

HEALTH WEALTH

&

THE NEW ECONOMICS

An agenda for a healthier world

This Report is based on the papers and discussions on health and the New Economics, which formed part of the proceedings of The Other Economic Summit (TOES) 1985.

The Report contains more than 40 specific suggestions for action as part of an Agenda for a Healthier World, in which health creation and wealth creation will be recognised as aspects of each other.

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[inside front cover]

"We cannot be fully healthy as long as a majority of the world's population is suffering and dying only because we cannot agree to a more just distribution of resources for health".

Dr Hakan Hellberg, 'Health For All' strategy coordinator, World Health Organisation, Geneva.

"Health promotion has come to represent a unifying concept for those who recognise the need for change in the ways and conditions of living in order to promote health".

Dr Ilona Kickbusch, World Health Organisation (Regional Office for Europe), Copenhagen.

"We know conclusively that doctors, drugs, and medical care will fail to remedy health problems arising out of unmet needs of adequate food, safe and adequate water, and healthy living and working conditions".

Dr Mira Shiva, Voluntary Health Association of India.

"In many low-income communities in the United States, publicly financed medical insurance systematically misdirects public wealth from income to the poor to income to medical professionals".

Professor John McKnight, Northwestern University, Chicago.

"There lies a profound difference between those who would place materialism, consumption, economic growth, profit and money first, and those who would place first human and spiritual values, conservation, a sustainable economy, people and personal growth. For the latter, and I am one, health is wealth".

Dr Trevor Hancock, community physician, Toronto.

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Appendices 1, 2 and 4 to the original Report are not included here:

1. List Of Papers Presented To TOES 1984 And TOES 1985
2. (1) Draft Agenda For Economic Recovery And World Development
(2) Chief Recommendations To The Bonn Summit, May 1985
4. Reading List And Resource Directory.

1 Introduction

This report arises from the Conference of The Other Economic Summit (TOES), held in London on 17-19 April 1985. One day of the three-day meeting concentrated on the health aspects of the need for a new economics. That part of the proceedings was sponsored by the World Health Organisation, in connection with the WHO strategy 'Health For All by the Year 2000'. The background is as follows.

There is increasingly widespread awareness that conventional economics and conventional economic policies are giving wrong answers and leading to wrong results. By 1984 it had become abundantly clear that the yearly series of Economic Summit meetings between the leaders of the rich countries was doing little to remedy the failure of conventional economics and economic policies to address the real economic issues facing their own countries or the world as a whole.

The Other Economic Summit was established in response to the need for an alternative approach. Some 170 people from 16 countries met together in 1984 and some 450 people from 20 countries in 1985. Their aim was to promote a new economics based on personal development and social justice, satisfaction of the whole range of human needs, sustainable use of resources, and conservation of the environment. Health is clearly one of the most basic human needs.

In TOES 1984 the first day of the three-day conference was on People and Work, the second on Finance and Trade, and the third on Resources and Environment. Each of the three days was structured into three streams: the local economy, the national economy, and the international economy. In TOES 1985 the first day of the conference was on Agriculture, the second on Trade, and the third on Health. Again, there were three general themes running through the whole conference and linking the discussions from one day to the next: Human Needs; Indicators and Targets; and Self-reliance.

Details of conference papers and documents are in the Appendices. Unless otherwise stated, references in this Report to authors' names are references to the TOES 1985 papers that were specifically on Health - or in one or two cases to other TOES 1985 papers.

This short report cannot provide a comprehensive account of the health

and economic issues raised in the papers presented to TOES 1985, or of the points, suggestions and proposals made in the plenary and workshop discussions at the Conference. For readers who wish for more information, copies of the papers can be purchased from the TOES Office, a summary Report of the proceedings of the TOES Rally and Conference will shortly be available for 1985 on the lines of the published 1984 Report, and a book based on the papers and proceedings of TOES 1984 and 1985 will be published in 1986.

The purpose of this Report is to give an impression of: some of the problems created in the health sphere by conventional economic policies; some of the issues to be faced in moving towards a new economics for a health-promoting society; and some of the items that might find a place on an agenda for a healthier world. The Report is a contribution to defining further TOES work in this field; and we hope it will also be useful to other people who are working to create a healthier future.

2 Conventional economic policies

As Hancock points out, it has generally been assumed in the past that the higher the national wealth, the better the national health. Within nations too, the higher the personal wealth, the better the personal health. Since people's health-needs largely coincide with human needs more broadly defined, it follows that as long as economic development is meeting basic human needs, it will also maintain and improve health. The question now is whether our present path of development can continue to improve health. It is clearly not improving the health of many of the poorer peoples of the world; and it may already be damaging society and the ecosystem in ways that are detrimental to human health.

Draper, Hancock and Robertson identify a number of major economic issues as having serious health implications, including:

- the kind of economic growth that treats the expansion of health-damaging activities such as the tobacco industry and the arms trade as if they were additions to wellbeing;
- the channelling of investment funds into unhealthy products and processes;
- the use of advertising to promote unhealthy products and lifestyles;
- high levels of unemployment, which damage the health of unemployed people and their families;
- occupational hazards, which damage the health of employed people

at work

- the failure of economic policies to ensure that socially necessary and useful work is done;
- the failure of economic policies to solve the problems of poverty, inequality and deprivation in industrialised countries, although it is well recognised that those problems are at the root of much ill-health;
- maldevelopment in the Third World, fostered by the western industrial model of development, leading to specific health problems (e.g. Bhopal, babyfoods, dangerous medical drugs), and creating general conditions that damage the health of the majority of the people (e.g. by encouraging heavy international indebtedness and therefore distorting the economy towards activities that contribute to the servicing of foreign debt and away from activities that contribute to the meeting of local needs);
- environmental pollution, not only creating direct health hazards for those immediately affected, but often (e.g. by mercury poisoning or by acid rain) destroying people's livelihoods or permanently damaging the health of the natural environment in which they live;
- depletion of resources, e.g. by over-fishing, mining the fertility of the soil, or lowering the water table, thus threatening the livelihood and health of those affected;
- the spread of armaments, including especially nuclear weapons, which may lead to the final epidemic – nuclear war.

Shiva powerfully confirms, from a Third World point of view, the health-damaging effects of the conventional approach to economic development. For example - and paradoxically - agricultural development and malnutrition are closely related.

In India the displacement of food-growing for local consumption by cash crops for export has reduced the amount of food available for the poorer sections of the population, and worsened the already horrifying incidence of malnutrition. Also, because cash crops demand higher use of fertilisers and pesticides, they cause serious long-term damage to the land. Moreover, because they need more water, they destabilise the hydrological cycle, lower the water table, and create shortages of water for drinking and sanitation - with the inevitable consequences for health. Uncontrolled deforestation and limestone mining in water catchment areas have further contributed to the water crisis, and therefore to the incidence - especially among poorer people - of diseases and ill-health associated with it.

Fisheries development has had similar results. The increasing export of fish, following the introduction of mechanisation and cold storage facilities (the Blue Revolution), has deprived traditional fishermen of their livelihood and has led to the disappearance of fish from local markets and the local diet. Meanwhile, overfishing is now reducing total fish stocks.

The health-damage caused by pollution is even worse in the Third World than in the industrialised countries. Shiva instances the Bhopal disaster as simply the most dramatic example of the continual impact of industrial and commercial pollution - including the pollution of water by toxic industrial effluent and of food by pesticide residues - and of the uncontrolled marketing of dangerous medical drugs.

Underlying these health-damaging effects of conventional economic policies are the conceptual assumptions of conventional economics. One of the most important of these assumptions is that the creation of wealth and the creation of health are quite different things, and that effort expended on safeguarding or improving health is to be regarded as an economic cost - as a drag and a constraint on economic and business growth. There is a need to redefine wealth creation so that health creation becomes an aspect of it, or even so that creating wealth comes to be seen as an aspect of creating health. The role that social investment might play in this is discussed below.

3 Conventional health policies

Kickbusch, McKnight, Robertson and Shiva draw attention to features of conventional health policies which must now be questioned. The World Health Organisation (see Kickbusch) has described some of these as:

- health prescription (in contrast with health promotion);
- individualistic behaviour modification (in contrast with a systematic public health approach);
- medical orientation (in contrast with recognition of lay competence); and
- authoritarian health education (in contrast with supportive health education).

McKnight shows that the conventional medical model of health merely transfers financial resources, which are intended to improve the health of

poor people, to a 'monumental medical system' and the expansion of ineffectual medical care. It also results in the medicalisation of people's lives so that, for example, old age comes to be treated as a disease. Robertson points out that the medical professions and established health services deal mainly with illhealth and disease: the National Health Service is really a national sickness service, and in its present form can do comparatively little positively to promote good health. Draper and Hancock concur that, if health policies and health professionals are to contribute to the creation of better health, they will have to extend their sphere of interest and activity beyond the 'health sector' as it is defined today - for example into such areas as agricultural policy, employment policy and general economic policy.

Shiva shows that these failings of conventional health policy are even more applicable in Third World countries like India, where 'the imported and inappropriate (western) model of health services is top-heavy, over-centralised, heavily curative in its approach, urban and elite-orientated, costly and dependency-creating'.

This concept of dependency-creation is of key importance. Conventional health services are dependency-creating. So are conventional economic policies based on conventional economics. The new economics, including a new economics of health, will place a positive value on self-reliance, including self-reliance in health. Today's dominant 'paradigm' tends to disable people, as regards both their health and their economic life. The new paradigm must be enabling.

The dependency/self-reliance issue is connected with the question of a mechanistic or holistic approach to health. The industrial-age assumption has been that the human body is best understood as a machine; that health consists in the proper functioning of this machine; and that the way to correct malfunctioning of the machine is by knowledgeable intervention from outside, e.g. by drugs or surgery, including transplants. This has encouraged people to feel dependent on doctors and the drug industry for maintaining their health. Today there is a growing awareness of the psychosomatic aspects of health. This is an aspect of the growing recognition of the value of holistic - or 'complementary' as contrasted with 'allopathic' - medicine. One of the aims of complementary medicine is to enable people to take greater responsibility for their own health and to become more self-reliant in this respect.

4 Towards a new economics of health

A new economics of health will be an economics which:

- 1) puts a value on meeting people's needs, including health needs, as contrasted with responding to 'effective demand' which is, by its nature, biased in favour of those who have money and power.
- 2) uses targets that properly reflect desired developments, including improved states of health, and indicators that properly measure how far they have been achieved.
- 3) enables people to live healthier lives and create a healthier society for themselves, and reduces their dependence on medical professionals; and
- 4) develops new methods of social accounting for establishing the value of social investment; so, for example, for establishing the role of health-creation in the creation of wealth.

Needs

Health needs are virtually synonymous with human needs. Thus economic policies and economic concepts that gave value to human needs would be health-creating. And, indeed, the WHO 'Health For All' strategy recognises the significance of basic needs.

However, as Doyal and Gough, Hancock and MacNulty all point out, there are difficult questions about how people's needs are to be defined and who is to define them. Doyal and Gough emphasise the need for autonomy - the capacity to initiate self-chosen action - and the need for the kind of society which will enable that and other individual needs to be met.

Hancock refers to psycho-social needs, such as the need for 'coherence', i.e. a sense that things add up, and for esteem, including self-esteem. MacNulty discusses the findings of consumer market surveys that different segments of the population have different values, and therefore different perceptions of their needs, and moreover that a shift of values may be taking place broadly in the direction of 'inner-directed' values and away from 'outer-directed' values. (This would coincide with a shift from allopathic toward complementary medicine.) Several of the papers refer to classifications of need, such as Maslow's 'hierarchy', and to the distinction made by Max-Neef (TOES 1984) between needs and the satisfiers of needs. The issues raised are complex, but two conclusions seem clear.

First, a healthy economy will be one that enables people to meet their own needs and help one another to do the same, i.e. an economy that fosters co-operative self-reliance. Thus the practical tasks will be to work out economic policies that enable people to develop new ways (and recover old ways) of meeting their own needs.

Second, the new economics must be an economics that gives value to such policies and such need-satisfying activities. Thus the conceptual tasks will be to clarify understanding of needs and how they are satisfied, and to develop relevant targets, indicators and other aids to effective appraisal and action.

Indicators and targets

The questions, as Henderson points out, are; what are we trying to achieve and measure? and what is the best way to measure it? If we are entering a post-industrial transition, our perceptions of what is important, what is valuable, the goals to be pursued, and the ways to measure progress towards them, will inevitably be changing.

Lintott shows that Gross National Product (GNP), which conventional economics now takes for granted as the measure of economic progress (or lack of it), was never designed for that purpose. The objective of the Keynesian economists who, in the 1940s, were mainly responsible for the form taken by the national accounts still in use today, was not to measure economic welfare but to measure aggregate demand and its main components so that governments could more effectively carry out Keynesian demand management policies. GNP was designed as a tool for that particular purpose. In fact, as several of the TOES papers show, GNP is a grossly misleading measure of economic welfare - for the following reasons:

- 1) GNP includes what should properly be regarded as costs, e.g. the costs of treating sickness, including sickness directly attributable to the side-effects of economic growth.
- 2) GNP excludes what are clearly benefits, especially the value of all goods and services provided by the informal economy - meaning whatever people do for themselves and one another without paying or being paid for it, e.g. the care and nurture provided by parents for their children, and the health care provided by families and neighbours.
- 3) GNP only measures flows, i.e. the transactions taking place during a particular period of time; it does not measure stocks, or states or positions, existing at one time and another; thus it fails to say

anything about the state of a nation's health or its stocks of mineral or agricultural resources, and the changes that have taken place in them from one year's end to another; in other words it fails to provide for society what would correspond to a company balance sheet.

- 4) GNP and other conventional economic indicators are almost all money-based; but the money system as it is managed today is very far from providing an effective scoring system for the game of meeting real human needs and creating real human well-being.
- 5) GNP and other conventional economic indicators are national aggregates, and useless as guides to action in the local context - which is becoming increasingly important for the creation of economic and social wellbeing, including the creation of health.
- 6) The very attempt to use a single aggregate measure like GNP as an indicator of overall social well-being is misconceived, in view of the plurality of people's needs and interests and the different priorities and values that different people give to them.

Carr-Hill and Lintott fear that attempting to construct any overall index as an alternative to GNP will obscure a vital aspect of social well-being, namely the proportion of people whose basic minimum needs are not satisfied in various particular respects. They therefore aim to develop a series of indicators of particular aspects of well-being. In the health sphere, their paper and Hancock's both contain valuable discussions of the possibilities, including infant mortality, life expectancy at birth, and length of life free from disability. Hancock describes the Herrera mathematical model of the world economy, calculated to maximise life expectancy rather than economic growth. It centres on the satisfaction of basic needs, including nutrition, housing, education and health, and shows - according to the authors - that "all of humanity could attain an adequate standard of living within a period a little longer than one generation" if the policies which they recommend are adopted. Robertson lists a wide range of specific indicators and targets, covering many different aspects of health and ill-health, now being developed by WHO in support of the 'Health For All' strategy.

Again, the issues are complex. But two main conclusions may be drawn. First, it is urgently necessary to discredit GNP as a policy guide and abandon the growth of GNP as a policy objective. Second, it is necessary to decide on real (not money-denominated) policy aims - in health and in other spheres - and to establish indicators and targets which will help towards their achievement.

Self-Reliance

Running through many of the TOES papers is the theme that the conventional approach to economics and the provision of health services is inherently dependency-creating. An essential feature of the new economics and the new approach to health will be that they attribute positive value to self-reliance. The principle of self-reliance will apply, and will contribute to improved health, at every level - person, household, locality, region, nation.

Self-reliance does not mean selfishness. As Galtung puts it, 'in self-reliance there is both an element of enlightened egoism (don't give away the positive "externalities") and enlightened altruism (don't damage others by exporting negative "externalities")'. Nor does self-reliance mean isolation; we are talking of co-operative self-reliance, self-reliant mutual aid. Nor must self-reliance be taken to imply carte blanche for the strong to abandon the weak, and the rich the poor, to stand unaided on their own feet. The principle of co-operative self-reliance implies that the abler will enable the less able - as, for example, good parents enable their children to grow up, and good teachers their pupils to learn.

The principle of self-reliance thus implies, not the total withdrawal of the state from the lives of its citizens, but a shift of emphasis in the functions of government. Instead of providing services that maintain people in a condition of dependence or even reinforce their dependence, governments should whenever possible adopt policies and programmes that enable people to meet their needs for themselves and one another. This applies in every area of public policy without exception. In the sphere of health it means positive support for self-help and community care in coping with sickness and disability, as well as measures to enable people to live healthier lives and create healthier living conditions for themselves and one another.

In general, an enabling society will be a learning society - a society that helps people to learn to help themselves and one another. The principle of self-reliance implies a developmental view of progress.

Three further points must conclude this brief discussion of self-reliance - which is without doubt one of the key principles of the new economics and the new approach to health.

First, enabling people to be self-reliant is an important role for professionals in all fields, as well as for the state. Precisely what this involves - in health,

as in other spheres - raises practical questions about the right working relationships between professional organisations, voluntary groups, and families and individuals. More generally, it raises important practical questions about the right relationship between the formal and informal spheres of the economy.

Second, self-reliance applies not just to individual people and small groups of people such as families and households. It applies particularly to localities. The revival of more self-reliant local economies will be a vital feature of the new economics. Linked with this, the development of a more systematic and sustained approach to local health and a healthy local environment will be a vital feature of what Peter Draper calls 'the new public health'.

Third, enabling people to become more self-reliant and healthier can be understood as social investment. Social investment is not a concept that conventional economics and conventional economic policies recognise. It will be an important feature of the new economics, as the following paragraphs suggest.

Social investment

Conventional economics makes an artificial distinction between economic and social expenditures. This corresponds to another artificial distinction - between 'wealth-creating' activities and 'wealth-consuming' activities - from which the assumption follows that 'wealth creation' must take place before 'wealth-consumption' will be possible, and therefore that 'wealth-creating' activities must necessarily be given priority over 'wealth-consuming' activities. In the sphere of overall national policy this translates into the further assumption, hitherto unquestioned by conventional politicians of all parties and conventional economists of all schools, that economic growth is an essential prerequisite to social progress. In specific areas of policy this has consequences that must be questioned. Health and unemployment are good examples.

The conventional assumption is that public expenditure on health is 'social' expenditure, involving 'wealth-consumption'. Thus the need to safeguard health, e.g. by safety or pollution-control measures, is seen as a cost. Measures to create a healthier physical and social environment which would enable people to live healthier lives are not recognised as productive investment in society's most important resource and capital asset, namely its people. Similarly, public spending in support of unemployed people is assumed to be unproductive social spending. For that reason unemployed

people receiving state benefits (or taking part in publicly funded training, work experience, and community projects) are prohibited, except in certain special cases, from building up their own earnings on pain of forfeiting their benefits and grants. The conventional view of 'social' spending as 'wealth consumption' thus disables them; it prevents them from graduating out of their dependence as unemployed people to the point where they can generate viable paid work for themselves.

The Catch-22 is that 'economic' spending, as conventionally understood, also excludes social investment of this kind. 'Economic' spending is taken to mean investment grants and tax incentives to existing employers to expand their businesses, and tax incentives to investors to put their money into new businesses. The assumption is that 'real' work for unemployed people can only be created by persuading other people to employ them; and this condemns them to continued dependence, either on the state for benefits or on an employer for work. As with spending on health, conventional economics does not recognise that public spending to enable people to generate viable work for themselves might be regarded as investment in a society's most important resource - its people.

The new economics will encourage the redirection of a substantial proportion of the public funds now spent on treating and caring for people after they have become sick, and on maintaining unemployed people in unemployment, into productive social investment, i.e. into enabling people to become healthier and enabling unemployed people to generate useful and viable work for themselves. And in every other field the new economics will aim to identify comparable ways of redirecting unproductive public spending into cost-saving social investment. An essential criterion for appraising and evaluating public expenditure proposals and programmes must be the extent to which they enable cost-savings to be made in future recurrent public spending, by enabling people and localities to meet more satisfactorily for themselves the needs presently met by public expenditure.

The new economics will also recognise the potential future importance of social investment opportunities for private funds. Increasing numbers of people are already seeking to invest their savings in enterprises and projects which they themselves support, even if this means they will not receive the maximum financial rate of return on their investment. Social investment funds of various kinds are springing up in Europe and North America to meet this demand. Health-promoting investment and investment in local economic revival could be important future fields for private social investment, and local community health projects could be favoured on both counts.

This foreseen growth in the role of public and private social investment does not imply that money will automatically be available for any socially desirable project. New techniques of social investment appraisal and social accounting will have to be developed to establish the expected value of particular social investment proposals and the actual achievements of particular social investments. Institutional developments will also be needed - new channels and procedures to enable investors to invest in social projects and enterprises. These will include new social investment facilities from existing financial institutions, as well as altogether new social investment institutions.

A feature of social investment will be that it usually saves costs (rather than raises revenues) and that the cost savings are often widely distributed (whereas revenues generated by conventional investment tend to accrue directly to the investor). For example, the revenue generated by investment in a new cigarette factory will come directly to the company that owns it (and then to a comparatively small number of shareholders, employees and suppliers, and to the state in taxation). But the cost savings achieved by a comparable investment in a successful health promotion campaign (which may involve a reduction in smoking) will be much more widely spread - e.g. among healthier individuals, social services (including health services), and many employers. Conversely, the costs of measures to safeguard or improve health, e.g. by reducing pollution from factory chimneys and car exhausts, will fall largely on the factory operators, car manufacturers and car purchasers directly concerned, whereas the benefits resulting from better health will be spread much more widely.

Opposition to health promoting measures of this kind therefore tends to be more easily mobilised than support for them. This is one of the issues that, in exploring the scope and practicalities of social investment and of developing a cost-saving economy, the new economics (including the new economics of health) has to face.

5 Agenda for a healthier world

An agenda for a healthier world - and a new economics to go with it - will involve action by people in every walk of life in every country in the world, and not just by professionals in the fields of health, economics and government. Indeed, it is probably realistic to assume that effective action from professions in those fields will only come in response to pressure from

people outside them. The first place on the agenda must therefore be given to mobilising a worldwide public movement for a healthier world.

A movement for a healthier world

Such a movement will not take the form of a monolithic organisation, but rather of a rising tide of public discussion and understanding of health issues, including the politics and economics of health and the links between health and other vital contemporary questions. A loose coalition of interests for a healthier world is already in the making, as the movements for community health, holistic health and consumerism in health, the feminist, environmental and peace movements, and those who are striving for more humane and more ecological approaches to energy, technology, economics, and Third World development, recognise the common ground between them.

One practical proposal is that interested groups in other countries should follow the West German example and organise an annual

(1) 'Health Day'

in the form of a big public event, including rallies, conferences exhibitions, demonstrations, etc., attracting many thousands of people and calling attention to the widespread demand and the widespread opportunities for creating a healthier society.

The health sector

A shift of emphasis from treating sickness to creating health must not mean that curative treatment, including hi-tech hospital medicine, will no longer be available where it is needed. Nor must the fortunate be allowed to use the rhetoric of self-reliance as an argument for imposing on deprived communities and families responsibilities for their own health care which they cannot bear, or for exploiting the informal unpaid health care work of women. But the new emphasis on positive health and self-reliance will recognise: that, in those areas of care and treatment where the psycho-social aspects of care are important, self-help and family/community care can - if adequately supported - be more effective than conventional curative medicine; and that professionals and organisations in the health sector could make a bigger contribution to improving personal health and healthy living conditions than they now do. So, for example:

(2) Health counselling

Health education and health promotion should become become

recognised aspects of general medical practice;

(3) Health advocacy

Health professionals should take part in health advocacy in all fields of local and national policy which have an impact on health;

(4) Community health initiatives

In particular, health professionals should encourage community health initiatives in their own localities - as their professional contribution to the revival of more self-reliant local economies based on the more effective use of local work and local resources to meet local needs, including local health needs;

(5) New and closer working relationships should be encouraged between health professionals, voluntary workers, and families;

(6) Health sector budgets

These should be regularly and systematically examined (at district, regional and national levels alike) with a view to increasing the share of spending on health promotion, health education, illness and accident prevention, and community care and self-help, relatively to spending on conventional curative medicine;

(7) The health impact of every proposal for new medical expenditure should be examined against the following criteria:

- a) could the money be better spent on increases in poor people's incomes, support for community organisations, or measures to promote health or prevent sickness?
- b) will the proposal enable people to become more self-reliant, or will it increase their dependence?

(8) In particular, the development of enabling medical technologies that people can control and use for themselves should be given higher priority than the development and use of technologies that reduce people to dependence on the medical professions and hospital medicine (childbirth technologies are one obvious example).

Other areas of public policy

The development of healthier public policies will call for political pressure and policy research in many specific fields. For example, it will be necessary to promote:

- (9) Healthier Work
- (10) Healthier Food
- (11) Healthier Agriculture
- (12) Healthier Housing
- (13) A Healthier Built and Natural Environment
- (14) Healthier Transport Policies
- (15) Healthier Energy Policies
- (16) Healthier Technologies
- (17) Healthier Local Development, with particular emphasis on programmes that integrate community health projects into employment/economic initiatives.

All the foregoing aspects of healthier public policies are equally applicable in the Third World and the industrialised countries They must be understood and promoted as aspects of:

- (18) Another Development In Health, which should be understood and promoted as an aspect of 'Another Development' more generally.

As background to progress in each particular field of public policy various 'possible futures' will have to be explored. For example where work is concerned, will the future bring a return to full employment? or a 'leisure society', in which increasing numbers of people will not be expected to work? or an 'ownwork' society, in which increasing numbers will be able to decide and organise their own work for themselves? Each of the possible futures for work - and for everything else - will have different implications for the promotion of health.

Thus:

- (19) Futures Studies
in every field of policy, on the lines of the 'scenarios for lifestyles and health' used by the European Region of WHO, will be needed to clarify healthier public policies and throw light on many of the issues to be faced by the new

economics.

To animate and facilitate this range of effort promoting healthier public policies, some kind of

(20) Centre For Healthy Public Policy

may be needed. Its tasks, based on recent recommendations to the Canadian Public Health Association for such a centre might include:

- a) monitoring legislation for its health effects
- b) developing health impact statements
- c) encouraging local healthy public policy groups
- d) publishing a newsletter
- e) issuing 'resource kits'
- f) education and dissemination of information
- g) organising conferences and workshops
- h) press publicity and journal articles
- i) advocacy and campaigns on specific issues
- j) linking internationally to other similar centres.

The business sector

Greater emphasis on health-promotion and sickness-prevention will be an important change in the environment for business, industry and finance. For some health-damaging industries, such as tobacco chemicals, pharmaceuticals, automobiles, and power generation, the threats are already apparent. But for most industries and technologies there will be important new opportunities and new market openings for goods and services that enable people and localities to live more healthily and to create healthier living conditions.

There will certainly be a growing need for research into:

(21) Market Opportunities In A Health-Promoting Society

Some obvious examples include: pollution control; clean energy; organic agriculture; nutrition; health monitoring and health care. But there will be examples in every field in which it can be asked: is this a product, or a service, which will tend to make people healthier or unhealthier, more self-reliant or more dependent?

In the financial sector there is likely to be a growing demand for ways to invest and channel savings into health-creating projects and enterprises. This will be one element in a wider demand for

(22) Social Investment Opportunities

which could mean new lines of business for banks and other financial institutions. There could also be growing

(23) Insurance Opportunities

for insuring against health risks on terms that encourage the insured to live more healthily or, in the case of organisations, encourage them to create healthier conditions, and therefore reduce health risks, for those - e.g. employees or third parties - on whose account they are taking out insurance. In this context, there may be opportunities for insurance companies to develop

(24) New Methods of Paying for Health Care

Research into the possibilities will be needed. This could throw up comparable business opportunities for the insurance industry in quite different fields of risk-reduction, such as pollution or crime. In general, there are likely to be new openings for insurance in a cost-saving economy.

(25) Corporate Social Responsibility

Hostile critics of business may be expected to step up aggressive health advocacy and health advocacy research, and it is right that they should. In response, progressive businesses and other progressive organisations will need to develop new methods of social responsibility accounting.

The new economics and health

The new economics will be a real economics of health, unlike conventional health economics, which concentrates on the economics of sickness and sickness services. This will require the further development of:

(26) Indicators And Targets

for assessing states of health and other aspects of the quality of life, for framing and implementing policies for improving them, and for integrating these into overall economic policies.

A connected task will be to bring into the annual national accounts:

(27) Balance Sheet Statements

showing the state of affairs in respect of the nation's health (and other capital assets such as the numbers of trained and educated people, the availability of natural resources, and the conditions of the built and natural

environment), and also showing changes from one year to another.

Also connected will be the

(28) Improvement of Monetary Indicators

such as GNP, with the aim of arriving at more useful surrogate measures of wellbeing than these provide today.

Also - though this is a larger topic in its own right - the new economics will require

(29) Reforms in the Money and Financial Systems.

one effect of which would be to make money values and monetary calculations a better calculus of needs, priorities and claims on resources than they are today.

Also linked to the need to develop new indicators and targets for economic policy-making will be the development of

(30) New Economic Models

which use quality-of-life and health indicators, such as life expectancy at birth, as the target variables to be optimised.

A key feature of policies guided by such targets, rather than by financial and money-based indicators like rate of return or GNP, will be the role played in them by

(31) Social Investment.

Work is needed to clarify and disseminate understanding of the practicalities of social investment, including the development of techniques and procedures for

(32) Social Investment Appraisal And Social Accounting

One example - at the micro level - is the development of accounting procedures for community businesses, whose objectives are social as well as economic. Examples at the macro level will be studies of the costs of making specific changes in, say, agricultural or transport or energy policy with the aim of promoting health, and of the value of the health improvements achieved - or, in the case of appraisal, expected to be achieved - thereby. On a number of such

(33) Social Investment Studies

it should be possible to base a generally applicable

(34) Methodology of Social Investment.

This needs to be followed up as one aspect of the economics of a health-creating society, in which health creation is recognised as playing a positive part in wealth creation.

Further understanding of the practicalities of social investment will be gained from studies of cost saving as an investment objective. Cost saving, especially the saving of labour costs by employers, is a recognised objective of corporate investment in the private sector. But conventional government policy concentrates on increasing money-measured turnover, i.e. GNP, as the key economic objective, even though GNP adds in (as earlier explained) what should properly be counted as increased costs. Cost saving, as an objective of public policy, is limited to securing savings in arbitrarily defined categories of government spending and borrowing, regardless of the increased costs often imposed thereby on other sections of the economy. It would be instructive to explore the

(35) Key Features Of A Cost-Saving Economy

for example by developing a

(36) Minimal-Health-Cost Model Of The National Economy.

This would assume a given level of health service and sickness care as the entitlement of all who needed it. It would then work out what policies would

- a) minimise the demand for health service and sickness care by reducing the incidence of sickness, accidents, etc., and
- b) provide the given level of service and care in the most cost-effective way.

A centrally important category of social investment with a view both to cost saving and to more effective results will be investment in the

(37) Informal Economy Of Health.

Studies and public discussion are needed to: explore how families and communities can be helped to take on more responsibility for their own health and health care; estimate the costs of such investments and the savings to be expected from it; and identify the non-monetary benefits likely to result. From such studies and discussion it should be possible to draw conclusions of more general application to investing in the informal economy. These would include conclusions about the extent to which an

expansion of unpaid 'ownwork', whereby people will meet more of their needs for themselves and one another, may be expected to alleviate the problems of high unemployment.

Principles of a health-promoting economy

At a more conceptual level, further research - economic, sociological, anthropological and philosophical - and more active public discussion is needed to clarify the principles of a health-promoting economy. For example, on the

(38) Satisfaction of Human Needs

how are people's health needs to be defined and how are they to be satisfied? And

(39) Is Self-Reliance a Human Need?

In so far as it is, and in so far as enabling people to be self-reliant is an aspect of a health-promoting society, how is

(40) The Enabling Role Of Government

to be interpreted in matters of health and economic policy in relation to the citizen?

And what political philosophical issues have to be clarified in relation to

(41) Self-Reliance, Mutual Aid, and Interdependence?

On this whole set of philosophical and political issues much valuable material is in the papers for TOES 1985, as a basis for further work.

6 Conclusion

Conventional economic policies are failing. Among other things, they are now failing to create healthier societies. They are positively damaging the health of many people in the world.

Underlying these practical failings, conventional economic thinking is based on false premises. Among other things, it places no value on health. It treats the maintenance and promotion of health as an economic cost, rather than as a positive contribution to the creation of wealth.

At the same time, conventional health policies and health services are

concerned with the treatment of sickness and the care of the sick, rather than with the promotion of health. Conventional health economics has been an economics of sickness and sickness care rather than an economics of health.

The WHO strategy 'Health For All by the Year 2000' is outstanding among many examples of the shift of emphasis now beginning to take place in the sphere of health. Associated with it must be a new economics of well-being - an economics of person, society and planet - which recognises the realities of human needs, social justice and a finite world.

This Report is published as a step towards that closer association between the movement for a healthier world and the movement for a new economics. Because it arises from the proceedings of a Conference focused on a Summit meeting of government leaders, many of the specific proposals in it are to do with public policy and the kinds of initiative that may be expected to influence it. In that context we hope that the Report will provide a basis for consultations, for example with WHO, about the scope of future TOES work on a new economics that will be health-promoting rather than health-damaging.

However, the main impetus for change may well come from people outside the professional fields of health, economics and government - from people insisting on a more humane and a more ecological economics that gives higher priority to health. We hope that the Report may be of interest and help to many such persons, groups and organisations in their efforts to promote healthier ways of living in a healthier society and a healthier world.

APPENDIX 3

Statement and Summaries

This Appendix contains:

- 1) The text of a Press Statement by Dr. Hakan Hellberg, one of the leading speakers at the TOES Rally, at Friends House, London on 16 April 1985, the evening before the TOES conference.
- 2) Summaries of the eight papers presented to the Conference that were specifically concerned with Health.

Medical doctorates only are shown in the following abridged biographical notes on Dr Hellberg and the paper-writers.

Dr HAKAN HELLBERG (Finland) is co-ordinator of the WHO Strategy on 'Health for All by the Year 2000', based at WHO HQ, Geneva.

ROY CARR-HILL (Britain) is Senior Research Fellow at the Centre for Health Economics, York University.

JOHN LINTOTT (Britain) teaches Economics and Statistics, and is a member of the Radical Statistics Group.

Dr PETER DRAPER (Britain), a community physician, directed the Unit for the Study of Health Policy from 1975 to 1984.

Dr TREVOR HANCOCK (Canada), organiser of the Toronto conference on healthy public policies in 1984, is a community physician.

ILONA KICKBUSCH (West Germany) is WHO European Regional Officer for Health Education, based in Copenhagen.

JOHN McKNIGHT (USA) is Associate Director, Center for Urban Affairs and Policy Research, Northwestern University, Illinois.

CHRISTINE MacNULTY (Britain/USA), a consultant on strategic planning, is Managing Director, Taylor Nelson Monitor Ltd.

JAMES ROBERTSON (Britain) writes, speaks and advises on economic and social change and possible futures.

Dr MIRA SHIVA (India) heads the Low Cost Drugs and Public Education campaigns of the Voluntary Health Association of India.

Hakan Hellberg **Towards a Healthy World**

We cannot be fully healthy as long as a majority of the world's population is suffering and dying only because we cannot agree to a more just distribution of resources for health. The common social goal of Health for All for the Year 2000, jointly accepted by the Member States of the World Health Organisation (WHO) in 1977, is the beginning of an international health policy. The central issue is 'for all', the need to share available resources and possibilities for health with greater solidarity and emphasis on social justice.

The perspective of 'the year 2000' is brought in to underline the urgency and the need to focus action in a prospective way to counteract the traditional retroactive perspective of medicine. This is dominated by action regarding what has already happened, but this is not enough.

'Health' includes the promotion of healthy lifestyles, prevention of disease and environmental hazards, care and cure of patients as well as appropriate rehabilitation.

Primary health care in different forms is an essential tool to achieve the 'Health for All' goals.

Is there enough international solidarity in order for us to move towards a healthier world? Are we ready for health policies requiring real sharing of resources, and not only hand-outs from our affluence? Are we, on the other hand ready for the consequences - social, economic and political - of not sharing enough?

A healthy world would depend on policy and programme changes developed and accepted by healthy, mature people, able at least to combine personal, national and global self-interest. If we are able to rise above such self-interest and move forward in solidarity towards health for all, we will really be on the move towards a healthier world.

Roy Carr-Hill and John Lintott
Measuring health and human activities

This paper describes a project concerned with producing an alternative to the government's 'Social Trends'.

It shows how the social indicator movement includes a wide range of approaches. Some, like the proposal of a welfare index or a social accounting framework make the fundamental mistake of proposing a technical solution to the fundamentally political problem of assessing the relative importance of different aspects of the quality of life.

The approach here concentrates on the measurement of individual well-being. It argues for the development of indicators of the proportion of the population who reach a certain reasonable standard in respect of different aspects of well-being; it argues against their hasty aggregation into an overall satisfaction index.

The paper also argues for accepting a plurality of vision of humanity and, as a first approximation, divides well-being into the following aspects: being, doing, having, relating, surviving, where:

being is concerned with the state of the individual and includes health and knowledge

doing concentrates on the nature of peoples' activities in all spheres

having is concerned with the satisfaction of basic needs

relating is about the nature of peoples' relationships with each other

surviving is concerned with threats to the security of individuals.

In measuring levels of health, the papers argues not only for measures of life expectancy free of disability, broken down according to a variety of socio-demographic characteristics, but also for measures of potential health such as the birthweight distribution.

In measuring the pattern of human activities, five aspects can be distinguished: the use of time, the quality of activities, social aspects of activities, the productiveness of activities, and access to activities. The data presented compares and contrasts the distribution of people between statuses with their patterns of time use.

Peter Draper

Economic policy as if people mattered

1. Economic and financial mismanagement, along with predatory policies, are in danger of making us believe that we can neither afford to feed the hungry nor care for the old - despite new technology and widespread unemployment.

2. Seven unhealthy features of predominant macro-economic policy are reviewed and they indicate the major (and formidable) problems we should have to tackle to develop health-promoting rather than health-damaging economies.

- 1) Hunger and poverty in the Third World.
- 2) Poverty and serious inequality persist in industrialised countries.
- 3) Paid work is not shared equitably and much socially useful work remains undone.
- 4) Investment too often funds unhealthy products and processes.
- 5) Serious pollution is tolerated.
- 6) Finite resources are used irresponsibly.
- 7) Massive advertising promotes unhealthy products and lifestyles.

3. Seven underlying factors are mentioned which serve to perpetuate and promote unhealthy economic policy.

- 1) The objectives of economic policy are inappropriate.
- 2) Economic concepts and indicators are increasingly inappropriate.
- 3) Investment decisions are narrow and largely unaccountable.
- 4) The operations of powerful anti-health interests are largely unchecked.
- 5) The public discussion of economic policy is typically out-dated.
- 6) A specialty of health economics is needed.
- 7) The Medical Officer of Health is dead.

4. Strategies for achieving health-promoting economic policy include the development of health economics and a new public health movement with a new kind of health education.

Trevor Hancock

Towards a healthier economy

1. Basic human needs have physical, mental, social and ecological components - human needs are largely identical with health needs.

2. In the past, economic progress and improved health and well-being have been virtually synonymous. To the extent that our economic development fails to meet basic human needs this may no longer be true.

3. The six strategic issues identified at TOES 1984 all have serious implications for health.

4. Many aspects of "modern" agriculture and trade are harmful to health.

5. Good health requires the satisfying of:

physical needs	food, water, clothing, shelter, safety, and protection from toxic substances.
mental needs	a sense of coherence, stimulating, satisfying and meaningful work, a sense of self-esteem and positive self-worth.
social needs	a sense of belonging, of being needed, the basic amenities of life (income, transportation, recreation), supportive communities.
ecological needs	minimal alteration of the ecological system, sustainability, maximal variety.

6. Possible useful health-based indicators of economic progress, in place of current indicators, are:

infant mortality rate
 life expectancy
 disability-free life expectancy
 coherence.

7. The next tasks are to build economic models using these indicators in place of conventional economic indicators, and to conduct health impact assessment of all public policies.

Ilona Kickbusch
Health promotion

1. A new programme on health promotion was started by the WHO Regional Office for Europe in January 1984.
2. Public health programmes have been biased towards the expansion of secondary and tertiary care systems. The new orientation towards primary health care should be seen as an orientation towards health not disease.
3. It involves increasing peoples' understanding of the relationships between lifestyles and positive health, and between lifestyle choices and wider social health issues.
4. It requires the development of intersectoral health promotion policies at national and local levels, and of policies and programmes to promote healthy behaviour.
5. It reflects an enabling approach to health, allowing for full public participation and empowerment for health.
6. The WHO (Europe) health promotion programme is one element in the European Region's strategy on Health For All by the Year 2000.
7. A WHO (Europe) discussion document (1984) on the concept and principles of health promotion is available.
8. The momentum of the WHO (Europe) health promotion programme has been taken up by WHO headquarters in Geneva, as an aspect of the global Health For All strategy.

John McKnight

Demedicalisation and the possibilities of health

1. Technological medicine is increasingly irrelevant as a tool to improve health status in modernised societies.
2. Nonetheless, the medical system and its method has spread across the social environment.
3. One expression of this medicalisation is the co-option of "alternative" approaches to health.
4. The alternatives become medicalised because they do not avoid the essential elements of the system of technological medicine, i.e. management, commodification and curricularisation.
5. There are numerous citizen initiatives that operate outside these systems and point toward new directions allowing health to prevail.
6. There are some public policies that could support these citizen health initiatives and limit the extension of medicalisation.

Christine MacNulty
Future Health Needs

1. Social change is leading to changed attitudes towards medicine and health. The paper reports findings of recent research on people's attitudes to health and health care requirements.
2. In advanced industrial countries a shift is taking place away from the values which are associated with agricultural and early industrial societies (i.e. values focused on economic security, a belief in the authority of the state, and a belief in traditional family structures) towards values that are more concerned with such things as freedom, autonomy and creativity.
3. These findings are based on a method of analysis called "Social Value Group Segmentation". This divides the population into groups whose values tend towards Sustenance values, Outer-Directed values, or Inner-Directed values in varying degrees. Changes in the size of the groups over time reflect shifts in values and attitudes in society as a whole.
4. From this analysis a polarisation of attitudes to health and health care can be forecast for the coming years. There will be a growing move towards self-help and holistic health on the one hand and a growing demand for high technology on the other.
5. However, demand is likely to increase on all sides for personal friendly care. There is likely to be a growth in the numbers of paramedical counsellors and therapists, for whose services increasing numbers of people may be prepared to pay privately if they cannot get

James Robertson

Health creation, wealth creation, and useful work

1. The WHO strategy for health for all by the year 2000 seeks a new direction of development in health. This must be an integral part of a new direction of development generally, both in industrialised and third world countries, the first aim of which will be to enable people to create wealth, health and wellbeing for themselves and one another.
2. Conventional economics excludes health creation from wealth creation, and counts the cost of sickness care as a contribution to national wealth. Conventional health services do not try to create health; they concentrate on treating sickness.
3. Conventional economics falsely assumes that human activity is divided into economic and social compartments - i.e. into wealth-creating activities which must come first and wealth-consuming activities which can only come second - and puts no value on enabling people to create wellbeing for themselves.
4. The conventional path of development is dependency-creating, not health-creating. It creates wants; it does not enable people to meet needs.
5. Conventional economic indicators and targets do not include health indicators and targets, and conventional national accounts pay no attention to the state of the nation's health.
6. Conventional economics does not value informal healthcare, or the informal economy generally. It does not value what has traditionally been women's work, in health and in other spheres.
7. Steps towards a healthier world will be needed in the spheres of: Work; Food and Agriculture; Energy and Transport; Housing; Local Development; and Corporate Responsibility.
8. Health professionals must become involved in non-medical matters to help people towards healthier lifestyles and a healthier world.
9. Steps towards the new economics of a healthier world are summarised.
10. An international movement for a healthier world will demand new economic policies from world leaders.

Mira Shiva

Health action to meet contemporary challenges

1. While India has made rapid strides in building its medical manpower and medical services, yet many of the major health problems are far from being controlled.
2. While the earlier health problems have not been resolved, newer threats to health through misguided development are being added to them.
3. The major health threats today are the denial of a minimal sustenance base, such as adequate food and water, to an increasing number of people.
4. The rapidly increasing uncontrolled chemicalisation of body and environment is another health hazard.
5. Experience has shown that health needs cannot be satisfied merely by expansion of the medical industry - doctors and drugs and through the health services.
6. Healthcare work must involve an attempt to arrest the growing threats to health and survival, and rebuilding of the ecological base to ensure provision of basic needs to all.
7. These efforts will be efforts towards a new economics, because they include radical shifts in food and agriculture policy, resources use policy, industrial policy, etc, and can only be guided by a deep sense of social justice and human concern.
8. Contemporary healthcare work has increasingly to involve those who are already looking for alternatives, eg those involved in the ecology movement, the feminist movement, peace and civil rights groups, alternative education, agriculture, healthcare and journalism.
9. Priority has to be given and strategies evolved to help add a health dimension to various health and non-health work and initiatives already existing, with a special effort to safeguard the traditional healthcare knowledge systems from total disintegration.
10. Grassroots feedback should constitute an essential prerequisite for any (health) policy formulation and its implementation.