establishment of a WHO group that would consider what was needed to achieve greater health equity. The WHO response under the then Director General Dr. Lee was to establish the Commission on the Social Determinants of Health (CSDH). One of PHM's nominees to this Commission was appointed as a Commissioner and PHM was centrally involved in the civil society engagement of the CSDH. Moreover, PHM activists and sympathizers were members of several of the nine knowledge networks established to undertake the in-depth work of the Commission. PHM's involvement was reflected in the relatively progressive nature of the CSDH's report which included a call for attention to unfair global trade agreements, accountability of transnational corporations and action on the unequal distribution of power, money and resources which underpin global health inequities. In the 11 years since the CSDH report there has been limited progress in implementing its recommendations but at the recent World Health Assembly (May, 2019) WHO announced it was establishing a Division for Healthier Populations with a branch devoted to social determinants of health.

PHM members and sympathizers were also involved with the development of the World Health Report in 2008, the 30th Anniversary of the Alma Ata Declaration, including facilitating a technical session for WHO, contributing to some chapters and reviewing the report before finalization. PHM was also invited to attend the launch at Almaty, Kazakhstan and speak in a panel discussion. Similarly, PHM was invited to participate as a member of the International Advisory Group for the Global Conference on Primary Health Care for Universal Health Coverage on the occasion of the 40th Anniversary of the Declaration of Alma-Ata, held in Astana, Kazakhstan in October 2018. PHM expressed concerns with the official Astana Declaration in a civil society statement signed by several hundred organizations and individuals (https://phmovement.org/alternative-civil-society-astana-declaration-on-primary-health-care/).

Examples of Action in countries:

The PHM draws its lifeblood from grass roots health movements across the globe. The overarching issues that are presented earlier are translated into an impact on the health of local communities. Hence a vital component of the PHM network is its country circles. In mid-2019 there were approximately 70 active country circles. Examples of recent actions organized by country circles include:

South Africa: South Africa experiences an extremely high burden of disease including the world's largest HIV/AIDS epidemic, persisting maternal and child health problems and a growing epidemic of non-communicable disease. It has a two-tiered health system– consisting of the public and private sectors with the

latter housing most of the country's skilled health personnel but covering less than 20% of the population at unaffordable prices, maldistribution of providers and facilities, over-servicing and lack of accountability. Public sector health services that provide for the majority are weak at primary and community levels and are of variable coverage and quality with many facilities experiencing severe staff shortages and sub-optimal governance and management. In response to these challenges the government has elaborated a policy termed the National Health Insurance scheme to provide Universal Health Coverage (UHC) through a single payer system that will purchase services from accredited public and private providers. PHM South Africa (PHM SA) has played a leading role among civil society organizations in mobilizing for a 'People's NHI' whose key features are social solidarity, equity, comprehensive care and community participation. Although the recently legislated NHI Bill espouses these principles, PHM SA is concerned that private sector lobbying is increasingly influencing a deviation from these towards a scheme characterized by a multi-payer arrangement and differential coverage of sub-groups with differing employment status. The People's NHI campaign is steadily gaining traction and PHM SA is being called upon within and outside the country to advise on the potential pitfalls of UHC.

India: Starting with the preparation of five little booklets as resource for the movement in 2000, later published as a resource book[21], the JSA (PHM India) engaged with the revise National Health Policy, 2002 where JSA cautioned against legitimising privatisation and commercialization of health care in the country[22]. Next a series of public hearings with the National Human Rights Commission on the denial of right to health care were organized. JSA's continued policy engagement in various ways resulted in the National Rural Health Mission. JSA has continued to engage with health policy action and dialogue as the country develops its response to the Universal Health Coverage scheme. Many JSA state networks are responding to challenges including essential drug availability, countering commercialization and commodification of health care and specific policies like prevention of privatization of vaccine units, and all the while promoting community action for health.

Australia: action has included a campaign against the introduction of user fees to the national health insurance scheme Medicare, lobbying for improved funding for Aboriginal community controlled health services and a campaign against trade agreements that will threaten health.

Scotland held an open health assembly in which participants called for concrete proposals for collective action to reduce health inequities. This led to PHM Scotland developing a Scottish People's Health Manifesto through an approach combining participatory action-research and proactive public health advocacy.

Europe: country circles participated in the demonstration and conference "Our Health is Not for Sale!" that took place in Brussels, organized by European Network Against the Commercialization and Privatization of Health and Social Protection. Activists from PHM groups in Belgium, Italy, Croatia and France joined both events, along with members of other networks including trade unions and patient groups.

PHM's country circles are supported by an interactive manual "Building a movement for health - a tool for (health) activists" (https://twha.be/PHM-manual). This manual describes the philosophy of PHM and provides practical advice, supported by lots of examples of how to take action in support of health. It places emphasis on the value of developing networks and coalitions with other groups including those mobilizing around the environment, water rights, food sovereignty, and with trade unions, small farmers and the women's movement to campaign on issues of mutual interest.

Challenges faced by PHM:

Like any social movement the PHM faces a number of organizational and campaigning dilemmas. Some of the most prominent are discussed below.

Is PHM a popular or professional movement?

PHM is a movement of committed activists. Many PHM activists are health professionals working directly with communities or progressive academics. By their nature the global programs inevitably involve predominantly professionals and academics. However, in several countries, especially in South Asia and Latin America, there are significant numbers of community practitioners and activists. There are sometimes tensions experienced as a result of the different backgrounds of members, ranging from differing emphases in the planning of actions to differing needs in terms of resources required to participate actively in country circles. These challenges notwithstanding, PHM is continuously exploring ways to increase the diversity of its base. This has generally been easier in situations where the tempo of struggle quickens and there is broader involvement of citizens.

Language:

PHM strives to work in multiple languages. Its two main languages are English and Spanish. The People's Health Charter has been translated into over 40 languages which includes Farsi, Guarani, Hausa, Ndebele, Quechua, Serer and Wolof, most of which are available on the PHM website. At the People's Health Assemblies efforts are made to translate in to as many languages as possible using the support of public interest translators working for such organisations as Babel.

Funding: Global co-ordination on a shoestring:

The Global PHM relies on donations from its members and some small contributions from the supporting networks. In past years PHM has also attracted core funding from donors including OXFAM, Novib and Open Society Foundation. More recently donor funding has been secured for specific projects such as for strengthening global health governance – which has part funded GHW and WHO Watch to support the People's Health Assemblies. PHM has managed to maintain a small decentralized global secretariat but most of PHM's activities are the result of volunteer effort. The Global Health Watch, WHO watch and the IPHU are all primarily resourced by PHM supporters donating their time. Those on the governance structures are also volunteers.

Country circles are also largely fueled by volunteer effort. A few circles such as in South Africa and India are able to employ some staff. Funding has been obtained for an African outreach worker who has been successful in helping to facilitate new country circles in that region. The recent review of the contribution of civil society to working for Health for All concluded with recommendations for bodies which fund civil society[22]. These suggested core funding in support of social movements and civil society should be provided in order to strengthen the kind of country and global processes described in this article; processes which ultimately contribute to improved health globally. The report further recommended that funders should be aware of the limits and risks associated with tightly specified project funding. Instead of such tight funding agreements the report recommended that accountability should be based on assessment of the core directions of the organization and its integrity.

Membership or Network?

An unresolved debate within the movement concerns whether or not the PHM should develop options for individual and organizational membership and become a legally registered organization. Some argue that the movement is better as a 'network of networks' while others hold that membership with a progressive sliding scale of fees could enable the movement to be more self-sustaining but also allow for more structured representation and accountability of representatives.

Conclusion:

In the near twenty years of its existence PHM has become one of the most powerful international voices presenting a progressive alternative to the dominant neo-liberal regime which governs the health and development discourse and its directions. It has consistently spoken from the perspective of oppressed peoples and communities and argued that people's and the eco-system's health and the quest for equity should take precedence over the quest for private profit. Its

consistent role of speaking truth to power is more than ever needed in an era in which inequities are increasing and power is being rapidly concentrated among the richest people and corporations in the world. Its vision of a people and eco-system centered world offers much better prospects for health equity.

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4

From primary health care to universal health coverage:

one step forward and two steps back

David Sanders, Sulakshana Nandi, Ronald Labonté, Carina Vance, Wim Van Damme

Primary health care (PHC), codified at the historic 1978 Alma Ata Conference, was advocated as the means to achieve health for all by the year 2000.[1] The principles of PHC included universal access and equitable coverage; comprehensive care emphasising disease prevention and health promotion; community and individual participation in health policy, planning, and provision; intersectoral action on health determinants; and appropriate technology and cost-effective use of available resources.[2] These principles were to inform healthcare provision at all levels of the health system and the programmatic elements of PHC that focused primarily on maternal and child health, communicable diseases, and local social and environmental issues. PHC emphasised community participation through a network of workers at all levels who would be trained both "socially and technically".[1]

Importantly, the Declaration of Alma Ata insisted that PHC was unlikely to succeed without the establishment of a New International Economic Order (NIEO) based on ensuring the rights of states and peoples under "colonial domination" to restitution and full compensation for their exploitation and that of their resources; regulation of transnational corporations; preferential treatment for low-income and middle-income countries (LMICs) in areas of international economic cooperation; transfer of new technologies; and an end to the waste of natural resources.[3] With the 1980s rise of neoliberal economics, the UN-supported NIEO was abandoned.[4]

In September, 2019, there will be a UN High-Level Meeting on universal health coverage (UHC). UHC is concerned with improved access to quality health services and protection from financial risks associated with health care. However, UHC, unlike PHC, is silent on social determinants of health and community participation. With the global mobilisation behind UHC, the health sector will probably limit its role to Sustainable Development Goal (SDG) 3.8—to achieve UHC. This shift in policy emphasis for the health sector threatens to minimise its role in promoting other health-related SDGs such as food and nutrition (SDG 2), gender equality (SDG 5), and water and sanitation (SDG 6); and, importantly, the reduction of inequality (SDG 10), promotion of environmentally responsible consumption/production patterns (SDG 12), and mitigation of climate change (SDG 4).

Moreover, the term coverage rather than care either suggests a limited scope of care or is being used to suggest enrolment in an insurance scheme. For many LMICs, this has meant operationalising UHC through government-funded health insurance schemes. The adverse implications are seen in countries such as India, where coverage by publicly funded health insurance has neither been equitable nor led to financial protection.[5] Involving the for-profit private sector in providing health care has allowed for funding imbalances and provider capture, with more funds from these public schemes going into the private health sector, thereby reinforcing existing health inequities.[6] Insurance-based models of UHC risk being promoted at the expense of funding PHC and other public health programmes.[7]

In 2018, the 40th anniversary of PHC was celebrated at Astana,[8] where references were repeatedly made to "quality PHC" when it was clear that primary care was meant—ie, care at the first level of contact with the formal health sector. Formulations such as "primary health care is essential to achieving universal health coverage"[8] portray PHC as a means to attain coverage of health services, whereas equitable access to basic health services has always been a component of PHC. As stated in the widely supported Alternative Civil Society Astana Statement,[9] it inverts one of the means to achieving PHC whereby UHC becomes the goal. This signals the risk of further medicalisation and commercialisation of health care under the UHC model.[10] This year a report of a Pan American Health Organization High-Level Commission raised concern that reform agendas exclusively focused on the health sector, centred on medical care services and the expansion of insurance coverage, have displaced public health and the social determination of health.[11]

Although the Declaration of Astana invokes PHC frequently, it gives scant attention to the drivers of ill health and inequity. There is no hint of the need for a new global economic order for the fullest attainment of health for all, despite the

stark social inequalities and greater concentration of wealth than at the time a NIEO was proposed. Indeed, the Declaration of Astana avoids the challenge of what needs to happen from within the health sector to mitigate inequality: intersectoral action at local and policy levels, and strong advocacy from the health constituency for measures to reverse the processes leading to unsustainable inequalities and planetary destruction.[12] Instead, Astana calls for "partnership" with the private sector, notwithstanding the mounting evidence of the commercial determinants of ill-health such as alcohol, tobacco, ultra-processed foods, and industrial and automobile pollution.[13] Calling for "private sector regulation" by national public authorities to manage conflicts of interest fails to recognise that such authorities, especially in LMICs, are often unable or unwilling to regulate the private sector. The power of transnational corporations, the main vectors of the commercial determinants of health, transcends national boundaries and requires strong and decisive global action both by global civil society and international institutions. In 2018, for example, of the 100 entities with the highest annual revenues, 69 were corporations and 31 were governments.[14]

The Declaration of Alma Ata and the movement it inspired was aspirational and ambitious. By reducing PHC to a cornerstone of UHC, as opposed to an umbrella under which UHC resides, the Declaration of Astana confines the health sector to a much more restricted role. With unprecedented threats to population and planetary health, the Declaration of Astana should have been more honest, bolder, and an inspirational guide for those working under increasingly difficult conditions to make health equity a reality. There are concerns that the upcoming UN High-Level Meeting on UHC will compound this policy retreat. Replacing the lodestar of PHC with UHC threatens to be one step forward and two steps back for health policy.

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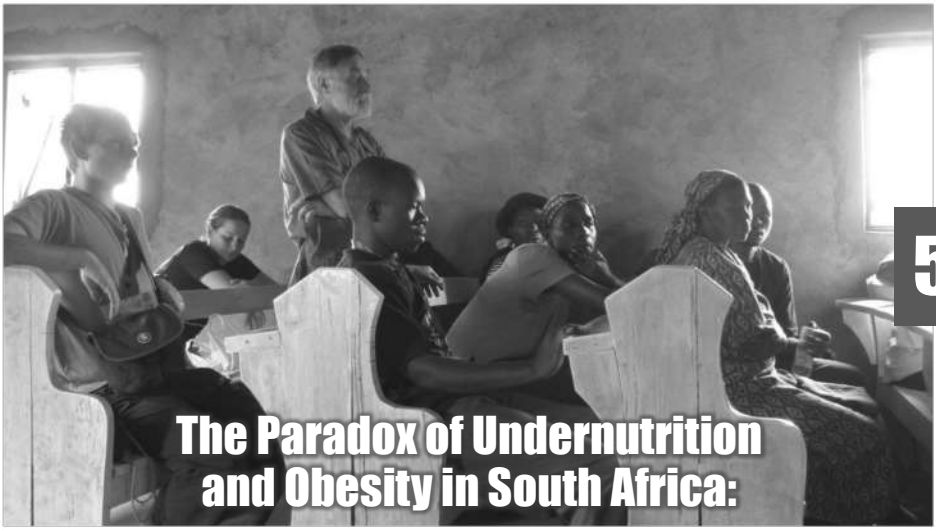

5 The Paradox of Undernutrition and Obesity in South Africa:

A Contextual Overview of Food Quality, Access and Availability in the New Democracy

Moïse Muzigaba, Thandi Puoane and David Sanders

South Africa's Historical, Socio-economic and Political Context

In 2014, South Africa was home to approximately 54 million people (Statistics South Africa 2011). The country has a rich heritage and ethnic diversity, with 11 official languages and several other indigenous languages and dialects (Steyn et al. 2006). With a Gross Domestic Product (GDP) of US$350.6 billion in 2013, and GDP growth of 1.9 % in 2013, South Africa remains the leading economy on the African continent (The World bank 2015). Within the Southern African Development Community (SADC) which consists of 15 countries, South Africa has over the years actively supported domestic and regional trade liberalisation to attract investments into the country and promote exportation of goods into other SADC countries (World Trade Organisation 2009). The country is not landlocked, has a high per capita income and is a net exporter of agricultural produce within and beyond the SADC region (Koch 2011). However, there are still some developmental challenges, many of which are a result of its apartheid legacy. South Africa had its first democratic elections in April 1994 and is currently undergoing a social transition from its repressive past to a democracy which boasts a constitution that embraces human rights and political freedom (Blaauw and Gilson 2001).

Nevertheless, South Africa's income distribution is rated among the most unequal in the world (Terreblanche 2004). The past few years have also seen the country experiencing major challenges of poverty, unemployment, urbanisation, and more

recently, increases in food and fuel prices, energy tariffs and interest rates (Department of Agriculture, Forestry and Fisheries 2014). These challenges have continued to undermine the policies put in place to ensure adequate food and nutrition security in South Africa. The Bill of Rights enshrined within the South African constitution guarantees every South African citizen "the right to have access to sufficient food, the right to basic nutrition and that the State must take reasonable legislative measures, within its available resources, to achieve progressive realisation of these rights" (South African Human Rights Commission 2004).

The South African National Policy on Food and Nutrition Security refers to food security as "Access to and control over the physical, social and economic means to ensure sufficient, safe and nutritious food at all times, for all South Africans, in order to meet the dietary requirements for a healthy life" (Department of Agriculture, Forestry and Fisheries 2014). As will be shown later in this chapter, food security for all is still not yet guaranteed. The South African National Health and Nutrition Examination Survey (SANHANES) report provides the most recent and comprehensive profile of under- and overnutrition in South Africa as well as its associated risk factors (Human Sciences Research Council 2013). This survey was conducted using a national representative sample of individuals across different age groups. Data from this survey as well as the data from surveys conducted in the past such as the 1999 and 2005 National Food Consumption Survey (NFCS) (Global Alliance for Improved Nutrition 2005; Labadarios et al. 2005) and other research articles, are used in this chapter to illustrate changes that have occurred in malnutrition prevalence over the past few decades as well as the associated key risk factors and determinants.

The State of Malnutrition in South Africa—Prevalence and Trends

Undernutrition

South Africa still faces challenges of food insecurity among certain population groups. Data from the NFCS surveys and the SANHANES study show that the prevalence of food insecurity has decreased from 52.3 % in 1999 to an estimated 26 % in 2012. However, only 45.6 % of the South African population was food secure in 2012, and 28 % were at risk of hunger. In the SANHANES study, food insecurity was defined based on a hunger index developed through the Community Childhood Hunger Identification Project (CCHIP) (Wehler et al. 1992). The CCHIP index has been validated and used internationally and is based on eight questions which represent a generally increasing level of severity of food access and whether adults and/or children are affected by food shortages, perceived food insufficiency or altered food intake due to the poor household socio-economic position Human Sciences Research Council (2013).

Stark racial disparities persist, with 67 % of African children living in poor

households compared to only 4 % of White children (Puoane et al. 2012). The SANHANES study showed that the highest prevalence of being at risk of hunger was in the urban informal—also known as shanty communities—(36.1 %) and rural informal (32.8 %) areas, compared to urban formal areas (19 %). The black African racial group also had the highest prevalence of food insecurity (30.3 %).

In South Africa, poverty and food insecurity are accompanied by undernutrition, which particularly affects young children. Overall, stunting presents a greater burden of undernutrition compared to underweight and wasting and severe wasting. Stunting represents chronic malnutrition and more accurately reflects nutritional deficiencies and illness that occur during the most crucial phases of childhood growth and development (UNICEF (2009). Based on the SANHANES estimates, the prevalence of stunting, underweight and wasting among children aged from 1 to 3 years were 26.5, 6.1 % and 2.2, respectively in 2012. For children aged from 4 to 6 years, the prevalence of each of the three indicators of undernutrition was much lower in the same year. In 1999, the national prevalence of stunting, underweight and wasting among children aged from 1 to 9 were estimated to be 21.6, 3.7 % and 0.8, respectively (Labadarios et al. 2005).

The prevalence of Vitamin A deficiency among children and Anaemia among women has decreased over the past decade but remains high, nevertheless. About 44 % of children under 5 years of age had vitamin A deficiency (Serum retinol < 0.70 μmol/L) in 2012, compared to 63.6 % estimated in the 2005 NFCS study. Similarly, the prevalence of anaemia was higher in 2005 (29.4 %) among women of the reproductive age (16–36 years) compared to 23.1 % in 2012.

Overnutrition and Associated NCDs

The high prevalence of overnutrition and its comorbidities continue to negatively affect the lives of many South Africans. Despite the high burden of poverty and infectious diseases, such as HIV/AIDS and Tuberculosis, NCDs which are in part associated with overnutrition continue to account for a larger proportion of deaths in the country. In 2000, NCDs accounted for 37 % of the total deaths followed by HIV which accounted for 30 % (Bradshaw 2000).

Surveys conducted in the past have shown that obesity is more prevalent among women than men and that it ranged between 48 and 58 % in women from different racial groups (Goedecke et al. 2006). A survey conducted in 2010 on a small sample of adults in the four biggest cities in South Africa also revealed that obesity ranged between 52 and 72 % among 500 adults who were assessed across the four cities (Health24 2010).

More recent national estimates of NCDs and major risk factors in the SANHANES showed that obesity prevalence was high among both males and females.

An estimated 19 % of males and 53 % of females in the 55–64 age groups were obese, whereas the prevalence among males and females in the 15–17 age groups was 1 and 7 % respectively. Furthermore, females had a significantly higher self-reported rate than males for high blood pressure (20.6 and 12 %), heart disease (3 and 1.5 %) and high blood sugar (6 and 4 %), respectively. For both sex groups, the reported rate of all NCDs tended to increase with age and there were no differences across the different survey regions. A study by Peer et al. (2012) also showed that diabetes has risen significantly for both men and women in the Western Cape Province of South Africa based on the 1990 and 2008 data, with the highest prevalence observed in the older population groups. Additional and more comprehensive statistics on the state of NCDs and the associated risk factors can be found in the SANHANES report referred to earlier.

Determinants of Over- and Under- nutrition in South Africa

At individual level, dietary and individual risk behaviour define people's nutritional status, health, growth and development. However, according to the World Health Organisation (WHO 2003) these do not occur in a vacuum but within a cultural, economic, social and political context, which can either aggravate or promote their health. Given, the political history of South Africa as well as its rich culture and the recent economic transition, it is important to also consider some economic, health and development trends in South Africa that may play variable roles in nutrition and health.

Undernutrition can be a result of one or multiple aetiological processes such as illness (e.g. infectious diseases), social and environmental factors (poverty and natural disasters) which are associated with decreased nutrient intake or absorption or both (Joosten and Hulst 2008). According to the SANHANES, the 1999 NFCS, and other surveys (Saloojee et al. 2007) conducted in South Africa, the leading determinants of undernutrition in the country include: low family socio-economic and education levels; sub-optimal food intake as a result of lower breastfeeding rates or early cessation of breastfeeding; lack of food; poor environmental and hygiene conditions leading to infections; HIV/AIDS; and Tuberculosis as well as recurrent infections. Under-nutrition rates are still highest among the poorest social strata, notably black South African children who reside in rural areas (Steyn et al. 2001).

In South Africa, as in many other countries, the nutritional status of the populationis influenced by multiple risk factors or determinants. These factors are modifiable or non-modifiable, and can act directly or indirectly, singly or synergistically to influence an individual's nutritional outcome. The non-modifiable risk factors of obesity comprise individual-level characteristics, such as gender, age, race and genetic makeup. The modifiable risk factors, on the other hand, include behavioural, social and structural determinants associated with

urbanisation.

Individual-Level Characteristics, Food Consumption Behaviour and Obesity

In South Africa, the burden of obesity differs according to gender. Women, particularly those of the African origin, are generally more obese than their male counterparts (Human Sciences Research Council 2013). Also, as was shown earlier, obesity increases with age. Furthermore, food consumption behaviour varies across ethnic groups. For example, in a study conducted in 2011, it was shown that 19 % of black South Africans were considered frequent (≥twice a week) consumers of street food (defined in South Africa as food prepared or cooked to be sold by vendors in a street or other public location for immediate consumption) compared to Indians (1.9 %) and whites (2.9 %) (Steyn and Labadarios 2011). However, a reverse pattern was observed when fast food consumption was measured (14, 12.5 and 5.4 % for Indians, Whites and Blacks, respectively). In a study conducted in South Africa, which included over 7000 South African women it was shown that black women and those of mixed ancestry had greater waist circumference and waist to hip ration—as a proxy for central obesity—than white or indicant women (Puoane et al. 2002).

Socio-economic Status, Food Consumption Behaviour and Obesity

There is also evidence in South Africa that socio-economic status can influence individual behaviour and contribute to obesity. Although this relationship begs further investigation, it has been shown that in some parts of South Africa obesity and its associated NCDs are high in underprivileged groups and therefore not only prevalent among the affluent (Puoane et al. 2002). This is partly explained by increased consumption of cheap processed and packaged food in rural and poor communities associated with the nutrition transition (Cordain et al. 2005).

The SANHANES study also revealed that the price of food was the leading factor which influences grocery shopping among South Africans, followed by convenience, health considerations, food taste, safety and hygiene, nutrient content and shelf life. In a study conducted in a predominantly black urban township in South Africa (Muzigaba and Puoane 2013), the authors showed that some South Africans prefer to buy less healthy food with high fat and added sugar, as this is cheaper and more readily available than the healthy food options. The same study also showed that people in this community had a low level of education and preferred eating fried food and chicken with skin as a result of inadequate nutrition knowledge. This confirms the role of socio-economic status in obesity prevalence in South Africa, particularly in the context of obesogenic environment as explained in the next section.

The Food Environment, Food Consumption Behaviour and Obesity

It is also important to consider the role of the so called "obesogenic environment" (Lake and Townshend 2006) in prevalence of overweight and obesity in South Africa. Like many other parts of the world, South Africa has also been affected by the process of globalisation with concomitant changes in food systems, notably food production, manufacturing and distribution. The changes in the food environment have been associated with a nutrition transition. South Africans are progressively changing their diets from the traditional high fibre, high carbohydrate intake to westernised diets characterised by food that is high in saturated fat, added sugar and refined carbohydrates (Steyn et al. 2001). Multinational food and beverage corporations have found a niche within the local food systems (Igumbor et al. 2012).

These include large companies such as the Coca-Cola Company; Cadbury Schweppes; PepsiCo Inc; Kraft Foods Inc; Mars Incorporated; ConAgra and SAB Miller and many other companies involved in the production and processing of dairy products; soft drinks; snacks and confectionery. More details on how these "Big Food" companies have changed the consumer food environment in South Africa can be found in the article by Igumbor et al. (2012).

The leading fast food franchises such as Kentucky Fried Chicken (KFC) and McDonalds also continue to mushroom in various parts of the country (International Trade Centre 2013). These corporations use strategic marketing campaigns to increase their market share and promote consumption of ready-to-eat and energy-dense foods and beverages which have been linked to obesity and other NCDs (Cordain et al. 2005). For example, compared with a worldwide average of 89 in 2010, South Africans consume 254 Coca-Cola products per person per year, an increase from 130 in 1992 to 175 in 1997 (Hawkes 2002).

Culture, Belief Systems, Food Consumption Behaviour and Obesity

Cultural dynamics also contribute to food consumption behaviour in South Africa. Studies conducted among black women in South Africa found that although overweight women are aware of the obesity-related risk factors, they consider themselves attractive (Ndlovu and Roos 1999). In a black culture, especially in the older generation, a woman is admired if she has some padding over the hips (Puoane et al. 2005). On the contrary, South African white girls exhibit greater body image concerns and body image dissatisfaction than their mixed race and black counterparts (Caradas et al. 2001). Another study also revealed that some South African girls associated fatness with happiness, respect and health, while thinness was associated with ill health particularly HIV and tuberculosis.

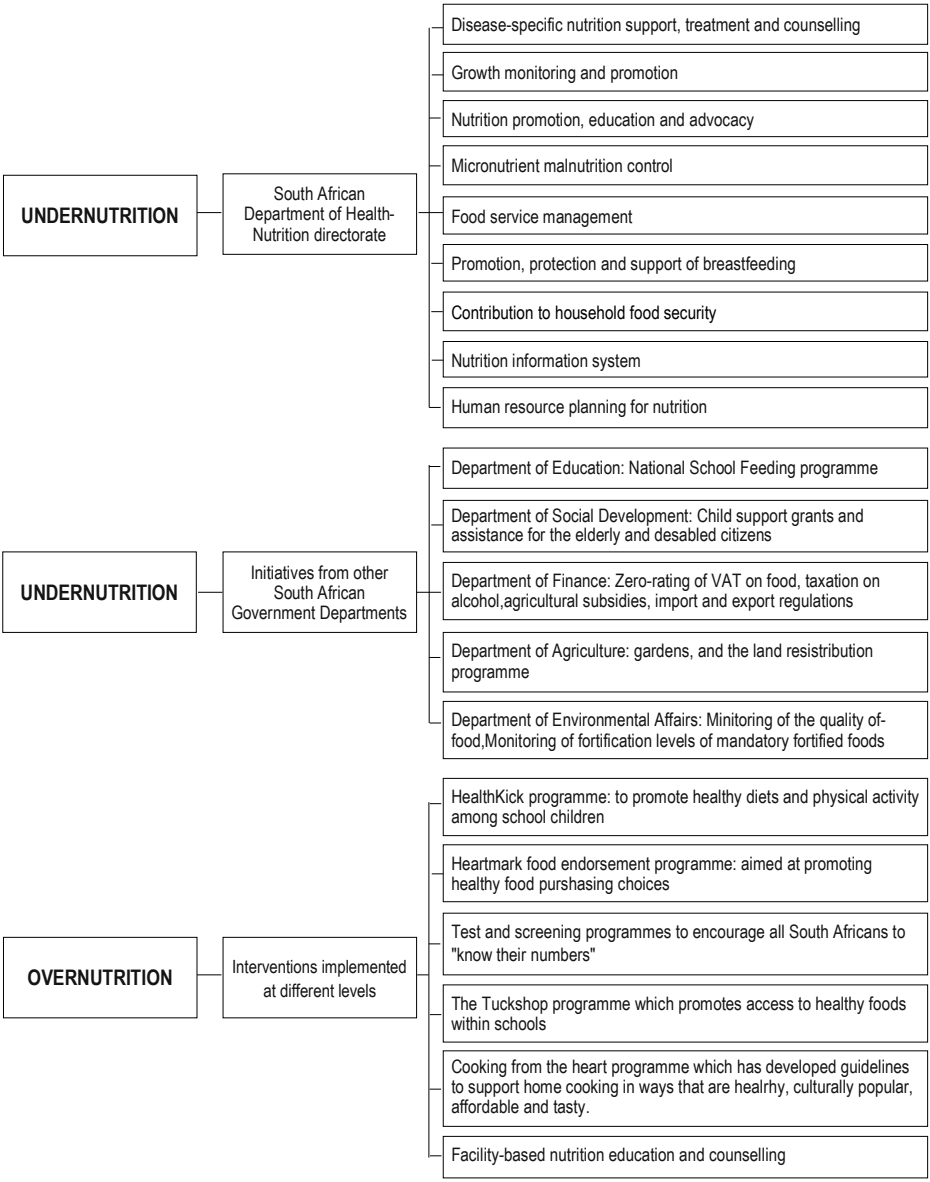

Fig. 4.1 Examples of strategies to combat under- and over-nutrition in South Africa. Sources Department of Health (2002), Swart et al. (2008), The Heart and Stroke Foundation South Africa (2015)

Interventions to Address Under- and Over-Nutrition in South Africa

A number of strategies have been formulated and implemented in South Africa to combat 'overnutrition'. These range from community-based interventions to prevent obesity and NCDs to health service management of NCDs, food-related policy responses, alcohol control legislation and food fortification of basic staples, such as bread and mealie meal, which are fortified with micronutrients, amongst others. Interventions to alleviate and prevent the burden of undernutrition also exist. Figure 4.1 illustrates examples of these strategies. However, although the Figure has been divided into two to illustrate interventions for each of the two malnutrition categories, it is important to note that some of these strategies can be and are used to tackle both forms of malnutrition. For example, the National School Nutrition Programme (NSNP) (Department of Education 2009) is used to fight both over and undernutrition. The objectives of the programme are to contribute to improving the learning capacity of all learners in needy primary schools in South Africa, to promote self-supporting school food gardens and other food production initiatives, and most importantly to promote healthy lifestyles amongst the learners. Learners are provided with daily meals based on menus developed in conjunction with the South Africa's Department of Health. The menus offer tasty, nutritious and adequate meals which must fulfil at least 30 % of the daily recommended allowance. Nevertheless, there are currently few evaluations of the NSNP, but these and anecdotal evidence suggests that the food supplied is not always optimal and may sometimes be obesogenic.

More detailed information about the large-and small-scale nutrition interventions to address malnutrition in South Africa can are available in the public domain and can be found in government policy documents (Department of Health 2002; Department of Agriculture Forestry and Fisheries Department of Agriculture Forestry and Fisheries 2014) review articles (Swart et al. 2008) as well as websites for civil society organisations involved in similar interventional efforts (The Heart and Stroke Foundation South Africa 2015).

Conclusions: Reflection and Recommendation

This chapter has summarised the state of malnutrition in South Africa and the context within which this public health and social problem exists. References to additional readings have been provided for interested readers to explore further the dual nature of malnutrition in the country. Based on the information provided in this chapter, it is evident that South Africa has a huge burden of malnutrition that is fuelled by a multiplicity of risk factors which require sustainable and multi-pronged inter-sectoral action.

There is an urgent need for concerted efforts by the government, civil society and community-based organisations, to institute and more effectively implement

nutrition-friendly policies and programmes that promote adequate and healthy diets and empower South Africans to make healthy food purchasing, preparation and consumption options. This falls within the ambit of the National Development Plan (NDP), Vision 2030, which stipulates the need for the government to continue addressing the issue of food and nutrition insecurity (Department of Agriculture, Forestry and Fisheries 2014). As outlined in the South African food and nutrition policy document, in order to ensure food availability in the country, there is a need to reform the agricultural sector and improve the country's ability to import, store, process and distribute healthy food. The document also highlights the importance of reforming domestic food markets as well as regulating food and beverage prices in a way that promotes healthy eating for the population.

The promotion of food accessibility and affordability for individual households also holds the promise of reducing food insecurity in South Africa. The National Agricultural Marketing Council has shown that there is a strong rural and urban food prices disparity, whereby consumers in rural areas pay more than consumers in urban areas to purchase the same basket of selected food products (Department of Agriculture, Forestry and Fisheries 2014). In order to achieve this, there is a need to put in place systems that are well supported to ensure sustainability. The South Africa policy on food and nutrition security recognises that the current food safety and quality control systems in South Africa are fragmented. The policy proposes a centralised food safety and quality control system with input from different players such as the Department of Health (Nutrition programming and food inspection services), the Department of Agriculture, Forestry and Fisheries (perishable products, Export Control Board etc.) and the Department of Trade and Industry (South African Bureau of Standards) (Department of Agriculture, Forestry and Fisheries 2014). It also recognises the need to institute information management systems with a mandate to generate timeous, accurate and relevant information about food accessibility and affordability (income, markets), utilisation (health, nutrition and sanitation), stability of supply (climate change) and availability (production, imports). These monitoring data will be used to conduct food and nutrition security and vulnerability analyses and to identify risk factors for these.

The policy also calls for robust and novel agricultural research and technology development. There is a need for improvements in agricultural knowledge systems to generate evidence around potential impacts of soil erosion, pollution, infestations and loss of plant and animal genetic diversity on the country's ability to produce adequate and healthy food for the population. Similarly, the potential contribution of agricultural engineering in improving food security needs to be explored by engaging in new scientific discoveries. Lastly, the policy states that the food and nutrition policy should be led by a consortium of public, private and civil society partnerships with overall leadership from government through the

National Food and Nutrition Advisory Committee (Department of Agriculture, Forestry and Fisheries 2014).

Other policy areas not included in the policy but which are equally important include for example regulation of manufacturing and retail of food substances, including legislation on salt and sugar and the regulation of placement of fast food outlets near schools, to mention but a few. The role of liberalised food trade is of prime importance particularly due to its public health implications.

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Source:
Caraher Martin and John Coveney (2016), Chapter 4,
Food Poverty and Insecurity: International Food Inequalities

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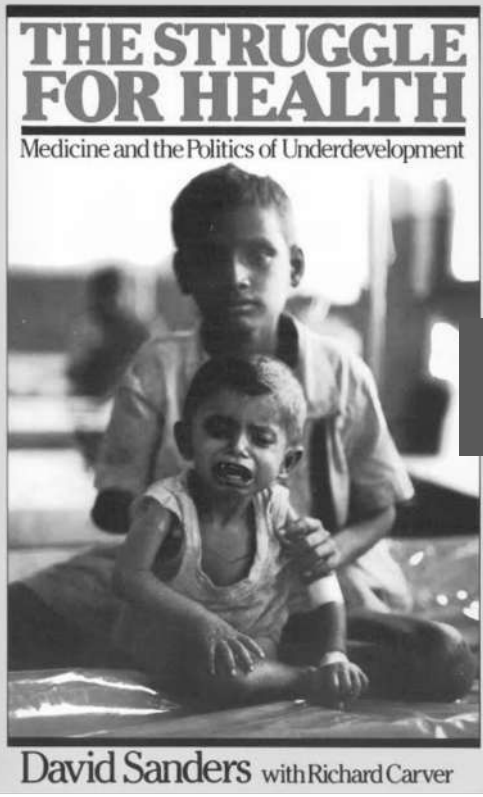
Medicine, Business and the State

David Sanders with Richard Carver

The book Struggle for Health emerged from the work David Sanders undertook for the British Volunteer Programme to provide expatriate health workers with a wider understanding of health. Struggle for Health attempts to relate poor levels of health in underdeveloped countries to capitalist exploitation, emphasizing the underlying relationships of poor and inequitable health status with socio-economic development David reviews the situation in Britain over a century and a half. This section reproduces Chapter 3 of the book



6

THE PART PLAYED BY THE HEALTH PROFESSIONS

History

The medical profession in Britain originated as one of the 'status occupations' of the leisured gentry. They possessed no specialized knowledge or skills, but derived their position from title and tradition supported by inherited wealth.[1]

Their theoretical training was restricted largely to the works of the ancient Roman physician Galen. No experimentation was taught and patients were rarely seen. Thus the university-trained physician, when confronted with a sick person, had to resort largely to superstition and quasi—religious rituals.[2]

The Crown recognized the first professional body — the Royal College of Physicians — in 1518. The Surgeons, because of their blood-spilling, were disapproved of by the Church and therefore in 1540 had to ally with the Barbers in a craft guild. The Royal College of Surgeons was recognized only in 1880. Apothecaries, of much lower social status, were reviled both by physicians and by

surgeons and were disallowed from charging for medical advice or their potions until 1815.[3]

The profession that was to emerge under capitalism grew out of these three groupings: the physicians from the 'status occupations', the surgeons from the craftsmen and artisans and the apothecaries from the tradesmen.

Women in Health Care

Women had been involved in health care from early times — mainly as midwives but also as healers. In contrast to doctors, they practised especially amongst the peasant classes. It was they who discovered and administered herbal remedies still important today such as ergot for labour pains, belladonna to inhibit uterine contractions during threatened miscarriage and digitalis for treating heart ailments.[4]

These wise women, or witches as they came to be called, believed in trial and error, cause and effect, relying on their senses rather than doctrine or faith. Their methods and results consequently posed a great threat to the Church which discredited material values and profoundly distrusted the senses. But they also threatened the emerging medical profession, who early on ensured their exclusion from the universities. English doctors petitioned Parliament concerning the 'worthless and presumptuous women who usurped the profession', and requested that fines and "long imprisonment' be imposed on any woman who attempted to 'use the practyse of Fisyk'.[5]

However, the great majority of female healers - the 'witches' - remained. This 'problem' was resolved by the witch-hunts of the fourteenth to seventeenth centuries when many thousands were tortured and burnt to death.[6]

The assault on the last preserve of female healing – midwifery – was led by non-professionals – barber-surgeons – who claimed technical superiority based on their use of the obstetrical forceps. (The forceps were classed as a surgical instrument and women were legally barred from surgical practice.) So began the rapid transformation of neighbourly midwifery into lucrative obstetrics, a business that was entered by doctors in the eighteenth century.

By the middle of the nineteenth century the only remaining occupation for women in health care was nursing. In the early nineteenth century some nurses were employed to provide token care in the hospitals which served mainly as squalid refuges for the dying poor. But most nurses were simply women who happened to be nursing someone — usually a sick relative.[7]

In order to be acceptable to doctors and women of 'good character' nursing had to be reformed. Florence Nightingale With her team of sober, disciplined, middle-

aged Victorian women in the battle-front hospitals of Crimea led the movement, and was soon emulated by Dorothea Dix in the Union hospitals of the American Civil War. This pursuit was deemed 'natural' and acceptable for women of their class.

But nursing was largely low-paid, heavy-duty housework and soon began attracting fewer upper-class women. However, the educators continued to impose their values on trainees. Until recently the teaching of upper-class graces was integral to nursing training.

Nightingale further strengthened the prevailing attitudes in society and confirmed the dominance of the male medical profession by reinforcing women's subservient role. When some English nurses proposed that nursing be modelled on the medical profession with examinations and licensing, Nightingale responded that 'nurses cannot be registered and examined any more than mothers'. She also said of the few female doctors of her time: 'They have only tried to be men, and they have succeeded only in being third-rate men'.[8] Indeed, in the late nineteenth century as the number of nursing students rose, the number of female medical students started to decline. Woman had been prescribed her place in the health care system.

The Modern Doctor

Many of the fundamental characteristics of today's medical profession can be traced to the period of the industrial revolution when the capitalist system became dominant and created an impoverished and urbanized working class – whose only source of wealth was its labour – and also the middle classes. Those gentlemen doctors without private means were now forced to seek payment for their services among these people. Public examinations replaced personal patronage as the qualification for membership of the medical profession.

Doctors also found it necessary to unify to preserve their privilege and status. So in 1834 the British Medical Association (BMA) was formed, which was initially a militant body representing those providing services under the Poor Law. In 1858 the Medical Act recognized all educational and licensing bodies and placed them under the supervision of the General Medical Council (GMC) which contained representatives of government, the universities and the profession. Medicine was thus formally linked with the State.[9]

Through the BMA and GMC a 'code of practice' was formulated whereby activities that might be detrimental to the profession as a whole — such as advertising and 'patient snatching' — were legislated against. Notwithstanding these controls, GPs continued to minister largely to working people and thus remained poor. Around the turn of the century a character in one of Bernard

Shaw's plays said:

> 'When you are so poor that you cannot refuse eighteen-pence from a man who is too poor to pay you any more, it is useless to tell him that what he and his sick child needs is not medicine but more leisure, better food and a better drained and ventilated house. It is kinder to give him a bottle of something almost as cheap as water and tell him to come again with another eighteen-pence if it does not cure him. When you have done this over and over again every day for a week, how much scientific conscience have you/got left?'
>
> *The Doctor's Dilemma*[10]

However, the specialists, physicians and surgeons, because of their long-established connection with the upper classes and the selfishly guarded knowledge, maintained their wealth and power.

Perhaps an even better example than the protracted British industrial revolution is the French Revolution when all areas of society, including medical institutions, came under close scrutiny. Two great ideas were born: first, that health care was a function of the State; and secondly, that social change could eradicate disease and return humanity to a state of original health. For a while the faculties were closed and doctors' societies and associations abolished: they were to be employed by the State. Sickness was to be dealt with at home with State-administered public assistance. Indeed, the first task of the doctor was seen as a political one; the struggle against disease was to be a fight against bad government.[11] In the words of one French revolutionary:

> 'Who then should denounce tyrants to mankind if not the doctors who make man their sole study and who each day in the homes of poor and rich, among ordinary citizens and among the highest in the land, in cottage and mansion, contemplates the human miseries that have no other origin but tyranny and slavery.'
>
> *Quality, Inequality and Health Care*[12]

However, these ideals - and many others - did not materialize. Throughout Europe the medical profession developed and strengthened — a profession that still today insists on the separation of 'medicine' and 'politics', and which in its practice and education promotes this belief. The main causes of this reverse did not lie solely in the area of medicine. All kinds of libertarian ideals thrown up in the popular struggles that swept Europe in this period soon became dreams of the past, as the previous ruling class of feudal lords and monarchs was replaced by the capitalists.

The most important way in which this new system differed from pre-capitalist

societies was in the area of production. All kinds of commodities necessary for a reasonable standard of living were now being produced on a large and much more efficient scale in factories and on farms.

In theory such ideals as 'Liberty, Equality and Fraternity' could have been realized. But in this system the means whereby these commodities were produced were owned by a very few people. The competitive nature of capitalism further accentuated this and eventually resulted in today's monopoly ownership. In practice, therefore, the ideals born in the overthrow of the old order inevitably foundered on new class divisions and inequalities.

Doctors had already secured a privileged position by an alliance with the wealthy and powerful who had helped them in defeating competition from lay healers. But with the emergence of capitalism status was no longer sufficient. In order to survive, it was necessary to possess a commodity that both satisfied a human want and could be exchanged for money. The new capitalists had their products and the workers their commodity, capacity for labour. The doctors too now needed a commodity. At this time a greater understanding of the body's structure and function – anatomy, physiology and pathology – was being gained through observation of corpses and ill patients. The invention of the microscope, one of the most advanced pieces of nineteenth-century technology,[13] gave birth to microbiology which in turn gave rise to the germ theory of disease. For the first time in history a rational basis for disease prevention and cure was established."[14]

These advances were timely since they constituted for doctors a body of knowledge which they appropriated for themselves and which became the basis for their commodity – modern health care.[15] The monopoly ownership of this commodity, health care, was consolidated by the establishment of professional associations, colleges and hospitals. Doctors now determined the entry, training, numbers and employment of graduates. In short, they controlled the production of their commodity. Similarly, they increasingly controlled its character and distribution.

But why should health care have become so inappropriate in character and inequitable in distribution? Is it because doctors — and other health workers whom they dominate w are innately insensitive? This question strikes a familiar note. When capitalism spread internationally, the capturing' of most of the world's population was not because the imperialists were particularly inherently malicious but because they were merely obeying a law of the economic system: the result was the brutal exploitation of the colonized. By the same token, although some health workers are often insensitive and even inconsiderate, their actions can only be understood as a result of the commodity nature of healthcare.

Why is Health Care so Inappropriate?

Under capitalism all production is geared to the manufacture of commodities. Commodities are produced in order to be sold for the highest price possible. The concern of the owner of the enterprise is not the usefulness of the product but the financial gain to be realized by its sale. Many expensive commodities may have little social utility. This applies also to health care as presently practised. Both in the underdeveloped and in the developed world the medical contribution is largely inappropriate to health needs and does not cope with the health problems of the vast majority.

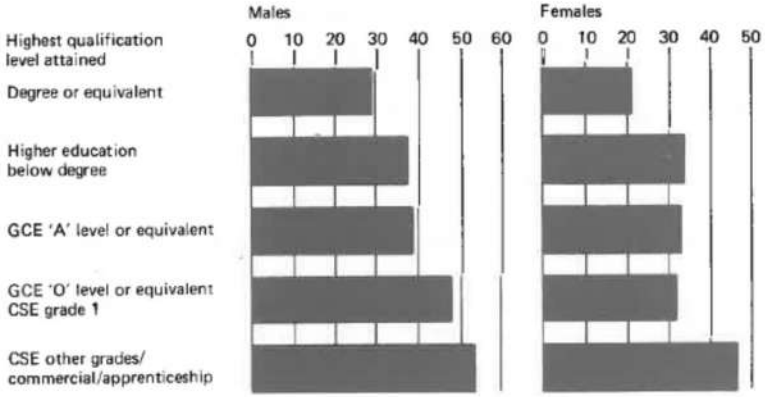


Figure 5.2 Cigarette-smoking status of current smokers aged 15 or over, by highest qualification level obtained. Results are given in percentages.

The germ theory of disease and advances in medical science created the basis for what has been termed 'the bio-engineering approach' to illness. This approach persists today where a patient is regarded as a set of systems, one or more of which go wrong in illness, and which health workers attempt to put right with drugs and high technology. But most illness in the developed and underdeveloped world has its origins in social conditions. This information is widely available. Indeed some of it is even taught – albeit in an abstract way – in medical schools. In the social medicine 'part' of the course, medical students learn of the similarity between the disease pattern of nineteenth-century Europe and today's underdeveloped "countries. But even social medicine books do not attempt to dissect the *social roots* of the new physical and psychological 'illnesses' of twentieth-century industrialized societies. For example, it is accepted that cigarette smoking is an important factor in the development of different cancers and vascular and lung disease, but few doctors question why smoking has become such a widespread habit with such a marked social-class distribution (Fig. 5.2).

Nevertheless, it is widely and increasingly acknowledged that living and working conditions and the social organization of developed societies underlie these new 'epidemics'. However, this awareness is in practice negated by concentration on a high-technology, individual-oriented, after-the-event curative approach, and the half-understood lessons of social medicine and epidemiology are largely ignored. This is illustrated by the following advertisement:

> 'Lack of space, lack of privacy, breeds unhappy people. But while society can offer little in the material sense, help is forthcoming where the effects of bad conditions are measured in human distress.
> 'Victims of overcrowding are familiar anxious faces in some surgeries. Yet their presence is often prompted by insomnia, headache, rash or other symptoms rather than their cause; anxiety or depression.

Figure 5.2 Cigarette-smoking status of current smokers aged 15 or over, by highest qualification level obtained. Results are given in percentages.

> 'The anxiety depression syndrome responds well to Limbitrol: swift anxiolytic action preceding gradual but sure elevation of mood.'

The inappropriateness of this approach is even starker in underdeveloped countries where the social origins of disease are so obvious. This is because the *fundamental* causes of ill health are out of the control of doctors. Indeed, any open recognition of the real causes would call into question the very system that allows doctors to own and market their commodity. In short, it is not in the interests of the medical profession to examine, and still less to confront, the fundamental social roots of illness.

It is not only this overwhelmingly important area of health promotion that is minimized and ignored. The medical contribution itself has been distorted in accordance with the demands of the market. Cure has become overdeveloped at the expense of care and prevention. Certain conditions susceptible to cure are highly researched and resourced. This is especially the case with those conditions that disproportionately affect the wealthy and powerful. The research goes into, say, coronary artery disease rather than a more 'class-conscious' disease like bronchitis, ort especially, a tropical one, like malaria. The most profitable sectors of the market are catered for.

The anomalies inherent in this 'free market' system are particularly clear in the fields of acute medicine and surgery, especially in countries where the market is 'free-est'. *For example, the disease pattern in Britain and the USA is very similar, yet the probability of a person in America undergoing surgery is twice as high as in Britain.*[16] The following examples emphasize this point.

Tonsillectomy is one of the most common surgical procedures. The frequency

with which it is performed varies so much that it is unlikely that the operation has any major beneficial (or harmful) effects. And though there are no known differences in the rates of tonsillitis, in Vermont, USA, the probability of having a tonsillectomy before one turns 21 is 66 per cent in one area and between 16 per cent and 22 per cent in the surrounding areas.[17] The operation is not without dangers; it results in an unknown number of deaths (possibly as many as eight) in the UK every year.[18]

Heart attack is one of the commonest causes of death among males in developed countries. While it, like nearly all other illnesses, is commoner in the lower social classes it is one of the least 'class-conscious' diseases, accounting for a high proportion of deaths in upper social classes. Since the 1960s intensive coronary care units have been developed in most hospitals to improve treatment of these cases. They are invariably expensively equipped and better staffed than other hospital facilities. Yet the first critical assessment of the efficacy of this super-technological intervention was published in 1976. *And, although it found that patients kept at home had a slightly higher survival rate than those treated in intensive coronary care units,*[19] *the latter continue to be built*!

At the same time State spending on all public services has been cut back. The caring services for the elderly, handicapped and chronic sick are becoming increasingly inadequate. Waiting lists for many beneficial but not dramatically life-saving surgical operations, like hip replacement and gynaecological operations, have increased greatly. This has mainly affected working people for the wealthier can afford to go 'privately'.

Victim Blaming

As part of the general economic crisis, inflation has affected the health sector too and cost increases are worrying economic planners. For example, General Motors claims it spent more money in 1975 with Blue Cross and Blue Shield (the major USA health insurance companies) than it did with United States steel, its principal supplier of steel. Indeed General Motors added $175 to the price of every car and truck in passing on its employee health benefits costs![20]

So a newer and more 'radical' approach is being advanced by those who yesterday were advocating the most costly, sophisticated curative techniques. The essence of this new approach 7 aptly termed 'victim blaming' by some Americans 7 is that if individuals take appropriate action, if they avoid unhealthy behaviour, then they may prevent most diseases produced by social conditions. Lifestyle and environmental factors are combined and the message is that individuals are the primary agents in shaping or modifying the effects of their environment. It is implied that little can be done about the living and working conditions of modern industrial technological society but we can do much for ourselves as individuals.[21]

It is reminiscent of earlier attitudes to disease sufferers and all-too-prevalent attitudes towards the poor and ill in underdeveloped countries. Remember the Victorian account of Snow's Rents in Westminster:

> 'There is an ease in the man's appearance which shows that his calling and his residence for many years among filth, have rendered him familiar with such scenes; it has almost made him love filth. His little girl has in one hand a bloater and in the other the Gin Bottle, the God chiefly worshipped among such people.
>
> *Health of Towns Magazine*[22]

The patent hollowness of this argument is best demonstrated for the developed world by a consideration of occupational disease. In the USA for example, 114000 people are killed and more than two-and-a-half million disabled by occupational accidents and diseases each year.[23] In the new 'radical' health ideology this is explained not by the hazards of work speed, the pollution of working environments or the danger of machinery, but by the lack of sufficient caution by the workers or even by their 'genetic susceptibilities'! And in Britain about 17 million working days are lost each year as a result of industrial injuries and diseases – considerably more than as a result of strikes – and over 500 000 reportable accidents with 1000 deaths occur annually. Yet the Health and Safety at Work Act puts responsibility for safety jointly on employers and workers – assuming that their interests in this regard are the same! It, like the American legislation, emphasizes individual initiative – the wearing of protective clothing etc. – rather than control of industrial processes. The general responsibilities of management under this Act are qualified by the phrase 'as far as is reasonably practicable'. In the current economic crisis, when safer working conditions would be 'economically unviable' and with fines for infringement ludicrously small, this loophole is likely to be eagerly used.

The unhealthy addictive habits of cigarette smoking and alcohol consumption are approached similarly. Health education attempts to persuade people to adopt healthier life-styles. Yet neither the social stresses nor advertising pressures that induce the habits are effectively confronted. In comparison with the £65 million budget spent in 1974 on alcohol and tobacco advertising, the total expenditure in Britain on health education, vaccination, immunization, water fluoridation and other specific preventive measures was £15 million.[24]

This same 'Victim blaming' argument is used in relation to the underdeveloped world's 'problems' of high population growth (solution: 'family planning') and under-nutrition (solution: 'health education') – rather than tackling underdevelop-ment.

So most people accept the proposition that illness caused by social conditions can and should be individually solved by 'professional' medical intervention or individual preventive action. Consequently any thoughts of a collective assault on the roots of illness – which are social – are undermined. This is one of the important ways in which the medical profession serves the interests of those in power and strengthens the status quo.

Why is Health Care so Inequitably Distributed?

The value of a commodity is roughly set by the amount of labour – mental and physical – expended in producing it. Ever since products first began to be exchanged, there has had to be a common, socially acceptable measure of their value – something that establishes an equivalence between items with different uses and characteristics. This measure is labour. Thus a manufactured product acquires its value from a combination of the labour time need to produce it and the previous labour time embodied in the tools or capital goods that are used.

In the case of health care this includes the labour expended by the student, the skilled labour performed by the teachers and the labour embodied in the various commodities consumed in the process of training.[25] When health care became a commodity there was therefore an incentive for the producers and owners – the doctors – to obtain as long and as complex an education as possible to *raise the value of the commodity.*

Despite the fact that much medical practice was not only unscientific but positively dangerous, the training period was very lengthy. Nowadays several years are spent on the 'preclinical' biomedical sciences although much of the detail learned is unnecessary for the sort of health care most doctors do most of the time, and is in any case rapidly forgotten by the student. So after at least 5 years of university training and 1 year's compulsory internship a 'jack of all trades and master of none' is produced. But, before this highly educated graduate can actually provide even a primary care service proficiently, several further years of experience and often specialist training are needed. The effect of such an educational system is to increase the value of the doctors' commodity and allow them a wide choice of specialization whereby their earning power can be even further increased. However, the useful skills that doctors eventually acquire can be learned in a much shorter time and far less expensively by non-professionals.

The usual arguments for this 'professional' training cite the necessity of preserving 'standards of excellence' and 'equipping doctors with the education necessary to enable them to make the weighty decisions demanded of them'.

However, these assertions are unrealistic. Most doctors, because of their class backgrounds, will have had a different social experience from most of the

population. Partly for this reason, but more importantly because of the inappropriate approach to health care already discussed, they will be unable to approach health problems sensitively and realistically. Similarly, they will be unable rationally to plan services that cater for the real health care needs of most people. Doctors want to *market* their commodity profitably. Therefore, those in private practice in developed countries will work predominantly in those localities that house the rich and will perform that sort of care – mostly high-technology cure – that can be easily sold to buyers who can afford it. *In underdeveloped countries this means that doctors are concentrated in the towns and offer a service both inappropriate to and inaccessible to most people.*

Nor does 'nationalization' of the health sector substantially overcome these problems. For doctors employed by the State medical service increase their income by climbing up the career ladder and especially by gaining a specialist qualification. Since medical skills are acquired through practice, there is an incentive for doctors to work both in the most technologically sophisticated institutions and in those specialities that provide the best possibilities for profits. Hence, even in a nationalized health service, GPs tend to work in richer localities where possibilities exist for private practice, and hospital doctors in the most technologically advanced hospitals in those centres where prospects for private practice are greatest.

Because doctors are so dominant in influencing the shape of the health sector, together with the wealthy and powerful whose diseases are most susceptible to high-technology individualized care, health services remain both inappropriate and inequitably distributed.

Summary

Doctors have not only appropriated health care as their commodity but have also determined its value. This they have done by various guild mechanisms which are by now accepted as 'natural' both by health workers and by the general public. These have ensured the profession's near-monopoly of knowledge about health. This has allowed it to pose the main questions about health in terms of itself. This prevents people learning about and acting confidently on their health problems – although most health care is in fact done by 'unqualified' people.

The other features of professionalism have resulted from the necessity for doctors to regulate the price of their commodity. This has been achieved by the guild mechanisms of controlling competition and monopoly price-fixing. Rules about advertising, under-bidding and patient-snatching are examples of this within the profession.

To avoid competition from non-guild health workers the profession strictly

defines what is a ‘doctor’ and determines all the privileges that go with it. The work of other health workers is then defined in relation to that of doctors – to whom they are sub ordinated. The scope of their knowledge and skills is regulated and they are categorized as ‘para-medical’ or ‘auxiliary’, to doctors. These are important ways in which the profession can regulate the supply of their commodity on the market, fix prices in private practice, and negotiate with governments their terms in any nationalized health service. And this is done not only at a national level by licensing bodies such as the General Medical Council in Britain, but on an international scale. For, still today, delegations from these registration bodies in developed countries visit medical schools in underdeveloped countries to assess the ‘quality‘ of their medical education and determine whether their graduates will be competent to practise in the developed country.

The international value of doctors’ health care — as with all other commodities is regulated by the most powerful monopolies.

Reproduction of the Profession

Another important way in which the price of the commodity is indirectly regulated is through selection of medical students and thus the control of the standard and supply of graduates. In Britain, despite widespread myths t0 the contrary, in recent years the social gap between doctor and patient has, if anything, actually widened. The profile of the profession has not changed greatly since Shaftesbury referred to ‘flash and fashionable doctors’ of the mid-nineteenth century (Table 5.1).

Table 5.1 Social class of medical students, 1961—6

Social Class	General Population	Final-Year Students 1961	First-Year Students 1966
1 and 2	18.3	68.9	75.1
3,4 and 5	81.7	31.1	24.2

Source: Robson, Duality, Inequality and Health Care (Chapter 3, reference 9)

Figures for the nursing profession in 1972 showed that 52 per cent chosen for State Registered Nurse training came from professional or managerial homes while only 12 percent were from the families of semi-skilled or unskilled workers.

Once selected, medical students and nurses are effectively isolated not only from the community they will eventually serve but even from other students, for entry

to medical or nursing school means virtually exclusive contact with professionals Consequently many attitudes, often already present because of social class, are reinforced by the inappropriate approach to health care that is taught, and by the organization of teaching and the example of 'superiors' — doctors and qualified nurses.

An indication of how open medical students are to being influenced by 'professional' ideas was revealed by a study in the USA which showed that one-third of junior medical students already considered themselves primarily as doctors.[26] An expression of this aspiration is seen in the way medical students often dress and talk. Not surprisingly, therefore, the scorn that most consultants pour on social medicine is readily echoed by medical students. Even when social factors are taken into account they are considered in individual terms. Illnesses attributed to unhealthy life—style 'diseases of affluence' in the developed countries or ignorance and 'over-breeding' in the underdeveloped world.

Social-class differences in health are blandly ascribed to 'more unhealthy life-styles" or 'greater ignorance'. (It is indeed difficult to ascribe worse statistics for all diseases in the lower social classes to 'more affluence!') The assumption is that disparities in living standards and inequality of access to education are "natural" and can be surmounted by individual effort.

Having been socialized in the 'professional approach' to health and health care, medical, and to a lesser extent, nursing students are taught a "professional approach' to patients. Patients are regarded as passive objects of care. Most training is done in hospitals where patients are either so ill or too intimidated by the hospital environment to be anything but passive. Patients who ask questions about their illnesses are often regarded as 'troublesome'. In fact, certain sociological studies have revealed that in the doctor's eyes the ideal patient is completely compliant, submissive, obedient and non-assertive.[27] An 'interesting' patient is one with a rare, complex and often fatal disease. The average patient with a common degenerative disease or psychological illness may be disdained. Given the social gap that we have referred to and the complex socialization process, it is hardly surprising that class distinctions are seen here too. It has been shown that patients from social classes 1 and 2 are given more time by doctors in consultation, receiving different treatment and more explanation.[28] Working-class patients are often given no explanation for their treatment or given one that is simplistic and patronizing.

In the past when neither doctors nor patients possessed much knowledge about the causes of and cures for disease, practitioners relied on mystification to maintain their livelihood. However, with the knowledge of disease that is currently available, most of which could be quite easily transmitted to patients, mystification becomes quite unproductive. It prevents patients, that is, all non-medical

people, from learning about their own bodies and understanding and dealing with their illnesses.

Doctors are reluctant to offer knowledge for fear of jeopardizing their authority and threatening their monopoly hold over health care. Also doctors find it difficult to talk to patients from quite different social backgrounds and with quite different vocabularies. This problem is considerably magnified when doctors trained in the West, or in medical schools modelled on those in the West, work in underdeveloped countries.

For here most patients not only do not understand medical terminology but do not even conceive of the disease process in terms that are familiar to most non-medical people in the developed world. For example, the notion that 'germs cause (infectious) disease' is commonplace in twentieth-century Europe and North America, whereas in much of the underdeveloped world it is literally a foreign concept.

Women and Health

Chapter 3 showed how underdeveloped countries and even underdeveloped areas in developed countries provide labour for the more developed regions. But there is in all countries an ever-present potential reserve work-force. Women are drawn in and out of employment when needed, not only on a large scale during times of boom and crisis, but also continually on a small scale when labour is required for short intervals, such as in harvesting or piece-work.

Like any other reserve work-force, because they are often temporary and therefore poorly organized and frequently unskilled, they are badly paid for long hours in bad working conditions. And immigrant workers, many of whom are female, have the same experience. Additionally, because in our societies a woman's place is seen as 'in the home', her primary task is as homemaker, not just cleaning and cooking but as nurse. Much responsibility in caring for the elderly and sick is, even today, thrust on to women. A job is therefore often regarded as less important for her than for a man and looked on as merely a part time pursuit or a way of earning 'pin-money'.

It is for all these reasons that women are poorly paid (Table 5.2). In short, the common denominator of 'women's work' is low pay for less skilled work. This is why the earnings of the vast majority of health workers, most of whom are women and immigrants, are so very low.

It is by now clear that there is a specific oppression of women as a sex, that is sexism. With the advent of private property and inheritance, a division of labour occurred according to sex. From that time assumptions about women changed fundamentally. They came to be regarded as 'natural' home-makers and 'natural'

servants although in reality this had not always been the case. In short, attitudes to women were and are still determined *primarily* by the role they play in production for society. The situation today confirms this.

Table 5.2 Women's average weekly earnings as percentage of men's fuII-time manual earnings

1950	1955	1965	1970	1974	1975
58.7	51.7	49.0	49.9	55.5	57.4

Source: quoted in Revolutionary Communist No. 5 (see Chapter 4, reference 57)

The dominant attitude towards women in developed societies remains fundamentally unchanged, yet the rapid increase in the number of women in employment during the post-war boom — and the corresponding decline in the proportion in the homes — has been the basis for the development of a powerful women's movement. Many women have started to challenge the assumptions about their 'natural' role.

Although most health workers are female, the vast majority of doctors are male. In the USA, only 7 per cent of doctors are female, in Britain 24 per cent, though in the USSR 75 per cent are female.[29] While in recent years in Britain the intake of women medical students has risen to approximately 30 per cent, it is already clear that women doctors are channelled into unpopular specialities and many are restricted in their careers by the demands of their families and absence of chiId-care facilities. But discriminatory practices against women in medicine are not merely institutional – such as poor child-care facilities. They are enforced within medical schools by the 'men's club' atmosphere.

Indeed, until recent years, in one London teaching hospital, nurses (female) were not permitted to walk along the same (main) corridor as doctors and medical students (predominantly male)!

As well as most non-professional health workers being female, a disproportionate number are foreign, and the proportion of immigrants and ethnic minorities increase the lower down the scale of technical expertise one proceeds. Most doctors, particularly in the super-technological specialities, are male, white and upper class while many other health workers, especially unskilled personnel, are female, black and lower middle class or working class, apart from a percentage of State Registered Nurses (SRNs). The composition of the health work-force reflects in a concentrated form the hierarchical arrangement of capitalist societies.

Women and the Family

In a more subtle way the medical profession helps to reinforce the sexual division of labour and hence the oppression of women. This it does by emphasizing that the family is the foundation of society. This sentiment is sometimes explicit, as in the way in which unmarried mothers are often regarded. More often, however, it is implicit. This is particularly so in such sectors as geriatrics and mental handicap. In both of these cases, medical staff often condemn families who are no longer willing or able to continue to look after aged or mentally handicapped relatives. Rather than insist that society as a whole shoulder its responsibilities for these people through the State, the health professions pressure the families – and that usually, means the women – to shoulder 'their responsibilities'.

In underdeveloped countries the demands made on women are often even greater. They often have other tasks such as fetching water and growing food for the family to eat.

Women as Patients

The medical profession's perception of the ideal patient undoubtedly overlaps with the predominant male perception, and even more with the medical perception ~ of the ideal woman. Blatantly sexist assumptions are quite explicit in many medical textbooks, particularly those dealing with obstetrics and gynaecology. One such widely used work, published as recently as 1975, asserted: 'The traits that compose the core of female personality are feminine narcissism, masochism and passivity.'[30]

The strength of such attitudes justifies the particularly unsympathetic way women patients are treated by the health profession. Women who manifest the illnesses of developed societies are dismissed as inherently neurotic. Their complaints are assumed to be 'psychosomatic' even when they may not be. Seldom is the isolation that many women (and some men) experience implicated in their depressions. It is seldom that better housing or nursery schools are provided, but almost invariably an antidepressant is! In 1972, tranquillizers, hypnotics and anti-depressants accounted for about 17 per cent of GPs' pharmaceutical expenditure and twice as many women as men are receiving prescriptions of this kind.

A more recent survey by Woman's Own also found that one in four women were taking tranquillizers or sedatives, usually Valium (diazepam) or Librium (chlordiazepoxide). According to one woman, 'My new doctor has signed a prescription for sleeping tablets every time I ask the receptionist, but not once has he asked to see me'.[31] Similarly, the medicalization of childbirth has resulted in 'planned delivery' that is, planned by and for the medical staff, and is a lonely dehumanizing, conveyor-belt type experience for women. These medical

instances of women's oppression are experienced especially by the least powerful and least vocal social classes.

Racism

The sexist attitudes doctors have towards patients are not merely a reflection of the attitudes prevalent in society but are actually reinforced within their medical practice. Much the same can be said about racial attitudes. Doctors in developed countries may be racist because of their ethnic origins and the racial attitudes they are imbued with in society. These notions of racial supremacy are likely to be strengthened by the racial stratification within the health work-force, which is assumed to be because doctors, mostly white males, are innately intellectually and technically superior to black females. These attitudes are further fuelled by such widely promoted assumptions that 'Overbreeding' is an 'inborn', 'natural' characteristic of blacks. Indeed, there is evidence that coercion has been employed in persuading black mothers in Britain both to have abortions and to be sterilized.

The injectable contraceptive drug Depo Provera (DP) has been widely dumped in the Third World, because it is well established that it has a number of dangerous and unpleasant side-effects. But it is also used on black women in the developed countries. For example, in 1977 in the London Hospital, Whitechapel, two-thirds of the women given DP were Asians. The medical profession is also complicit in racist 'virginity tests' carried out on black women at Britain's airports. This is the account of a 35-year-old Indian woman who arrived at Heathrow Airport to meet her fiancé:

> 'I was sent for a medical examination by immigration officials: A woman told me to take all my clothes off, I was given nothing to cover myself with no dressing gown or blanket although I asked for one. I waited like that for 20 minutes.
>
> 'Then a man doctor came in. I asked to be seen by a lady doctor, but they said no. I was most reluctant to have the examination, but I didn't know whether it was normal practice here. So I signed the consent form. I was frightened that otherwise they would send me back.
>
> 'The doctor was wearing rubber gloves and took some medicine out of a tube and put it on some cotton and inserted it into me. He said he was deciding whether I was pregnant now or had been pregnant before. I said that he could see that without doing anything to me.
>
> 'I have been feeling very bad mentally ever since. I was very embarrassed and upset. I had never had a gynaecological examination before'

This test took place at a time when the British Government claimed to have

banned them. Such tests would be intolerable even if they achieved what they claimed. In fact they would not prove whether a woman was pregnant and might not even prove whether she was a virgin. Their purpose can only be to humiliate the woman.[32]

Conclusion

Because of its narrow class background and its material interest in preserving the status quo, the medical profession retains an unquestioning belief in the values set by the ruling class and institutionalized by the State. Indeed, in the way it relates both to workers and to patients, it reinforces both sexist and racist assumptions. This 'medical consciousness' is transmitted first to other health professionals and then generalized to the population.

The medical profession believes itself to have a monopoly of the knowledge necessary for the health of the people. The two words 'health' and 'medicine' have become virtually interchangeable in the popular consciousness. Thus people are actively discouraged from seeking non-medical causes – and therefore remedies – for their illnesses.

In short, one of the important effects of the health-care system is to support and reinforce the present arrangement of society. So, it is now possible to answer the earlier question: *What other functions might health care systems have in society*?

The health professions, under the dominance of doctors, have in large measure determined the nature of health care and the distribution of health care resources. But what of the other social forces that have participated in this historical process? The most important instances of popular pressure in stimulating certain improvements in health and health care in Britain were:

(1) The struggle over the institution of the First Public Health Act, where the medical establishment and water companies were greatly opposed to such legislation.

(2) The struggle for reforms in welfare legislation which resulted in the National Health Insurance Act of 1911, opposed only by medical interests.

(3) The struggle to set up the NHS, where a section of the medical profession, represented by the British Medical Association, was a consistent opposition force.

THE PART PLAYED BY BIG BUSINESS

In general business interests and their representatives in government have resisted pressure from the people for improvements in living and working conditions and provision of health services: However, in some situations, business interests have recognized it to be in their interests to support certain reforms and social

provisions. The best demonstration of this is the 1911 British National Health Insurance Act. This Act gave, for the first time, a measure of health care free at the time of use. However, it applied only to working males, while unproductive sectors of the population such as wives, children and the unemployed were left to fend for themselves in the private sector.

The Act reflected not just the demands of the people but also the needs of big business, which required a healthy working population for the rapidly expanding industries, and also the needs of the State, which required a healthy fighting population for the wars of colonial expansion. For it was reported that the recruits for the Boer War manifested 'the gradual deterioration of the physique of the working classes from whom the bulk of recruits must always be drawn'.[33] And towards the end of the First World War it was revealed in a Ministry of National Service Report that only one man in three was medically fit for military service.[34] Not surprisingly, therefore, the representatives of business interests in the government – the Conservatives – voted unanimously in support of the Act. It was only medical interests that remained opposed.

However, medical interests have not, for the most part, been in conflict with the State and business interests. Indeed, they have helped create the conditions for the continued operation of business interests and have even linked up with business in opposing the struggles of the people for health. *This alliance between medical and business interests has existed for a long time but it has become increasingly prominent over the last few decades.*

The Private Health Sector

In Britain in 1948 private health insurance schemes catered mainly for a small section of the middle class. The growth of these schemes has depended on tax relief and especially on their access to NHS facilities at low cost. By 1978 nearly two-and-a-half million people were covered by private health insurance, compared with just over half million in 1955.[35] They have fostered a corresponding increase in part-time private consultants. The board members and directors of these schemes are businessmen and eminent doctors. Many of the latter and most part-time private consultants receive 'merit awards' and also occupy influential positions in the Royal Colleges and on the staff of teaching hospitals. The already inappropriate development of the health service is further distorted by the influence of these powerful professionals who help decide siting of medical schools, plan medical training, and in the many other ways help to 'socialize' medical students and doctors.

In purely economic terms, it is well established that the private sector is a parasite on the NHS. The relationship between these sectors is analogous to that in the underdeveloped world between the developed sector of the economy, catering

mostly for the external market, and the underdeveloped sector, where the majority lives.

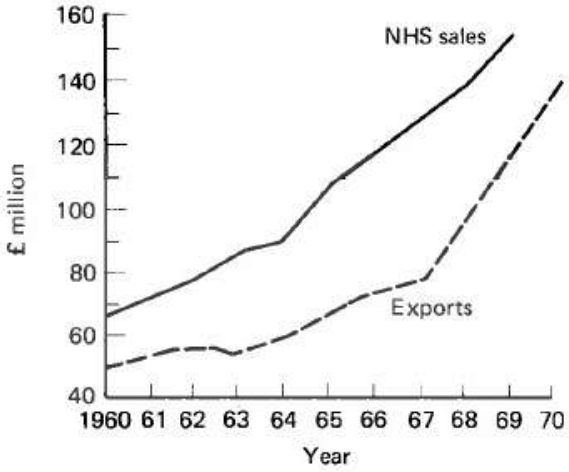
A similar thing happens in the case of professional health workers. Doctors and nurses — trained at public expense — are increasingly being supplied to the NHS at double the cost of their counterparts in the NHS by locum agencies. The rapid growth of nursing agencies has been ensured by chronic understaffing and poor pay and the need for a mobile pool of trained nurses in the NHS.

Accompanying the cuts in the NHS referred to earlier there has been a rapid growth of the private health sector. This has included not only the building of large numbers of hospitals but even the 'privatization' of services – catering, cleaning, laundry – in NHS facilities.

The Drug and Medical Supplies Industry

Spending on drugs has increased rapidly over the past 20 years not only in the NHS but in all developed countries' health services (Fig. 5. 7). More is being spent now on drugs in the NHS than on the GP services.

Figure 5.7 British drug industry: expenditure. (Courtesy ABPI.)



In 1970, profit from the sale of drugs to the NHS amounted to £70 million and it continues to increase.[36] The drugs industry has a vested interest in ill health, as the chairman of Beechams indicated in his 1972 annual report:

> 'The pharmaceutical side of the business, including proprietary medicines, was clearly not helped by the very low level of winter sickness throughout the Northern Hemisphere'.

Table 5.3 Percentage return on capital employed in the pharmaceutical and comparable industries, 1963-5

Year	Chemicals	Food	Drink	Pharmaceuticals
1963	13.2	15.9	13.8	16.1
1964	13.9	14.9	14.5	17.8
1965	13.5	14.7	14.7	19.9

Source: Quoted in Robson, Quality, Inequality and Health Care (Chapter 3, reference 9)

However, pharmaceutical companies still manage to make the highest profits when compared with other sectors (Table 5.3).

However, even these averages mask their exorbitant profits. For example, in Britain in 1973, Boots and Beechams showed 45 per cent and 41 per cent return respectively on capital employed. Similarly, Merck, Sharp and Dohme, the second largest drug manufacturer in the USA, enjoyed a 50 per cent return on capital in 1973.37 One indicator of the driving concern of the drug industry is that it spends more on advertising than on research. The advertising budget of over £300 per year for every British doctor covers, in addition to mountains of mailed literature, such subtle promotional gambits as free gifts ranging from stethoscopes to bed-socks embroidered with the drug's name.[37]

The crucial role doctors play, sometimes unconsciously, in the current operations of the drug industry is revealed in the statement of a Geigy delegate at a 1970 seminar on marketing:

> 'All of us recognise the end purpose of our efforts in the area of physician technology. It is to identify those segments of the physician population which contain our best customer prospects. . . . By far the most important criteria is estimated or observed prescribing volume. Informal spot checks of local pharmacy files, plus conversational exchanges with pharmacists themselves afford the most direct evidence of high-level prescribing . . . the classifications of each physician are then coded into the company's promotion units and used to control the number of detail calls, sampling practices, direct mail advertisements and so forth. . . . Geigy categorises physicians primarily on the basis of judged overall "prescribing productivity".'
>
> *Take a Pill*[38]

Those doctors with 'high prescribing productivity' – defended vigorously by many as their 'clinical freedom' are those most susceptible to the persuasive power of drug representatives.

Table 5.4: Promotional Expenditure as Percentage of Sales Costs to Retail Pharmacist

Antacids	13.9
Cough and Cold Preparations	12.9
Anti-Obesity Preparations	11.1
Sedatives and Hypnotics	10.3
Cardiovascular Preparations	4.3
Diabetic Therapy	1.3

Source: Robson, Take a Pill[39]

A confirmation of the economic importance that drug companies attach to promotion is revealed by considering expenditure on advertising different preparations (Table 5 .4).

Clearly those drugs used for the least easily definable conditions and whose effectiveness is questionable are most heavily promoted. And the 47 million prescriptions for psychotropic drugs alone in Britain in 1970 show that the drug companies are not being wholly unsuccessful![40]

But in this area too the link between business interests and medicine is not just informal. For, while most significant advances have been the result of research discoveries in publicly-financed institutions ~ hospitals, universities and research centres W subsequent commercial development has been by the drug companies, and the *profits* accrue to a few individuals with financial interests. In fact a body, the Medico-Pharmaceutical Forum, has been set up in Britain by the drug companies and the Royal Colleges to promote closer links between medical faculties and the drug industry. Some members of the medical profession even act as paid advisers to industrial concerns. In the USA the links between big business and the medical profession are even more overt.

Apart from the direct *economic* burden it imposes on any country's health services and thus on the taxpayer, the drug industry also shifts the focus of society

and the research resources committed by it away from the fundamental causes of ill health. So, as cardiovascular disease in the developed world assumes frightening proportions, 'after the event' cardiovascular drugs constitute one of the fastest growing sectors of industry. Yet the root causes of this disease remain under-researched.

Moreover these 'breakthrough' drugs are not without their risks. Practolol, one of the first of them, was withdrawn after severe side- effects, including blindness and even death. The Thalidomide disaster is even better known, while many of the barbiturate and non barbiturate hypnotics (sleep- inducing drugs) encourage dependence and addiction. In fact it has been estimated that at least 400 000 people in Britain are on long-term treatment with dependence-producing barbiturates!

Conclusion

From all that has been said it becomes clear that the history of the medical contribution, like all history, is one of conflicts and relationships between certain social forces. In the case of health services these forces are medical interests, business interests and the State on the one hand, and the people on the other.

Business interests are the owners and controllers of finance, industry and property and specifically of the water companies in Britain in the past, and private health insurance schemes and the drug and supply industries nowadays.

Medical interests are that sector of the medical profession – historically the dominant sector – that has consistently allied with business interests.[41]

The State is broadly all those agencies, institutions and groupings through which the class dominating the economy assumes political power to become the ruling class 1n the Western developed countries and in most underdeveloped ones, the State is a capitalist ones Because capitalism is fundamentally competitive there will be conflicts at different times between different sectors of the capitalist class. Then the State has to act as a mediator between these different groups. This is how, occasionally, the State has even intervened against the combined opposition of medical and business interests to promote measures that, in the long term, have turned out to be in capitalism's best interests. The most notable examples of such State interventions in Britain were during the cholera epidemics of the 1830—505 and again in 1948 with the introduction of the National Health Service.

THE MEDICAL CONTRIBUTION IN THE UNDERDEVELOPED WORLD

Chapter 4 showed that the early truncated health services provided by the colonial State were directed towards caring for the colonial administrators and their

dependants and maintaining a healthy labour force. And, the mission health services, although their overriding motive was evangelical, did not differ substantially from those of the State.

In addition to the disastrous effects on large sections of the population of the importation of new communicable diseases, ill health was indirectly produced by the adverse effects of cash-cropping, the money economy and population movements on nutrition and environment.

One of the results of the advent of imperialist medicine was the discrediting and partial displacement of traditional practitioners, though this process was far more limited than the previous elimination of 'witches' in Europe. This was first because the medical services provided by the State were available to only a tiny minority - the settlers and urban, mining, and plantation work-force. The mass of the population who continued to rely on traditional healers were of little concern to the colonial administration. Secondly, Western-trained practitioners were few since in most colonies it was only the small European communities who could afford private medical care. Since Europeans were in any case unlikely to resort to traditional healers the competition offered by the latter did not constitute a great threat to the monopoly of private practice. However, it has already been seen how doctors have resisted the acquisition of skills by auxiliaries and it will be seen later how they have actively opposed the successful operation of non-professional village health workers in some areas.

The transplantation to the underdeveloped world of this Western medical contribution was part of the more general process of the extension of the capitalist system. Medicine was just one of many commodities now circulating in the dominant sectors of the economies of underdeveloped countries. This resulted in the neglect of health promotion, the stunting and individualization of preventive care and the overdevelopment of curative medicine and also in the gross mal-distribution of these inappropriate services.

Education

This approach to health and health care has been made possible through the transfer of medical curricula and attitudes from the developed to the under-developed world. This was initially effected through colonial educational institutions. In most independent countries that remain dominated by imperialism the same general and medical educational systems persist today. Thus in a comprehensive review of medical education in Latin America in 1973, it was shown that most medical curricula have been patterned on German, French, Spanish and new American models. All of these reflect the 'engineering' approach to understanding the body and its diseases and neglect the socioeconomic environment that caused the diseases, the emphasis is on hospital-based

technologically-oriented medicine and especially on individual, acute-episodic care, which is typical of the medical education in developed countries. Rural, ambulatory, social and continuous care were under-represented in the curricula, if not non-existent."[42]

Indeed, many of the underdeveloped countries have gone to great lengths to obtain recognition for their medical educational standards from the professional registration bodies in the developed world. One negative and extremely costly product of this has been the international migration of health workers, particularly doctors, to developed countries or even to other underdeveloped countries where a larger market exists for private practice.

The attempt to offset these losses and to improve the spread of health service personnel by developing the auxiliary grade has met with only limited success. For here too the impact of the "professional approach' on the practice and attitudes of auxiliaries has had negative effects.

The criterion for selection of medical auxiliaries is, invariably, academic attainment, which reflects social background even more than in developed countries. In Tanzania a recent investigation into the social and educational background of student medical auxiliaries found that over 30 per cent of students had received more than the minimum standard of education. They tended to come from more developed regions of the country. Between 20 and 40 per cent of students' fathers and between 50 and 70 per cent of their eldest brothers had a non -farming occupation.

The survey also looked at the attitudes that medical auxiliaries acquired in their training 4 which are strikingly similar to those found in health workers in developed countries. Both students and graduates identified the medical auxiliary with the clinical, and not with the public health hierarchy. Students saw the auxiliary primarily as a curative worker and often as a hospital worker. Male students regarded the medical assistant in the hospital as an assistant to the doctor, whereas the female students saw the assistant as a help to the nursing staff.[43] This comes from a country that has an unusually explicit commitment to a more equitable distribution of health care. So it is no surprise that similar findings on selection and training of auxiliaries come from Ethiopia and other underdeveloped countries.[44]

The Drugs Industry

It was noted earlier that pharmaceuticals in the developed world are exorbitantly priced. In underdeveloped countries prices are, as one British trade unionist has put it, 'near criminal'.[45] Whereas Britain in 1975 paid American firms $2.50 per kilogram for vitamin C, India paid nearly $10 per kilo. While a semi-synthetic

penicillin, Bristol's Polycillin, has been sold for $41.85 per 100 tablets in Brazil, the price in the USA was $21.84. Similarly the tetracycline antibiotics, costing at that time $24—30 in Europe, were being sold to Pakistan, India and Colombia for between $100 and S270. Furthermore, the cost of well-established drugs whose patents expired years ago declines in the developed countries but continues to rise in the underdeveloped.[46]

Most of the overpricing of drugs both in the developed and in the under-developed world is achieved through a mechanism that was mentioned earlier: transfer pricing. The parent company sells the drug ingredient to a subsidiary at an artificially inflated price. The subsidiary then markets the drug at a price related to the cost of the ingredient from the parent company. In this way the subsidiary's declared profits are artificially low and the real profits accrue to the parent company. Thus an investigation of foreign drug firms in Colombia in the early 1970s revealed that their profit rate was not 6 per cent as had been declared to the Colombia Government, but was over 79 per cent. The average overpricing of imported intermediate ingredients was 155 per cent. For Valium (diazepam) and Librium (chlordiazepoxide), the two worst cases, overpricing was 6155 per cent and 6478 per cent respectively! It is hardly surprising that the world-wide profit on these two drugs alone was over $2000 million.[47]

Such profiteering is possible only in a situation of monopoly control. Competition is minimized by a patent system. After a patent is registered, whether or not it is being exploited by the patent holder, no competitor can enter the market. Thus in underdeveloped countries, even those that are relatively industrialized such as India, 90 per cent or more of drug patents are foreign-owned.[48] These patents are concentrated in very few hands: in Colombia in 1970, 60 per cent of drug patents were held by only 10 per cent of all foreign patent holders. So patents preserve secure import markets for foreign companies without necessitating investment and block any potential competition.

Qualitative improvements in health will come about through far-reaching social changes. But there has been a positive, if limited contribution made by medical technology in alleviating disease and suffering. Some obvious examples are: on the preventive side, certain vaccines; and on the curative side, antibiotics like penicillin, which has helped to reduce substantially diseases such as yaws, and anti—malarial drugs. The drug industry with its highly developed international research and productive facilities is ideally placed to develop effective drugs and vaccines for diseases prevalent in underdeveloped countries. Yet in 1976 total world expenditure on tropical disease research was about $30 million a year — just 2 per cent of the amount spent each year on cancer research.[49]

This low level of investment is undoubtedly related to 'poor market potential'. It is more profitable to develop yet another tranquillizer or analgesic for the already

over-drugged but lucrative Western market. On the other hand, the people of underdeveloped countries are increasingly used in clinical trials. This has particularly been the ease with women who have in recent years been used to determine whether oral and injectable contraceptives are effective or safe for women in the developed world. For example, Depo-Provera, an injectable hormonal contraceptive, has had its licence for general use in America withdrawn because of unpleasant and potentially serious side-effects. Yet its US manufacturer continues to export under 'clinical trial' status quantities sufficient for over 1 million women in 70 different countries.[50]

If the gap between expenditure on research and that on advertising and promotion is large in the developed world then in underdeveloped countries it is truly enormous. In a recently completed study in Tanzania it was revealed that there is one drug representative for every four doctors as opposed to one for every 30 in Britain. (In Mexico and much of South America there is one drug representative for every three doctors.) Three times as much as in Britain is spent by the drug companies on each doctor. The estimated £1 million which the companies spend on 'educating' doctors about which drugs to use is more than the £800 000 annual budget of the faculty of medicine![51]

A British doctor who studied this situation advanced three reasons for the drug companies' concern with the Tanzanian market – and no doubt similar reasons apply for other underdeveloped countries. First, each doctor in effect controls on average more than three times as much as a British doctor will spend on drugs. Secondly, the rate of increase in drug spending in Tanzania is 33 percent per year as compared with 10 per cent in other countries – also, a rapid increase in the number of health workers ensures an ever-increasing market for the drug if doctors can be persuaded to advocate its use. Thirdly, drug company representatives are often the only source of information about drugs, little counter-information being available.[52]

The promotional methods used in underdeveloped countries are similar to those in developed countries. Apart from the familiar free gifts, drug company parties and free samples for doctors, there is the fact that drug advertisements in Tanzania (and most other underdeveloped countries) do not include prices, and drug representatives have easy access to government medical stores where they can influence ordering of stocks.

Taking advantage of the fact that in most underdeveloped countries the regulations governing advertising, packaging and labelling of drugs are weaker, representatives suggest hazardous drugs for the treatment of minor conditions. The risks or side-effects are minimized.

Yet given that many drugs, available only on prescription in developed countries,

can be bought over the counter in much of the underdeveloped world, the need for adequate labelling and warnings is even greater.

For example, in the USA the analgesic drugs dipyrone and aminopyrine can only be prescribed for patients with terminal cancer. Since 1964 the packages have had to carry a label: 'Warning - this drug may cause fatal agranulocytosis' (failure to produce the white blood cells which protect against infection). However, in the African Monthly Index of Medical Specialities (MIMS), which includes information provided by drug companies about their products and is sent free of charge to all African doctors, there are drugs containing aminopyrine produced by Ciba-Geigy, Sandoz, Hoechst, Ravensberg and Polfa. While some preparations any a mention of 'very rare' agranulocytosis, several are advertised as 'having a wide margin of safety' and their use suggested for such complaints as toothache, sprains, headache, gynaecological pain and 15 or 20 different indications. Furthermore, in many countries it is possible to buy these preparations without prescription.

In 1977, drug regulatory bodies in a number of countries including Switzerland, recommended the withdrawal of aminopyrine Ciba-Geigy, the Swiss multinational, said that it would reformulate all aminopyrine products. Yet in 1979 a Ciba-Geigy representative was distributing samples of Cibalgin, an analgesic tablet containing aminopyrine, in Maputo in Mozambique. This case came to light when an English teacher bought some Cibalgin tablets without prescription in Beira. Within 4 days she was suffering from the symptoms of agranulocytosis and almost died. This case is known because she was a foreigner. It is not known how many Africans may have suffered and died from this condition.[53]

Similarly, use of the powerful antibiotic chloramphenicol which produces an infrequent but fatal blood disorder is restricted in the USA to patients with the life-threatening infections of meningitis and typhoid fever. In South and Central America, Africa and Asia the multinational corporation Parke-Davis promotes its use for a variety of minor infections and in many countries it is available without prescription and often there is no mention of side effects. In 1972 the annual meeting of the Warner-Lambert Company's Parke-Davis division considered the following resolution: 'That the company should include the same details of the toxicity of chloromycetin in package inserts and advertisements for other countries as are required by US law for promotion in the USA'. Ninety-seven per cent of the shareholders voted against![54]

As these instances show, the foreign drug companies are responsible for the suffering of a large and unknown number of recipients of their irresponsibly marketed products. The following statistics for Tanzania — which are certainly not extreme W also show the debilitating impact of the drug multinationals on the health services of underdeveloped countries.

(1) In 1976 spending on drugs accounted for 22 per cent of the recurrent budget of the Ministry of Health: by 1980/1 the drugs bill was projected to have consumed 40 per cent.

(2) Over three-quarters of all money spent on drugs is used by hospitals although much of the expenditure, especially in large hospitals, is not on life-saving drugs, but on sedatives, tranquillizers and antidepressants.

(3) The money spent at the country's university hospital each year on Avafortan and Baralgan (two aminopyrine/dipyrone analgesics), Valium (21 relaxant) and Melleril (a mood-stabilizing drug) could be used to protect half a million children against malaria.[55]

The Baby-Foods Business

As in the developed world the pharmaceutical industry has had the greatest impact among medical business interests on the health services of underdeveloped countries.

However, it is the baby-foods industry that has probably attracted most attention. This has mainly been a result of the vigorous campaign in recent years to expose the milk companies' activities. These have been described in detail in a report entitled *The Baby Killer*.[56]

Human breast milk is nutritionally superior to artificial formulas (Fig. 5.9). It protects against infection. Breast feeding acts as a contraceptive, both directly through its hormonal effects and often indirectly for cultural reasons. Yet in the past few decades the practice has declined considerably both in the developed and in the underdeveloped world. In Chile where the fall has been extremely marked, 95 per cent of 1 year olds were being breast-fed 20 years ago. Now only 20 per cent of infants are being breast-fed at 2 months! In Jamaica a survey revealed that nearly 90 per cent of mothers started bottle feeding before 6 months. In Ibadan, Nigeria, where traditionally breast feeding continued for up to 4 years, over 70 per cent of mothers surveyed recently began bottle feeding their babies before they were 4 months old.[57] In Britain today breast feeding is practised very uncommonly. In 1946, 60 per cent of infants were breast fed to 1 month, in 1970—1 possibly as few as 8 per cent. A recent revival in breast feeding among some of the middle and upper classes is reversing this trend.[58]

A number of problems results from this decline in breast feeding. Diarrhoea – a water-related disease – is an important cause of illness and death among infants and children in underdeveloped countries. Breast-fed infants are not immune to bowel infections, but they are considerably protected not only by antiviral and antibacterial factors present in breast milk, but also by being spared exposure to infective organisms present on sometimes inadequately sterilized feeding bottles.

Under-nutrition can lead to more frequent and more severe diarrhoeal attacks and is aggravated if, as often happens, the powdered milk is over-diluted.

Research performed recently in Chile showed that babies who were bottle fed during the first 3 months of their lives suffered treble the mortality rate of their breast-fed brothers and sisters.[59] Similarly, in a recent study of 339 children admitted to hospital in Manchester, England, 79 per cent were under 12 months of age and only one was being breast fed.[60] This relationship between early weaning on to breast-milk substitutes and disease and death has been documented for India, Jamaica, Jordan and Arab communities in Israel.[61]

Access to reasonable quantities of safe water is extremely limited in Africa, Asia and Latin America. Very few mothers can carry out the instructions of the baby food companies 'to wash your hands thoroughly with soap each time you have to prepare a meal for baby'.[62] Nor is it possible for more than a small minority to follow the *Cow & Gate Babycare* booklet for West Africa and 'place bottle and lid in a saucepan of water with sufficient water to cover them. Bring to the boil and allow to boil for 10 minutes'. The vast majority of West African mothers have the use of one pot and a wood fire– a far cry from the gleaming aluminium saucepan and electric stove pictured in the brochure. Furthermore, although Nestlé's products have accompanying instructions leaflets in the main languages of the countries of sale, most mothers in underdeveloped countries are illiterate even in their native language. Finally, Cow & Gate's argument that their product '. . . is a complete food for babies under 6 months and can be used as a substitute for breast feeding. . .' takes no account of the widespread, often desperate poverty. For example, in Nigeria the cost of feeding a 3-month-old infant is approximately 30 per cent of the minimum urban wage and for an infant aged 6 months it is 47 per cent.[63] There is no explicit indication on the labels of baby milk tins of how long a baby can be fed from the contents. Combined with illiteracy and poverty, this leads inevitably to the preparation of over-diluted feeds.

Here are all the ingredients for the fatal cycle of under-nutrition and bowel infection. And in the developed world bottle feeding is increasingly being implicated in the development of childhood allergies and even in unexplained infant 'cot deaths' as well as obesity and its attendant problems in adulthood. Small wonder that the feeding bottle has been termed 'the baby killer'. Perhaps the most callous example of the exploitation of mothers and children comes from Nigeria. The government there recently took tough action against two firms who were selling custard powder – that is, corn starch, flavouring and colouring – as baby food. The food was packaged and labelled in Lagos after being exported to Nigeria by a British company, Bestoval. The label read: 'For strong growth of your baby insist on nothing but Daily Baby Food Custard Powder.' With none of the proteins, fats, minerals and vitamins needed for proper growth, 'nothing but'

custard powder would soon starve any baby to death.[64]

Why is it then that breast feeding has declined so much and been replaced by bottle feeding which is clearly so inappropriate and even dangerous in under-developed countries? The impact of capitalism or rural pre-capitalist societies has been the underlying factor. It has resulted in a large increase in the proportion of women in waged employment who are discouraged from breast feeding. This situation has been reinforced by the attitude that regards the breast as a cosmetic sex symbol rather than a source of nourishment.

But in order to move from breast feeding it is necessary for an alternative form of infant feeding to exist. It is this 'alternative' that the baby-food companies have vigorously promoted. They justify their operations by asserting that a large proportion of mothers are unable to breast feed and therefore have to rely on breast-milk substitutes. Yet a survey in rural Nigeria found less than 1 per cent of mothers with serious breast-feeding problems, and 2-3 per cent who had temporary trouble because of illness still managed to breast feed for most of their babies' first 6 months.[65]

Also, contrary to popular belief, failure to breast feed for physical reasons is uncommon even in developed countries. One English hospital discharges 87 percent of its new mothers successfully breast feeding, most of the remaining 13 percent being unwilling rather than unable to breast feed.[66] Undoubtedly, emotional and psychological reasons most commonly underlie 'lactation failure', but many of these cases simply involve mothers losing confidence in their ability to perform what has been portrayed as a difficult and even distasteful duty. Company promotion that frequently emphasizes 'when mother's milk is not enough, our product will help make up the difference' surely encourages and aggravates any possible lack of confidence. The promotional methods used are strikingly similar to those of the drug companies, although the milk companies approach not only health professionals but also mothers directly.

Doctors and maternity unit nurses are often already 'primed' by their training to accept the use of breast-milk substitutes. Still today many medical students receive no instruction about breast feeding. On maternity wards the 'convenience' for the nursing staff of routine bottle feeding is very likely to be viewed both by junior nurses and by mothers as an endorsement of this practice. Health professionals are then susceptible to the promotional activities of milk companies. They are visited by nurses and representatives who explain the 'benefits' of their products in much the same way as do the drug representatives. Indeed the drug companies are increasingly 'diversifying' into the baby-foods field. Those companies like Cow & Gate and Nestle which do not market drugs create a relationship with the health profession through sponsoring and organizing conferences on, for example, nutrition, using such occasions to promote their

products. The professionals now 'informed' about the 'advantages' of this or that milk, act, often unwittingly, as promotional agents.

In some underdeveloped countries it is, ironically, at the 'well-baby' or under-5s clinics that many mothers will first encounter information about bottle feeding, usually in the form of milk company posters which frequently decorate such buildings. Understandably, mothers are impressed by the well-clothed, clean, chubby baby in attractive surroundings. The feeding bottle which is part of this highly desirable overall image becomes for many mothers an attainable symbol or even a possible key to the whole package. And the presence of such posters in the clinic surely indicates that bottle feeding is good for babies. Promotion on press, television and radio is also used extensively by the milk companies. A Nigerian survey revealed that of the significant percentage of mothers who recalled media advertisements for baby milks, most remembered the positive statements about bottle feeding rather than the cautionary information.[67]

But it is perhaps the operations of the 'milk nurses' in underdeveloped countries that are most "unethical. Nurses are employed by both Nestle and Cow & Gate for sales promotion. Although they are instructed to emphasize the importance of breast feeding in the early months, it has been shown that the following serious abuses of this 'educational' approach occur:

> 'Medically unqualified sales—girls are hired and dressed in nurses' uniforms to give their sales pitch in the guise of nutrition advice.
>
> 'Mothers are encouraged to bottle feed their babies while they are breast feeding them satisfactorily and before there is any need for supplements.
>
> 'Qualified nurses are paid on a sales—related basis belying their educational role.'
>
> *Baby Killer*[68]

That such promotional methods are effective was shown by Nigerian and Jamaican surveys. Mothers cited company nurses as an important reason for starting bottle feeding. And the great majority started bottle feeding long before it was necessary to give additional food. Nine per cent of the Nigerian and a much larger proportion of the Jamaican mothers had received samples either at a hospital or through nurses. It could not be determined whether these were real or company 'nurses'. The proportion of illiterate mothers receiving samples was almost the same as educated mothers, showing that no attempt had been made to ensure that mothers were affluent enough to be able to purchase adequate quantities or sufficiently literate to make up the milk correctly. Some companies even offer a free feeding bottle with their product.

In May 1981, the campaign against the baby-foods industry scored a major success when the general assembly of the World Health Organization adopted a code of practice whereby the companies would stop advertising and stress the benefits of breast feeding. This was based on a code agreed in October 1979 between WHO and UNICEF and the International Council of Infant Food Industries, representing the companies.

But although the code of practice is a step forward there are still problems. For example, what constitutes advertising? Many baby-food companies reluctantly came round to supporting the code because they realized that there was nothing in it to stop them sending promotional 'information' to the medical profession. An even greater problem is whether the companies can be trusted to stick by the agreement. A few months after the October 1979 agreement campaigners against bottle feeding released details of 202 examples of advertising in Violation of the code. One spokesperson said that 19 companies in 33 countries were involved.

'Mothercraft "nurses", wearing uniforms but without any medical training, are still being used by Nestlé to promote their products in South African clinics; tins of "Nan" infant formula which make no mention of the superiority of breast-feeding are still on sale in Mexico; plastic bags advertising Lactogen are being distribution to shoppers in Zimbabwe; baby care booklets advertising bottle-feeds are being distributed by Nestle in Malaysia; and the Wyeth company is still advertising its SMA and S26 formulas in "African Buyers Guide" as being "Good for Babies, Good for Profits, Good for You".'

Since the code is voluntary it is difficult to police. The most effective way of enforcing it seems to be the approach adopted by a handful of countries like Mozambique and Papua New Guinea who have nationalized the import, distribution and marketing of baby foods. Often powdered milk formula is only available on prescription.[69] There is little effective alternative. A voluntary code is all very well but Nestlé has an annual turnover larger than the gross national product of any African country except Nigeria and South Africa. It spends more on advertising each year than the total budget of the World Health Organization– which is meant to police the code.

The companies have said that they will rewrite and redesign their product labels and educational materials to conform with the code. But altering labels will not improve the food supply or the availability of fuel for sterilizing bottles. The redesign of educational materials will not help the illiterate mother to follow instructions. And the companies have not yet suggested dropping the price of their baby milk so that mothers who over—dilute the mixture to economize may be able to give their babies the correct amount.[70]

Medical Equipment

The drugs industry is responsible for a significant slice of many countries' already inadequate health service budgets. The direct cost of the baby-foods industry falls on individual families rather than on countries' health budgets, although the treatment of childhood diarrhoea often associated with bottle feeding certainly imposes a financial burden on the health sector. In both cases though, the costs in terms of human suffering are high partly as a result of blatantly unethical marketing methods.

A third example of capitalist medical technology is that of medical equipment. The operations of the medical equipment industry are not frankly 'unethical' – and therefore do not attract investigation by the media – but they are important both in diverting health care resources and in influencing the shape of health services. Although the 'market potential' in the underdeveloped world is necessarily limited by its lack of purchasing power there are still some areas where such 'potential' exists and recently certain new markets have presented themselves.

Middle East Health, a new journal which describes its function as 'serving the needs of the rapidly expanding hospital and health-care market throughout the Arab world and Iran', notes that 'of all the areas of the world today, the Middle East countries are being looked at as having the fastest expansion rate and the greatest potential for trade and. . .enormous opportunities . . . exist in the region as an export market for manufacturers of medical and hospital supplies, equipment and pharmaceuticals from across the world'.[71] It goes on to add that:

> 'A recent press report valued the world medical market at more than £50 billion over the next 10 years and nowhere is this growth more apparent and conspicuous than in the Middle East region, enriched by substantial oil revenues. . . Now more than ever, manufacturers should endeavour to capitalise on this vast health market. . . . There is no doubt that, providing correct procedures are undertaken for dealing with particular countries in the region, the Middle East provides an extremely valuable export market for manufacturers of medical and hospital supplies.'

And they substantiate these claims by providing information under the heading: 'Market Facts, Summary' (Tables 5.5 and 5.6). Thus while the drugs industry remains most significant in absolute terms, the rate of growth of the medical equipment, dressings and medical furniture components is especially rapid.

A similar venture whose role should be viewed in the light of the above 'Market Facts' is what is now called the British Health-Care Export Council (BHEC). As its glossy publication, Health-Care, Equipment and Technology, observes, Health-

Care was substituted for the original Hospitals in 1976 to 'indicate more clearly the comprehensive nature of its coverage'. (Could it also have been a semantic manoeuvre to convey a more progressive image?) BHEC, a private organization supported financially by British industry, was started to 'promote the use of British goods and services for the design, construction, equipment, staffing and management of health-care facilities overseas'.

Table 5.5 The medical equipment market

Country	Medical Equipment	Dressings	Medical Furniture	Drugs	Total (£000)	Total (US $000)
UK	11168	3488	2753	43097	60506	108910
France	2662	165	266	18799	21892	39407
Germany	13929	1128	1973	41957	58987	106178
Japan	5304	424	121	2113	7962	14330
USA	12785	964	2656	24925	41330	74393
1975	45848	6169	7769	130891	190677	343218
1972	16391	1649	1920	51635	71595	128871

Source: Middle East Health, Media Information File

Table 5.6 Percentage growth from 1972 to 1975 of medical equipment sales

Country	Medical Equipment	Dressing	Medical Furniture	Drugs	Total
UK	540	257	1140	236	284
France	289	259	505	122	137
Germany	37	205	48	121	91
Japan	314	266	10	342	301
USA	415	584	1177	130	203
Total	180	274	305	153	166

Source: Middle East Health, Media Information File

It "works closely with Government Departments, particularly the Department of Health and Social Security, the Department of Trade and the Central Office of Information'.[72] What kind of goods and services are promoted and what sorts of health-care facilities are thus encouraged by such initiatives?

MEH's stated editorial policy is 'to educate and inform its readers of the best and most recent developments in hospital supplies and services and in health-care at all levels from across the world, suitably highlighting their relevance to the Middle East'.[73] Thus it carries such news items as: 'Kuwait, which has one of the highest rates of kidney disease in the world, is to launch an all-out attack on the problem this year' (1977).[74] Led by an associate professor of medicine from Dublin, 'the campaign will be centred on an ultra-modern renal clinic to be built next to the 800-bed Al—Sabah Hospital.' It is questionable whether the 12 artificial kidney machines or indeed the ultra-modern renal clinic are the appropriate approaches to widespread kidney disease in such a country where the causes are likely to be rooted in the environmental conditions of underdevelopment. These are indeed examples of the 'most recent developments in hospital supplies and services in health-care. . .' but what is 'their relevance to the Middle East' or at least to the health problems of the vast majority of people?

Similarly, BHEC's 1978 Medical and Surgical Equipment' asserts that 'ultrasound is now firmly established as an important clinical aid and no hospital can claim to be up-to-date unless it is equipped with ultra-sonic instrumentation.'[75] And conveniently juxtaposed to this article are advertisements for the various Sonic Aid Obstetric monitors! But it is perhaps in BHEC's 1978 'Intensive Care' publication that the 'relevance' of the advertised medical equipment to the health-care needs of underdeveloped countries is most strained. For the equipment demonstrated here ranges from the 'cardiovision mobile image intensifier' through the 'Beaufort—Winehester flotation bed" to the truly indispensable 'hospital nurse call system equipment'.[76]

And though the Middle East is currently the most lucrative region for British medical capital, most of the medical technology used in underdeveloped countries comes from the developed world. For example, it has been estimated that 80 per cent of Latin American equipment is imported, mostly from the USA. So in Bogota, Colombia, a city of over 2 million, where nutritional and communicable diseases predominate, the annual running costs of its three open-heart surgery units could provide a quarter of the city's children with 1h litre of milk daily for a year![77]

How is this grotesque situation brought about?

Doctors in particular and health workers in general are, through their practice and training, oriented towards individual, curative medicine. They are therefore

susceptible to sophisticated, expensive technology which may be inappropriate to the needs of most people. So for example health workers trained in Britain or trained in countries where British curricula and methods have been followed are likely to have used British-made medical equipment and be easily influenced by those promoting its sale. These companies advertise in such publications as Health-Care, Equipment and Technology and Middle East Health, which, as the latter journal's circulation policy states, is 'circulated free of charge to medical and administrative personnel who purchase= or directly influence the purchase of, medical and hospital supplies and services (including equipment and pharmaceuticals)'. Like the drug and baby-food firms, they sponsor conferences which often attract an international contingent of health workers – mainly doctors – and which tend to focus on those aspects of medical care involving the use of up-to-date equipment – which invariably is displayed adjacent to the conference room.

But while it is largely the health workers of underdeveloped countries who act as a channel through which the medical equipment companies can direct their goods, it is not only they who are biased towards the urban-based, curative medical services. It is also the small ruling elites who push for such medical services. They tend to live in the urban areas, suffer developed country diseases, and may have had treatment (often private) in the super-technological hospitals of London, Paris, New York and so on. They argue that it is scandalous that their country, new independent of the former colonial power, should still be dependent on medical services overseas. As two sociologists researching in Zambia in the early 1970s explained:

> 'Their reference groups were their opposite numbers from neighbouring States and the whole world. In less than a generation they had genuinely forgotten the circumstances of life and death as experienced by the ordinary villagers as they, or at least their parents, had been.'
>
> *Sociology and Development*[78]

Medical Aid

Another way in which the door is opened to the medical equipment (and drugs and baby foods) business – and this is most relevant to concerned health workers going to work in underdeveloped countries – is through foreign 'experts' and expatriate health workers. These people, often unconscious of the negative aspects of their approach, bring with them not just their ideas about health and health care, but their practical experience of using particular types of equipment. Hence they may become the unwitting agents of medical big business. Undoubtedly they are frequently seen as such by the companies concerned. As the *Middle East Health* editorial policy puts it, '. . . while the will and finance is there [the Middle East] the technology and expertise must be imported.' And an article in an early issue

illustrates the point perfectly:

> 'According to its second 5-year development plan – currently in its third Year of implementation – Saudi Arabia has a purse of $3.48 billion for new projects and an additional $1.4 billion for existing recurrent expenditures in the provision of medical and health services.
>
> 'There is, as in so many other sectors of this rapidly expanding economy, no shortage of money. But there is, more perhaps than in most other sectors: a shortage of expertise with which to tackle the problems of medicine and health care in the desert kingdom. . . .
>
> 'Clearly, the success of the plan still depends much on the import of foreign doctors and nurses, most of whom are from the West. . .'
>
> *Middle East Health*[79]

The form in which medical aid is provided will help influence the approach taken by the recipient to health and health care. For example, aid tied to technological inputs will reinforce the curative, technological approach to health care. Britain's official aid programme is managed by the Overseas Development Administration (ODA – now part of the Foreign Office). It involves more than 120 countries and in 1978—9 an estimated expenditure of £714 million.[80] In 1977 it represented approximately 1 per cent of total government Spending. A tiny proportion of this is health aid. Government disbursements for health projects in 1973-4 amounted to only about £8 million — which was only slightly more than the amount of aid to the health sector provided by British voluntary agencies.[81]

Health sector aid from British voluntary agencies is widely distributed to more than 50 countries with most going to Africa and Asia."[82] In Asia, India and Bangladesh receive most 'project' and personnel aid. In Africa, Malawi, Ethiopia and Tanzania received most 'project' aid with Nigeria getting 32 per cent of personnel aid, nearly three times more than any other African country.[83]

How then is official British aid apportioned? As a recent ODA leaflet stated:

> 'About 40% of the aid budget is directed to the developing countries via international agencies such as the World Bank. ODA then decides how to apportion the remaining 60% between the different countries and how best to use it, for example, by providing finance or personnel, research or training facilities. Whatever way it is used, it is in response to requests from developing countries themselves. ODA doesn't initiate a country's development plans. Any suggested project is, however, carefully and expertly examined and appraised before acceptance.'
>
> *Britain's Aid Programme*[84]

One phrase is often used both by governments and by voluntary agencies to legitimize what might be inappropriate aid: '. . . it is in response to requests from developing countries themselves.' But who in developing countries? The demands of the mostly urban élites in underdeveloped countries are usually for health care facilities which they perceive as appropriate to their needs. These are not only inappropriate, but also frequently inaccessible to the vast majority of the population. The leaflet later continues:

> '. . . the use of experts from overseas remains an important part of the aid Britain can offer. There are still not enough people in the Third World who have had the opportunity to develop their skills and rural development involves particularly intensive research, planning and appraisal. . . So technical co-operation – providing essential skills and helping to train local people – is vital and this is where people like you who are qualified to practise, teach or research, contribute to the aid programme as a whole.'
>
> *Britain's Aid Programme*[85]

Certain skills are always necessary, but it is seriously questionable whether the ways in which many skills are applied are relevant to the majority in underdeveloped (and indeed many developed) countries. For example, underdeveloped country health workers are trained as physiotherapists who are able to work only in well-equipped units in hospitals. Such skills are inappropriate to the needs of the vast majority. On the other hand, many lower-level health workers could be trained to perform certain basic physiotherapeutic techniques which have been developed to treat common local deformities. This would be an appropriate skill.

During 1977 there were 8652 British professional men and women working in underdeveloped countries, partly or wholly financed by ODA, although only a small proportion of these were health workers.[86] In 1973-4, 1053 health personnel were supported in underdeveloped countries by voluntary agencies, 64 per cent of them nurses.[87]

The inappropriate contribution to health care by 'experts' is vividly illustrated in this account by a Bengali doctor:

> 'Recently in Dacca airport I met an acquaintance who said to me in the course of our brief discussion that he had counted 72 experts in Dacca on that one day alone. And yourself, I asked. "73", he admitted. It will be an uphill road, overcoming this favourable bias towards the wisdom of the West. For a long time to Come we will continue to credit foreign expertise unquestioningly with any knowledge they may lay claim to.
>
> 'Who are these experts that come from thousands of miles away with the

perfect plan for a village they have never seen, and a culture they have never lived?

'Our "Western trained medical profession, sanitary inspectors originating in the British Empire, the malaria program established by the WHO, the Rural Health Centres devised by Western public health experts, and most recently, the family planning programs", all are forms of expatriate expertise that have left the health and family planning system of Bangladesh crippled, confused and utterly dependent. . . .

'It is accepted that Bangladesh needs barefoot doctors, people trained in the village and able to meet the needs of the villagers, but the World Health Organisation experts proposed an elaborate 3-year programme to produce medical assistants. This training will take place in the towns, and most of the students will have a background of 12 years formal education.

In one centre visited, 65 out of 80 enrolled had had 12 years or more educational background, and nearly all felt that the course itself should be 4 or more years if the programme Was going to equip them to "better serve the people". Serve, no doubt in Dacca, or Libya, as experience attests. But the expert advisers of the WHO refuse to see any other way.

'These are the experts. They have been with us, as was noted earlier, for some time. Will we sell ourselves out to them unconditionally now? There are real experts, however, and there is such a thing as appropriate aid. Neither is it impossible to discern the real from the "invested aid". Does it reach the real problems with realistic solutions? Does the plan provide for local responsibility in the foreseeable future? Is it honest in assessing its weaknesses as well as its strengths?'

Bangladesh Times[88]

He cited other examples of inappropriate aid and looked particularly at the field of medical research. He examined the operations of the world-famous Cholera Research Laboratory which made the breakthrough discovery of simplified oral therapy for cholera. This was still unavailable for most of Bangladesh Further, the villages whose water was contaminated by material from the hospital had rates for cholera and diarrhoea] disease 20 times higher than the average.[89]

These are only some – perhaps particularly stark – examples of inappropriate health sector aid, although there are certainly many others in different countries. Aid should in each case be critically evaluated for it is by no means always advantageous to the recipient. Moreover, health-sector aid is nearly always dwarfed by health-sector trade, much of which is inappropriate to most peoples' needs. So, when on the one hand the British Overseas Development Administration argues for aid to be increasingly directed to the poorest, and on the other the British Department of Health and Social Security in co-operation with the BHEC

launches an export drive for British medical equipment and expertise, this throws into question where the real interests of the British State lie.

Summary

As the capitalist economic and political system extended over the whole world, capitalist medicine was introduced into the underdeveloped countries. As in the developed countries, the starkly inappropriate health services have been primarily a result of the transformation of health care into a commodity. This has led to the neglect of health promotion, the stunting of preventive activities and the over-blowing of the curative component. In most post-colonial countries both the health professions and the local élites have argued for Western-style health services. They have sealed this by adopting the educational curricula and institutions of the former colonial power in many cases. In this way the international saleability of the professionals' skills is ensured and with it their frequent international migration. The transmission of this approach to health and health care to lower-level health workers has created professional aspirations, upward migration and high drop-out rates.

This is further entrenched by medical business interests. The examples of the baby-foods business and the drugs and medical equipment industries show how the transfer of largely inappropriate technology aggravates the diversion of resources and the distortion of services in the interests of only a few. Much foreign 'aid' has similar effects, often benefiting the donor more than the recipient.

The transfer of capitalist medicine to underdeveloped countries has had other important effects. The medical profession, as in the developed world, comes predominantly from the higher social classes and frequently allies with both local and international business interests, particularly in the medical field. Behind the apparently reasonable argument of 'professional freedom', doctors insist on the right to private practice, sophisticated and expensive facilities and equipment, and unrestricted prescribing of expensive drugs. Their vested interests have led them to resist social change that would threaten the status quo nationally or internationally. For example, during the brief period of Salvador Allende's left-wing government in Chile in the early 19705, many professionals resisted democratization of health care institutions.

The health professions internationally have given powerful encouragement to the idea that disease in the underdeveloped world is due to 'ignorance' and 'overbreeding', rather than underdevelopment. The medical contribution, while its major determining forces remain the medical profession, big business, and the State, rather than the people, is much more part of this problem of underdevelop-ment than part of its solution.

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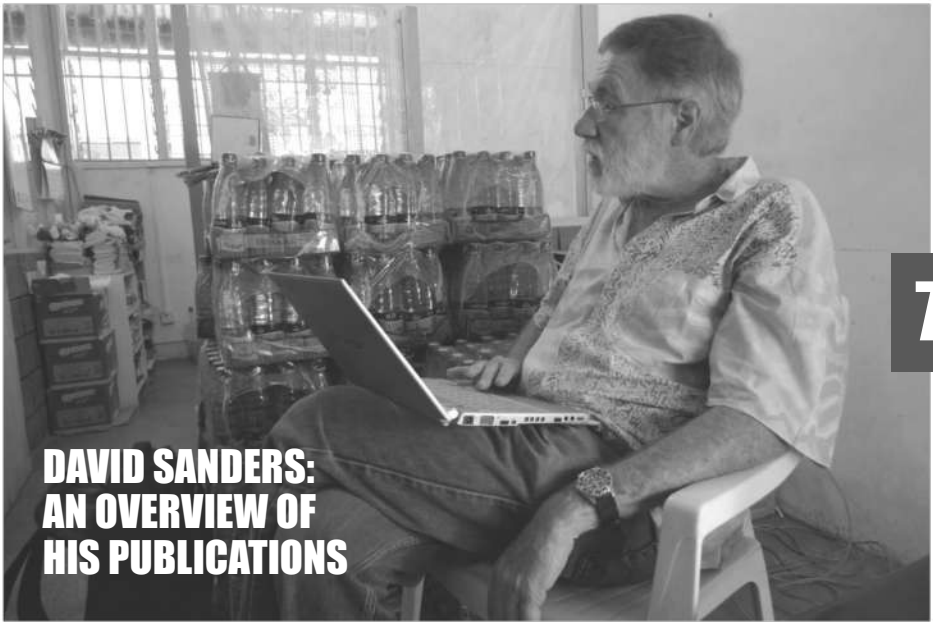

7

DAVID SANDERS: AN OVERVIEW OF HIS PUBLICATIONS

Over the 39 years of his professional life- David had an impressive academic output. This included at least four books, 5 monographs, 59 chapters in books, 206 peer-reviewed articles, 55 conference articles and 21 abstracts and posters.

Through these publications he contributed to the emerging discipline of public health, sometimes challenging existing frameworks of analysis and formulating his own- and sometimes working within the existing structures of the discipline. Most of these publications were not merely reflections of his academic career, but also reflected the burning issues of the politics of health and healthcare that were then being discussed amongst both policy makers and activists or were the topics of public discussion. His writing were always awaited for among activists and used extensively to inform their own understanding on such issues.

Other than these publications, he developed a considerable number of training materials as well as course materials to support his teaching in the School of Public Health, University of Western Cape (UWC). Much of his influence over the development of this discipline, especially within Africa was through the students that he taught and the very innovative distance education program on public health that he founded in this School.

David also advised the World Health Organisation on community participation in health in the 1990s and on the revitalisation of primary health care in the 2000s. He always challenged the WHO to look to the inspirational WHO/UNICEF (1978) Alma Ata Declaration on Primary Health Care in regard to both of these topics.

Other than publishing in academic journals and his formal teaching, he also wrote

extensively in newspapers and periodicals so that the public was better informed and could better participate in these on-going debates. The compendium compiled by his co-authors and colleagues lists at least 44 such newspaper articles- but there are many more. His influence over the public discourse was also through his invited presentations, and the compendium lists 366 such invited presentations- though even this is likely to be an underestimate.

It would be impossible for anyone to do justice to his entire work - much less within this small collection of articles. So the editors have selected is his three important books and a selection of his peer-reviewed publications. The latter is categorised into three periods and as against 206 articles in the compendium we provide reference for just 50 of these. The selection is subjective- and is mainly made with an eye to give the reader an understanding of the breadth of issues he dealt with. This could enable future researchers and activists working in similar areas to take a look at what the pioneer David Sanders had to say on that topic.

Books

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There is one more publication on the way where David co-authors with Labonte and others in documenting case studies in the *Struggle for Comprehensive Primary Health Care.* (A more recent and revised version of the Struggle for health is also being worked upon.)

Peer Reviewed Journal Articles

David's first peer reviewed journal papers date back to 1981, with a year of his joining the University of Zimbabwe's Medical School. In the first period of his academic career that was spent in Zimbabwe (1980 to 1992) there are 24 papers. Remarkably from the very beginning he was publishing in some of the leading international medical journals- 4 in the Lancet, 2 in Social Science and Medicine, and 3 in Health Policy and Planning and 1in the International Journal of Health Services. There were also a number of publications in journals on Tropical Medicine and African journals of social development and public health. The

themes he published on were some of the concerns, which defined his work over the ensuing years. These themes included Under-Nutrition, the Political Economy of Health with special reference to structural adjustment policies and their adverse impacts on child health, and on measures to improve child health outcomes. Of the 24 articles from this period we list 10 below, which we hope are good examples of how he approached these themes. We have also preferred articles where David was the first author.

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1993 to 2007

Listed below is a selection of about 25 publications from a total of over 55 peer reviewed publications in the period from 1993 to 2007. In this period his work on child health and malnutrition continues with some landmark papers reporting empirical work and policy studies in this area. There are also a large number of papers on the social determinants of health and the political economy of health and healthcare with particular reference to health and development in Africa and to the importance of community participation in healthcare. David also published extensively on how primary health care had been undermined, and the needs and possible approaches to its revitalization. This period also sees a number of publications related to priorities in public health education and public health research. The selection below is purposively done to give an idea of the range of topics David Sanders commented on. Now, as a leading global scholar and activist, these papers probably had lasting impact in the public discourse on these topics. Every one of these papers continues to be as relevant today as when they were written.

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2008 to 2019

The last decade of his life sees a huge increase in his publications reflecting the number of persons who want to work with him and the number of networks in which he was engaged. The compendium of his publications lists close to 130 publications in peer-reviewed journals in these 11 years. Many of these are the outputs of working groups or research programs that he had been part of initiating and guiding. Many of the articles of this period are also a triggered by developments in the public health discourse or in global health policy that requires a critical response from the People's Health Movement. We have selected a mere 35 of these below- and the selection is to draw attention of readers to some of his recent work that has relevance to recent discussions and debates around universal health coverage and primary health care. We are also in this selection highlighting examples of how David Sanders uses the political economy approach to inform understandings of what is required for better health and health systems strengthening including his work on trade and its impact on nutritional status and obesity.

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"David is a symbol of commitment and dedication to the cause of equity and justice in health for people. David will be always with us as a source of inspiration, hope and confidence for us in struggle for health"

Sharad Onta (PHM Nepal)

"Friend, activist, compatriot, combatant (intellectually), socialist, person of incredible principle, leader by example, inspiration, mentor to many mentors of others over generations, fearless fighter for justice, joker, supporter, facilitator, pioneer, warm, and beloved by family, friends, fellow activists - and respected for all this even by some of his biggest foes. David was all these things and more.. he believed another world is possible and so do we. That is David's legacy"

Leslie London (PHM SA | University of Cape Town)

"...you have been a warrior for global health justice. Always deeply insightful in your analysis of the global political economy and fearless in speaking truth to power. How many times have you stood up in an international forum and swum against the stream to point out the obvious injustices in the world? How many times have you challenged us on the PHM Steering Council and caused us all to stop, think and reconsider... How many times have you convinced young doctors and other health professional to consider more than just medical treatment..."

Fran Baum (People's Health Movement (PHMOZ) | Flinders University, Australia)

"David was a man of character... in Uganda in July 2019, inspired me to stand boldly and firm for what is right even in the face of compromise. He told me "even if the integrity of the African leaders has been bought through huge monies of multinational corporations, the few of us can remain in the right standing." The role David has played in advancing social justice in health globally is unforgettable. We shall forever miss him"

Michael Ssemakula (PHM-UGANDA)

"To me the most wonderful theme running through the many accolades to David that come flooding in is the way he influenced so many people's lives. Even small children loved him instantly. He recognised immediately what made each one of them tick, and nurtured it in their games and the tricks they played and their conversations with him. Our grandchildren felt important when he was around. Few people who had meaningful encounters with David came out unchanged. They saw themselves and the world, and their place in it, in a new light. They understood that they have power, and that they could use that power to change things, especially if they encouraged and mobilised others to join them. Many of them went on to do great things and to change the lives of others. And this ongoing cascade of bringing people to new insight and influencing others will be part of his enduring legacy and true to his utter and uncompromising dedication to make the world a better place for us and future generations to live in"

Louis Reynolds (PHM South Africa)