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Medical Modernization: A Macro Level Conceptualization of Medical Care Programs
La modernisation médicale : une problématique macroscopique des programmes de soins médicaux
La modernización médica: una problemática macroscópica de los programas de atención médica

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Article abstract

The authors seek to conceptualize the assumptions underlying the theoretical models of medical modernization. They note that the implantation of a rational and scientific health care system has often meant simply copying western models.

The application of medical modernization models is examined in relation to marginal and disadvantaged groups in the United States as well as developing countries. The authors attempt to identify the general characteristics of these programmes and to evaluate the outcomes.

The main outcomes of the transplantation of this model are seen as:

1. a heavy accent on curative as opposed to preventive medicine which, due to the high costs of training and equipping specialized personnel has meant an astronomic increase in health spending.
2. a medical "brain drain" towards richer countries or regions.
3. a tendancy for the distribution of health care to be oriented towards the higher-income, highly industrialized segments of the society.
4. a deepening of political and economic inequalities.

For the purposes of comparison, the authors briefly examine another model which they term "health development". This models indicates that a general improvement in the health of the population depends as much on economic, political, ideological and technological factors as health care itself. Drawing on examples from China and Cuba, the authors note the importance of a more equitable distribution of goods, power and participation in the process of improving health. They conclude by stressing the necessity to carefully wegh the effects of importing modern medical practices.

Medical Modernization: A Macro Level Conceptualization of Medical Care Programs

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Abstract

This paper is an attempt to conceptualize an unspoken, yet often assumed basis for health planning in developing areas, that of medical modernization. The developing areas may be in third world countries, or in marginal populations within the United States. Taking a theoretical cue from modernization theories of social change, medical modernization here is defined as that process by which a society changes its way of achieving a healthy population from a traditional, non-scientific approach to a modern, rational and scientific one. Modernization of a health care system is viewed as requiring predictable changes in the social, technological, cultural, ideological, and political-economic bases of that system, resulting in a transformation of the society of which it is a part.

Properties of the concept may be appreciated at both the institutional and individual levels. At an institutional level within the United States, the medical modernization concept demonstrates three characteristics : 1) development of delivery structures in shortage areas ; 2) upgrading quality of care ; 3) development of minority health professionals. Developing countries exhibit an additional four characteristics : 1) opposition to indigenous health systems ; 2) concentration on development of professionally oriented quality ; 3) increase in total expenditures for medical care ; 4) use of modern facilities as show pieces of modernization.

At an individual level, within the United States three characteristics of the concept are seen : 1) physically bringing the patient into the delivery system ; 2) educating the individual to be an intelligent consumer of services ; 3) involving consumers in certain types of policy advice or decision making. At an individual level in developing countries, the major characteristic appears to be attempting to encourage individuals to reorder their priorities so that modern medical care activities achieve prominence. Outcomes would seem to indicate major questions of expenditures and benefits, distribution of goods and services and political ideological reinforcements.

An alternative to medical modernization is briefly introduced, with some key features taken from the experiences of community clinics in the United States and experiences of countries which have refused to accept modernization as the sole approach to social change.

Introduction

The basic question which health planners and medical care administrators must constantly face is simply this : How can one achieve a healthy population, given limited resources ? The more limited the resources, the more critical this question becomes in determining health policies.

For decision makers in many developing countries, and for those acting on behalf of marginal groups within our own society, this question often tends to evoke a single, uncritical response : problems of development of the health sector, and indeed of all sectors in a society or country, can be solved by adopting the social patterns of modern society. When this "modernization

approach" constitutes the health planner's basic orientation, the programs he/she develops. whatever the intent, often represent conceptions of quality medical care best suited to a small segment of the people, charateristically the urban elite, rather than the population as a whole. (See Navarro, 1976, Illich, 1975, Bland, 1976.)

An alternative approach to development generally, and the achievement of healty populations specifically, holds that the health of a population is affected by social policies which determine the major conditions of living : income, education, nutrition, housing, participation, etc. This assumption would argue that such conditions must be addressed on a basis of equitable distribution, and may require substantial societal restructuring before a healthy population is achieved. The alternative approach further argues that while western models of development may be useful as heuristic devices, they are not totally applicable to the "developing countries" in today's world. The approach, therefore, does not seek to replicate modern western society, but to develop new models which borrow in part from developed countries, retain some of the original society, and generate in the process new syntheses, which often have not been formally conceptualized.

While some developing countries and marginal groups within the U.S. have turned increasingly to this alternative approach to the development of a healthy population, the aforementioned modernization approach, bases upon the Western medical model, remains predominant.

This paper is an attempt to conceptualize the basic assumptions underlying the predominant approach to the question of how one achieves a healthy population. We shall develop what we term the concept of "medical modernization", which describes that process by which an underdeveloped society or country changes its mode of achieving a healthy society from the use of traditional, non-scientific ways to modern, rational and scientific ones, thereby adopting the medical model developed in Western society. We will then briefly introduce the alternative approach, which we term "health development" to provide a comparative framework for later analyses.

To facilitate examination of the process and assumptions underlying medical modernization, we will begin by identifiying those inherent in the parent concept, modernization.

Modernization Theory

Modernization theory [1] is an attempt to conceptualize an immanent process of change in societies. Because it constitutes the intellectual underpinning of development programs, a quick look at its major features will be useful. Modernization theory is basically a conceptualization of societal change concerned with the process by which traditional societies become moderns ones. This theory looks at the difference between "developed" and "developing" societies, posits reasons for failure to develop or modernize, and suggests possible barriers to modernization.

While definitions of modernization have varied on several key dimensions (Inkeles 1969 ; Schwartz 1972 ; Halpern 1966 ; Eisenstadt 1966), the term here will be defined simply as that process by which traditional societies acquire attributes of modernity. Thus conceived, as Tipps (1973 ; 204) has noted, "modernization is not simply a process of change, but one which is defined in terms of the goals toward which it is moving".

Societies are classified as either traditional or modern, partly on the basis of their structural characteristics. Traditional societies are thus described as agrarian, rural, non-scientific, with low level technology, and as having diffuseness of function, while, in contrast, modern societies are characterized as being industrial, urban, scientific, having a high level of technology, and by possessing high differentiation of function (Parsons, 1951). Modernization theory further suggests that there are a number of societal values which have made modern society possible, and which give it its particular flavor.

According to modernization theory, traditional structures and values need either to be changed to or replaced by modern ones in order that modernization might take place. The modernization process thus is held to be necessary, universal, and unavoidable.

Recently, numerous critics of modernization theory (see for example Tipps, Nisbet 1969; Rudolph and Rudoph 1967; Inayatullah 1967) have questioned the theory's inherent assumptions that (1) Western society's values, ideals, and technological advances are intrinsically right for all people and that (2) peoples and nations are invariably moving in the direction of these Western norms and achievements.

Critics further have attacked the "whole package" notion that "modernization in one sphere will necessarily produce compatible (eurythmic) changes in other spheres." (Tipps, 1973 : 215). It is argued that in buying the symbolic trappings of modernization, traditional people do *not* necessarily also accept and internalize the underlying values and world views of their more modernized neighbors. Indeed, the adoption of aspects of Western medical care which "make sense" in developing countries, with concurrent rejection of other less appropriate aspects, will be seen as constituting an important departure from the modernization dynamic in the health development model to be discussed later.

Medical modernization

Modernization has been conceptualized as the process by which an entire traditional society assumes the values and social structures of another more modern society. Taking a theoretical cue, we have then conceptualized medical modernization as that process by which a society changes its mode of achieving a healthy population from use of traditional non-scientific ways to modern, rational and scientific ones. Indeed, the presence, absence, or failure of modern medical care to be established and accepted in an area may constitute a litmus test of the degreee of modernization a society may have undergone.

Although the process of medical modernization has not been previously conceptualized, it clearly underlies much of the theoretical and applied work on the health care of developing nations. The medical modernization bias has been used theoretically to attempt to explain the lack of modern medical programs in certain areas or the failure of such programs to reach certain segments of traditional populations. It has been used programatically to forward the notion that a healthy population can be achieved only by wholesale application of the western medical model. In analyzing the medical care situation in an underdeveloped area, the medical modernization assumption lets a planner know what changes have to be made in traditional health care systems and suggests possible barriers to them.

Medical Care and Society

As Parsons (1951) has pointed out, medical care is a product of modern society. We would like to expand that observation to state that *any* health care system is deeply rooted in a society and reflects that society's perceptions and definitions of the world in general. A health care system may be conceptualized as having at least six bases in society : social, cultural, political, economic, technological, and ideological. A change in any of the societal bases may easily be reflected in a corresponding change in medical care.

In order to modernize the health care system of a given area, the following six bases would have to change in the following manner :

Social. Health care in developing countries is often delivered by non-physicians (folk-healers of various types) or by poorly trained physicians. Modernization would require the development of a solid corps of physicians with a strong professionally shared outlook. This would place a premium upon specialized knowledge and increase the capacity for its development and application. To accomplish this, medical schools and teaching and research hospitals are required ; the result is a highly specialized body of knowledge which is socially distributed.

Technological. Health care in a traditional society is often provided by means of low-level technology : herbs, folk therapies and manipulations, scantily equipped public health offices, etc. Modernization necessitates the development of higher level technology in drugs, therapeutics, and diagnostic equipment, with modern facilities needed to house all of these.

Figure 1

Characteristics of Structural and Value Orientations of Traditional and Moderns Society

Traditional Society		Modern Society
Structure		
agrarian		industrial
rural		urban
non-scientific		scientific
low level technology		high level technology
diffuseness of function		differentiation of function
Values		
present-oriented		future-oriented
ascribed status		achieved status
private interest		collectivity orientation
particularism		universalism

Figure 2

Non-modernized vs. Modernized Medical Care Systems

CHARACTERISTIC	NON-MODERNIZED SYSTEM	MODERNIZED SYSTEM
Social	low degree of profes-sionalization, specialization of knowledge, or skills	high degree of profes-sionalization, with specia-lisation of knowledge and skills
Technological	low level of technology	high level of technology
Culture	non-scientific basis or loosely based on scientific basis	scientific basis
Ideological	wide variety of illness ideologies	medical model only accepted ideology
Political	low degree of profes-sional autonomy	high degree professional autonomy
Economic	low level expenditure, national and personal	high level expenditure, national and personal

Culture. Health care in traditional societies is often predicated upon non-scientific notions, or at best, on loosely based scientific approaches. The culture of science must permeate any health care activity for modernization to be accomplished.

Ideology. Traditional societies have a plethora of health and illness ideologies, changing over time and distance, and borrowing and adapting new knowledge in rather unpredictable, uncontrolled ways. The ideology of the medical model (Hayes-Bautista and Harveston, 1977) must form the ideological basis of health care efforts. It is in this fashion that a profession can exert some control over the corpus of knowledge used to achieve health (Hayes-Bautista, 1976).

Political. The medical market is not often controlled by physicians in underveloped areas, but rather by other ruling groups. As the medical profession becomes strengthened, it must also be given the social sanction to define its own needs and the ability to police itself.

Economic. While modern medical care may be practiced under any number of economic philosophies in developing countries (capitalist free market or socialist health services), traditional societies tend to spend little on medical care, and hence it remains in a state of arrested development. A fairly large national expenditure is necessary in order to supply the capital necessary for the growth and financing of modern facilities. This increased expenditure may be generated either by increased participation of private paying patients in a fee-for-service model or by increased national expenditures.

The changes that would be necessary in a traditional medical system, or medical care system operating in an underdeveloped or traditional society, are summarized in Figure 2 below.

Theoretical properties of medical modernization

Now that we have defined the concept, we can begin to develop some of its theoretical properties. We shall do this by looking at various programs, both within the U.S. and in developing countries, which were designed to achieve a healthy population by concentrating on providing quality medical care. It will be noted that modernization attempts may be focused on the individual level (in attempting to change an individual's behavior to fit modern institutions) or on the institutional level (when attempting to build a modernized infrastructure).

Modernization within the United States

While the majority of the U.S. population appears to have relatively easy access to medical care, there are many groups for which this is not the case. These groups, which include the elderly, the poor, and certain ethnic minorities, may be termed as "medical marginals", whose marginality to medical care is only a reflection of their overall marginality to the society as a whole (Hayes-Bautista, 1976). Such groups have often been conceptualized as being traditional, parochial, and folk oriented (Suchman, 1967), hence poor utilizers of medical care. In this sense, they may be considered similar to the populations of developing countries.

The medical modernization assumption would posit that the level of health of these marginal groups be raised by providing for easier access to medical care. In order to raise the health level of such communities, a health planner operating with the medical modernization assumption will often choose to follow at least two approaches. The first is to operate at an institutional level, both to provide for services where none exist, and to upgrade the quality of services wherever they might be offered. The second is to medically modernize individuals so that they will appreciate the benefits of modern medical care.

At least three characteristics of institutional level modern medical modernization have been observed. The first is the tendency to develop medical care delivery structures to introduce care into shortage areas. The United States already possesses a highly developed medical infrastructure which surrounds the marginal populations; this includes large hospitals, university research complexes, high level technological equipment, and drug and medical supply manufacturers. What is lacking is some means of entree for the excluded

groups. The medical modernization response takes the form of providing outlets for care to marginal groups, in the apparent hope that these outlets will serve to channel the marginals into the rest of the medical care infrastructure. A most visible example of this was the medical modernization approach to the problem of the marginal population's non-use of available services. Numerous Neighborhood Health Centers were developed by the Office of Economic Opportunity, which was concerned in part that illness was keeping many of the poor out of the work force.

A second characteristic of medical modernization at the institutional level is the striving to upgrade the quality of care given in scarcity areas. Programs such as the Health Systems Agencies are especially mandated to bring the quality of care given marginal populations up to the standards enjoyed by mainstream medical care utilizers.

Finally, a third and related characteristic is seen in the notion that better health could be achieved by educating members of some marginal groups to become full-fledged health professionals. The Health Manpower Development Corporation was formed in 1972 to "increase and improve health services for the more than 40 million black, Chicano, Native American, Puerto Rican, and impoverished white Americans who have been denied adequate health care" by "encouraging disadvantaged and minority students to enter health careers" (Health Manpower Development Corporation, n.d.). This (medical modernization) approach assumes as Parsons did (1951) that a highly autonomous profession is the epitome of a modern society; a sizeable minority presence in the most modern of professions would be a tremendous step in the eventual modernization of the entire community.

The apparent major goal of medical modernization at the individual level is to create a modernized patient, who will make full and intelligent use of high quality medical care. At least three characteristics of the modernization process at the individual level can be seen as directed toward this end.

The first is to bring the individual physically into the medical care system. While there are many ways in which this is done, the one which has attracted most attention has been the Titles 18 and 19 of the Social Security Act. As noted by Davis (1976), the Medicaid program sought to increase participation in medical care by relieving poor persons of its financial burden. It was hoped that this would bring persons into mainstream medical care, and that after enjoying the benefits of such care, their health status would be improved.

Once the patient is physically involved in medical care, the next relevant characteristic of modernization on this level involves education of the individual to become an intelligent consumer of health care services. Typically, patient education has been aimed at creating attitude change in individuals so that they will perform in a way amenable to the structure of care delivery. These efforts often include instruction in areas such as the proper making of appointments, appropriate utilization of emergency rooms, and compliance behavior.

Once the patient has been brought into the modern medical care system and educated to its proper use, a third characteristic can be seen, which is the involvement of the individual in medical care decision making. Since the mid-sixties, the mandate has been given for some form of consumer representation in planning and delivery agencies. Health task forces, comprehensive health planning agencies and their successors, Health Systems Agencies, Neighborhood Health Center governing boards and the like have been attempting to add an element of consumer representation to medical care decision making.

Modernization in Developing Countries

The medical modernization dynamic is perhaps most apparent in the developing countries, where large scale efforts at improving health through the wholesale transporting and adopting of the Western medical model have been witnessed.

Four overlapping theoretical characteristics appear to characterize these medical modernization efforts.

On an institutional level, medical modernization in many developing countries has involved

active, often formalized opposition to indigenous health care systems. Frequently, therefore, homeopathic and other forms of "traditional medicine" are not accorded legitimacy by Western trained health officials and ruling elites, who see these competing systems as thorns in the side of "real" (Western/scientific) medical care.

A second, linked, characteristic is the quest for quality. Given the preoccupation of health planners in many developing countries with comparing their systems to those of the developed countries, and using the former as models of excellence after which to pattern their own health systems, much effort is put into the construction of medical education facilities, modern showpiece hospitals, and provision for the highest levels of training for the urbanized health care professionals. Health policy planners correspondingly have, at times, opposed the development of inexpensively trained and non-exportable "medical assistants" or other paraprofessionals, as being sidetracks into low quality medical care (Bland, 1976).

A third characteristic of the institutional level modernization process in developing country medicine is the rise in spending for facilities and care. The United States spends increasingly larger amounts of money on medical care, both in total amounts and in relation to population (Milbank Commission, 1976) in order to achieve high quality. As other countries attempt to imitate a U.S. level of care, their expenditures must increase in a similar fashion, in order to provide an adequate economic base for a Rostrowian "take-off" for medical care (Rostow, 1956).

A final theroretical characteristic of medical modernization on the institutional level involves the role which the accoutrements of modern medical care may play as status symbols in the developing countries. While such nations typically have established networks of primary health centers and sub-centers in the rural areas, the monies allocated for maintaining and equipping such clinics are often minimal in comparison with the resources devoted to "showpiece" hospitals and medical institutes in the urban centers (see, for example, Banergi, 1975).

While medical modernization efforts in the developing countries have been disproportionately concentrated on the institutional level, some efforts to bring individuals *to* the system and to educate traditional men and women to become intelligent (modern) utilizers of Western medical care may be observed. Particularly in areas such as family planning, where governments perceive themselves as having a large stake in popular compliance, mass awareness and motivation campaigns have been launched with the intent of bringing individuals to the service, by fostering internalization of appropriate values and attitudes.

As on the institutional level, the adoption of certain "desirable" health practices may be equated with modernity and increased social status to facilitate their acceptance. Thus, canned milk and baby bottles were helped to become status symbols for Indian and Chilean women in the '60's (Illich, 76 : 87) in the same way that modern hospitals and medical institutes had taken on symbolic importance for their respective governments and health ministries. That neither level adoption was in the best health interest of the populace appeared to matter little in comparison with the symbolic significiance of these developments, each of which reprensented a move toward more "civilized", modern practices and priorities.

The overall goal of medical modernization on the individual level may, in sum, be viewed as an intensive reordering of priorities such that Western medical care and modern health practices achieve hegemony in the minds and actions of the people.

Outcomes

The characteristic properties of medical modernization in the U.S. and in developing countries suggest a number of possible outcomes. These may be broken down in terms of (1) expenditures and benefits, (2) geographic distribution of goods and services, and (3) the political/ideological outcomes of the medical modernization dynamic. Each of these outcome areas will now briefly be examined.

Expenditures and Benefits

In both developed and developing countries, the medical modernization model has, by its very

nature, placed a heavy accent on curative, as opposed to preventative and health promotional, services.

While national expenditures on health care rage from $128 billion in the United States (DHEW Task Force ; 1976) to less than $1 million in the poorest of the developing countries, the pattern of allocation within the broad health care category is remarkably similar. Therefore, in the United States only 2 to 2,5 % of health care expenditures go to preventative health measures and only .5 % to health education (DHEW Task Force ; 1976). Similarly, in developing countries such as Chile and Sri Lanka, 90 and 94,4 % of the total health care budget respectively goes to curative services, with only 5-10 % allocated to health education and preventative measures (Wilenski, 76 : 6).

The financial burden which this lopsided emphasis on curative services imposes is particularly evident in the developing countries, where already limited resources are quickly dissipated by modern, capital intensive medical care. Thus, Nigeria and Uganda, with per capital incomes of U.S. $68 and $83 respectively, invest an average of $30 000 to train a single medical graduate (Bland, 76 : 14). Such graduates in turn demand complementary outlays for structural supports in the form of modern hospital equipment and sophisticated medical institutes, and the bulk of health expenditures goes to just such infrastructure development.

The benefits of this prevalent pattern of health care resource allocation have been seriously called into question, with the World Health Organization noting, for example, that inexpensively trained "medical assistants" or para-professionals are capable of dealing with 85 % of the health needs in developing countries (Bland, 76 : 16). Continued emphasis on the training of "top quality" medical personnel, however, and concommitant opposition to the alternative development of a sizeable cadre of lower echelon health workers, remains an important and unfortunate outcome of the medical modernization bias in many developing countries.

A related outcome of medical modernization is, of course, the "medical brain drain"which results when highly trained medical personnel from poor countries or communities migrate to areas where sophisticated equipment and lucrative private practice facilities are readily available.

Noting that 58 000 imported physicians now practice in the U.S. alone, Illich has stated that "medical schools in poor countries constitute one of the most effective means for the net transfer of money to the rich countries" (1976 : 57). The existence of a similar phenomenon has yet to be conclusively demonstrated within the U.S., *.e.g.*, among members of low income Black and Chicano communities who graduate from medical school and who are then faced with the choice of practicing in their communities of origin or outside, where there is greater financial gain. While indigenous organizations, such as the National Chicano Health Organization, have been developed to encourage such graduates to practice in their respective communities, data are not yet available which would confirm or disprove the existence of a feared internal domestic brain drain.

Distribution

Another outcome of the medical modernization bias in both developed and developing countries is the skewed distribution of health and medical care manpower and services. Domestically, the fact that medical modernization benefits the higher income, highly industrialized segments of society becomes particularly apparent in the distribution of physicians, where two types of maldistribution may be noticed, each resonating with the other. Geographically, physicians in the U.S. are not distributed proportionately with the population, with the result that large metropolitan areas have a much lower physician/population ration than do rural areas. The State of New York, for example, boasts 249 physicians for every 100 000 inhabitants, while in South Dakota, the ratio becomes 84 : 100 000 (Roback, 1974 : 23-24). Nationwide, only 7,7 % of practicing physicians in the U.S. serve in nonmetropolitan areas, where 18,4 % of the total population resides (Univ. of Michigan Bureau of Health Economics, 1972 : 116).

With the developing countries, still more striking maldistributions may be observed as sophis-

ticated services available to the urban elite exhaust already meager health budgets, leaving rural majorities with scant services. India is typical in this regard, with 90% of her hospital beds located in urban areas containning only one-fifth of the total population (Banerji, 75 : 78). Correspondingly, 80% of the nation's doctors serve the privileged urban minority, most of them working as private practitioners.

The paucity of physicians in the poorest of developing countries is itself a matter of great concern. Accordingly, Ethiopia, Chad, and Upper Volta report one doctor for every 65 000, 71 000, and 74 000 persons respectively (Univ. of Michigan Bureau of Public Health Economics, 1972 : 130).

In sum, both within the United States and in the developing countries, uneven expenditures and consequent uneven distribution of health manpower, services, and facilities constitute important and interconnected outcomes of the medical modernization dynamic.

Political

By far the most critical outcome of medical modernization, and one which dominates and helps to shape those previously described, is the political outcome. Medical modernization has the effect of strongly reinforcing existing economic and political power imbalances between the elite and the masses. As Navarro has suggested, the "Flexenrian transfer" which helped establish "centers of excellence" in many developing countries also facilitated :

> ... an international solidarity in defense of class and professionnal interests. ... In that transfer, usually presented as humanitarian and certainly as value-free, there is a transfer of an ideology that supports and replicates established power relations (76 : 7).

Indeed, the whole modernization notion which would have developing communities or societies buy the values as well as the trappings of Western medical care appears to assume the continuation of significant class differentials and of hierarchical power relations both within the health professions and in the larger societies they seek to serve.

While the political outcome of medical modernization will be discussed at length in a later paper, the importance of this topic cannot be overemphasized, and the reader is encouraged to see Navarro 1974, and Alford 1975, for more depth of analysis.

Health development : an alternative to modernization

As noted earlier, the medical modernization approach to achieving a healthy population may be contrasted with an alternative approach which we have termed health development. This latter perspective suggests that the health of a population is dependent upon social, economic, political/ideological, and technological factors, and that medical care is but one of many tools to be used in achieving a healthy society. Simple application of the medical model will not, in this view, achieve a healthy population if it does nothing about the root causes of illness such as gross maldistribution or resources.

In addition to the above noted linking of health with the economic and political well-being of a society, key features of the health development model include :

(1) a stress on the equitable distribution of goods, power, and participation in a society, rather than simple aggregate levels of consumption, and

(2) the notion of partial (as opposed to "whole package") adoption of those features of moderns society which may be relevant and useful to a developing community.

While it is beyond the scope of this paper to explore these features in any depth, it should be noted that their theoretical underpinnings stem from recent development literature, in which development ceases to be defined in terms of a society's ability to imitate modern society, and leavers it freer to generate its own definition in terms of its ability to survive (Stavenhagen, 1974 ; Quijano, 1973, Frank, 1969).

In the developing world, China and Cuba (Moran, 1974) have provided perhaps the most

comprehensive examples of health development, through their attempts to redefine and reconstitute the health structure by infusing political ideologies into health care.

Similarly, within the United States, clinics which have involved themselves in food distributions programs and in political consciousness raising among their clientele (Hayes-Bautista, 1977) have begun to embrace a "health dévelopment" approach to the achievement of healthy populations. These departures from the norm of medical modernization, as well as its theoretical basis, will be explored at length in a later paper. For the present, however, we may sammarize by noting that health development is concerned with all of the areas of development of a society or community and considers them all to be areas of concern for medical care.

Furthermore, and in stark contrast to the medical modernization approach, health development visualizes the process of development as being fully as important as the actual achievement of development itself.

Conclusion

This paper has sought to conceptualize and develop the theoretical properties of one approach to the question of how a society achieves a healthy population. Because this approach is so pervasive as to have been almost taken for granted, a thorough examination of its premises and major characteristics appeared in order. We have looked at modernization as a formulation of some assumptions in many areas of societal development and have attempted from that body to draw parallels to a similar process in the area of health care. We have further begun to develop a rough theroretical framework, examining some of the potential and observed outcomes of medical modernization, both on a community (macro) and individual (micro) level within the United States and in many developing nations.

Finally, to draw attention to the fact that an alternative approach to medical modernization exists and is increasingly making its presence felt through marginal community clinics in the United States, and on a far larger scale, in countries like Cuba and the People's Republic of China, we have introduced the concept of "health development". While some of its theoretical properties are described, the health development model was presented here only as a comparative device and will be described a length in a later paper.

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Footnotes

1 While the term "modernization" has replaced in the literature its more ethnocentric precursor "Westernization", some argue that the latter term is more blatantly realistic. (See Inayatullah, 1967).

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