As my thinking, knowledge, and responsibility have grown, so has my appreciation of the need to define how development is unsatisfactory as an unqualified term in the context of our responsibilities in health. I am now firmly wedded to the concept of human development and the need to define more clearly how health is related to it. I will adopt a quasi-historical approach to this complex task, because if we do not know where the currents of thought that bear us come from, we will not appreciate where we are and cannot entertain a vision of where we are going or should go.

I embrace the current thinking that human development is the basic aim of all of us who are engaged in work that improves any aspect of human life. Human development is about enlarging people’s choices and expanding their possibilities; to use the concept of Goulet (1), it is a means to human ascent. This was not always the prevailing idea, but I like to think that in some ways we have come full circle in our thinking.

The postwar period saw the burgeoning of development almost as a growth industry, and the main focus was on an increase in the availability of material goods. The concept of development in terms of physical resources is, of course, as old as humankind, but the concern with a national or international responsibility for improving the lot of a large number of the world’s people is a relatively recent phenomenon—one that is essential postwar (2). For several reasons, not all altruistic, there was enthusiasm for raising the standard of living of the newly emergent nations, and such improvement translated into enhancing some measure of economic growth. Very subtly, but very definitely, economic growth became virtually synonymous with development (3). The great goal was to increase the per capita income of the underdeveloped or, more euphemistically, developing countries.

The orthodox paradigm elaborated by Rostow (4) was that there was a progression from underdeveloped to developed. Given that the touchstone of this development was increase in per capita income, and the thesis that people would act rationally to improve their state, considerable attention was paid to the conditions that impeded this natural passage. Poor or inefficient government that stifled market forces was the culprit most often cited. Thus, underdevelopment had its origin in local behavior which could be changed over time to allow development to take place.

The success of countries that moved from underdevelopment seemed to be
based primarily on a high rate of investment from internal savings and emphasis on a well-trained labor force. The concept of human capital, formalized by Schultz (5), evolved as related to the need for this trained and competent labor force.

In the late 1960s and early 1970s, however, a strong movement began to develop that addressed the poor social conditions that seemed to resist development planners. Perhaps it was fitting that much of the early disquiet about the poverty and inequality that resisted development came out of the United Nations and is attributed to Singer (6), who claimed that development was about growth and changes in the social and cultural conditions of countries. Attention began to be paid to "growth with equity" and definition of what constituted the basic needs of a society and its people. Dudley Seers was among the first to question the effect of previous development strategies (7), but some of the most compelling statements on this issue came from Robert McNamara when he was president of the World Bank. In his 1972 presidential address he concluded:

Current development programs are seriously inadequate. They are inadequate because they are failing to achieve development's most fundamental goal: ending the inhuman deprivation in hundreds of millions of individual lives throughout the developing world. (8)

Although it became standard dogma to look for improvement in social conditions as a goal of development, and the human state was seen as being all-important, it was UNDP's landmark publication of its Human Development Report in 1990 (9) that brought together much of this thinking. An early paragraph in the report states:

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

I will posit that there are five major components of this human development that are intricately intertwined: health, education, economic growth, a safe and healthy environment, and personal freedoms that include democracy and human rights. Some aspects of human development are fairly easily quantified and some are not subject to quantitative measurement. This must not disturb us; many aspects of a humanly better life will never be subject to ready quantification and can only be gauged by proxy measurements.

Regarding the treatment of these ideas in PAHO, from our Sanitary Code (10) it is clear that in 1924 our founding fathers appreciated that disease and its spread would influence international trade and commerce and, by extension, the economic growth of the countries. However, there is little evidence of serious treatment of the role of health in relation to economics until after the initiation of the Alliance for Progress. In establishing a place for the health sector in this movement, the role of health and of PAHO was emphasized principally in the context of the economic relationship between health and development (11). In the 1980s, PAHO paid considerable attention to the effect of the economic crisis on health, and the important formal documents that addressed the relationship between health and development were essentially focused on the importance of economic growth for health and vice versa (12). My predecessor as Director, Dr. Carlyle Guerra de Macedo, showed a considerable conceptual advance in his presentations about this issue, frequently questioning the kind of development our countries should seek during the economic crisis and as they emerged from it (13).

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

The association between economic status and health has been dealt with extensively (14–16). Numerous studies have shown that the rich tend to live longer and be healthier than the poor. There is no doubt about the association; the real question is the underlying mechanism. The explanations range from the simple to the complex, but perhaps the most compelling explanation is that economic status is a determinant or expression of social class, and the evidence is now unequivocal that health outcomes are firmly linked to social class.

This relationship is important for us with regard to policies about allocation of resources and energy for health improvement. The best exposition I’ve found of the determinants of health and the possibility of health improvement is in the book Why Are Some People Healthy and Others Not?, by Evans, Barer, and Marmor (17). Their view is that a focus exclusively on poverty may block our understanding of many of the basic mechanisms that underlie the relationship between economic status and health. There is some basic process—probably involving biological mechanisms that are associated with social gradients—that leads to a gradient in health outcomes which is seen even when access to health services is improved. The authors show that health outcome gradients are constant over time even though causes of death change and health status of the population improves. A general conclusion that follows from this observation is that it will never be possible for any country to satisfy the health care demands of its population.

It is important for us in the health sector to note that there is no essential genetic or fixed characteristic inherent to poverty that determines ill health. It is even more important to appreciate that although it is true that the rich are healthier, at the level of populations the distribution of income is a more important determinant of health outcomes than the average income (18). In other words, health outcomes are one reflection of equality or resource availability.

It has always been taken almost as an item of faith that a healthy population produces more, and studies have shown that improved nutrition can increase the productivity of workers. What is less well documented, and is of importance at the policy level, is that national investment in health enhances the possibility of economic growth. It is now being shown that there may indeed be a causal relationship between investing in health and other social goods and a country’s future economic growth (19). In an Inter-American Development Bank report on human resources, Behrman claims that “for very poor areas where there has not been rapid technological changes, the returns from investing in health and nutrition appear larger than those for increasing schooling” (20).

It has been suggested that the persistence of a very high degree of income inequality in Latin America is not inherently structural, but derives from maldevelopment of human capital. The case is made by data on the impact of education on reducing this inequality (21); by extension, I would theorize that health investment would have the same, as well as a complementary, effect.

The relationship between health and education has always been assumed, and there are good data on the impact of health and nutritional status on the capacity of children to learn. One might also argue that improvement in health status that
leads to a lengthening of productive life would decrease the rate of depreciation of the investment in education (22).

The relationship between health and a safe environment is so obvious it does not need much discussion. I would only point out that it is the safety of the air, water, and soil and the quality of housing that have the most direct bearing on human health. That is not to say that we should ignore concerns about the global commons, but at the operational level we in the health field must focus on the immediate environment and act locally.

Perhaps the most difficult concept to grasp is that there is a linkage between health and forms of societal organization. The idea that health may be better in a democracy is not new; it was said very clearly 150 years ago by Virchow (23). The more intriguing possibility is that attention to individual and collective health may favor human development through involvement and improvement of people. One first step toward the changes necessary for any aspect of human development is the recognition by people not only that the current state of affairs is aberrant and modifiable, but that they themselves can change it. I would propose that health status might be the kind of trigger that awakens people to the possibility of a better life. It may be that we are not using health sufficiently as a change agent to influence people to play positive roles in society.

Health is one of the "noble" areas around which it is fairly easy to achieve dialogue, as experience in war-torn Central America showed. Similarly, I believe again without empirical evidence—that the practice of genuine participatory democracy enhances the possibility of community action that can lead to better health.

If one accepts the relevance and centrality of human development and the systemic approach to such development, and if health shares the spotlight with those other areas that contribute to improving the human condition, then it follows that there can be no single development agency or simple recipe for development. Those agencies concerned with health and those concerned with education are by definition also development agencies. In this light, I wish to address the role of PAHO managers in a development agency concerned primarily with health.

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

The unit of PAHO that occupies itself with this strategic orientation is the Division of Health and Human Development. The relationships between health and the other facets of human development (with the exception of health and the environment) are considered under this heading. The Division has prime responsibility for PAHO's technical cooperation on the interaction between health and economic growth and, to a lesser extent, on the economics of health care, important though the latter might be.

It may be felt that since paying attention to people's health is a moral imperative, the health sector should not have to justify it further. I do not dispute the moral and ethical considerations, but I continue to say that there must be additional justification for investing in health. To make our case more compelling, we need to have data and to transform it into information. One of the staff's critical responsibilities is not only to advocate for attention to health, but to collaborate in providing the countries with information that shows where the inequalities in health lie and the effectiveness of interventions to reduce them.
It is not enough for PAHO to be aware of the general positions I have outlined above; it is necessary for us to sow the seeds of understanding in the countries and, equally important, in our partners—some of whom, for one or another reason, may persist in the reductionist approach that I hope PAHO has abandoned. Meaningful intersectoral activity will be possible if there is this understanding, which PAHO is working to obtain at the highest levels of government.

The need for increased understanding of the issues is even greater now, for several reasons. First, there is a cry for health sector reform in almost every country of this Region. Much of the concern is with the cost of care and the extent to which the system should be reformed so that it is more equitable and so that its financing is no longer an excessive drain on the public purse (24). In discussing reform it is important not to lose sight of the fact that the care services, important though they may be, are not the major determinants of health status. It must also be understood that there are certain health services—those with high positive externality content—for which the State must assume responsibility. The focus on the population's health and reducing the inequality and inequity that exist with respect to health cannot be lost.

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

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

The fourth reason we must understand the importance of health and human development is that it will be a matter for our technical cooperation. As originally conceived, technical cooperation had two main components. First was the transfer of knowledge, which allowed the recipient to master the technology that could ensure change. The other component, less often discussed, was the change in power relationships between the two parties. When the developed countries transferred technological know-how, they never dreamt of the power-sharing that might result from the development of others. We at PAHO are in a unique position because we can facilitate the enhancement of capacity without being concerned with power relationships, and even when we promote cooperation among countries it is on the basis of equals. We must make maximum use of this nonthreatening position to promote understanding of human development and the improvement of health as one of its consequences.

All programs of PAHO must share in the understanding of what is meant by and needs to be done in human development. For example, the importance of nutrition is obvious, as well as the relationship of disease control to many of the other components of human development. Once again, I insist on the systemic view.

But there is yet another reason for dealing with this issue. PAHO is engaged with its Member States in an effort to renew the enthusiasm and interest that characterized work toward the goal of health for all in the years following the
Declaration of Alma-Ata. This initial impetus waned for several reasons. The economic crisis of the 1980s caused attention to be turned away from many social issues; some of the moral force of the leaders appeared to be dissipated in other things; and, perhaps equally important, not enough effort was put into the preparation and careful follow-up of the plans needed to ensure that the basic primary health care strategy was implemented and evaluated. But perhaps the most important reason was that health was seen in purely sectoral terms. The dominant thinking did not accord to health the same programmatic and operational importance as was accorded other social endeavors.

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

Perhaps because of the history of medicine, the instinct of health workers to give care, and the attention paid to care as a determinant of health status, priority is often given to the individual human condition. While we must never denigrate this genuine concern for the individual, at the same time we must promote vigorously the attention to collective health. It is in the collectivity of action at the national and particularly at the international level that our Organization should have its strength. We were created for this purpose—the promotion of Pan American thinking and action—and that is one responsibility we must never abjure. Our mission statement, crafted last year through collectivity of action within the Secretariat, will guide our work:

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

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