Point of View

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Maintaining the health-for-all momentum

The efficiency and effectiveness of the health-for-all strategy have been judged largely by the results achieved in the developing countries. Assessments of progress have, for the most part, failed to take account of the slowness of advances previously made in the developed countries, and to allow for the fact that health services develop in parallel with teaching institutions and other bodies. In most African countries the whole process has been hindered by worsening economic, social and legal conditions. In considering how the momentum of the health-for-all strategy may be maintained, this article argues against undue bias towards the profit motive, which could lead to many people having access to only second-class services.

By the mid-1970s, the developing countries were becoming a cohesive force in the international agencies. Meanwhile, in the developed countries the rising cost of largely curative health services was creating immense pressure on the public authorities. Certain vertical programmes, notably that for malaria control, had failed, and hospital structures in developed countries had often proved ineffective. University-based groups in the developed countries began to conduct experiments in non-institutional health care. Health professionals in these countries demanded public funding systems and remuneration for preventive services.

The health-for-all strategy, based on integrated health care delivery systems, won enthusiastic support from developing countries at Alma-Ata in 1978. The need for political commitment by governments was proclaimed: social inequalities and injustices had to be reduced, a multisectoral approach adopted, and leadership for change promoted. Primary health care was seen as a prerequisite for extending coverage. Improved planning and administrative capabilities were required, together with a network of services of expanding scope and new functions. However, some governments saw primary care as only a second-class service intended for marginal populations lacking access to hospitals, and as a means of coping with possible social confrontations.

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Since the beginning of the 1980s, most Third World countries have been faced with economic recession of unprecedented gravity, to which the response, with rare exceptions, has involved programmes of economic readjustment. The usual manifestations have been a reduction in funding for the public social and health sectors and the promotion of private initiatives. The cuts in public funding have been reflected in the quality of services already undermined by administrative and logistical shortcomings. In several countries, access to and consumption of medical care have diminished. Particularly in Africa, crop failures and armed conflict have forced people to abandon their homes. The deterioration of health status is widespread because of reductions in purchasing power and the withdrawal of subsidies for staple foods.

The Third World has also suffered from a decline in political enthusiasm during the 1980s. Several governments are

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encountering unexpected difficulties in realizing economic liberation. Because of economic difficulties, compounded by the unsuitability or ineffectiveness of new public institutions, improvements in welfare have been much more modest than expected. Consequently, it has become increasingly hard to mobilize popular support.

In many countries, second-class structures giving no access to referral facilities have been created. This means that the most disadvantaged people are precluded from obtaining the specialized medical care they need. There have also been failures to integrate technically simple, vertical programmes into primary care: the lack of coordination between immunization and maternal and child health care is perhaps the most striking deficiency. Administrative and logistical inefficiency, along with unduly centralized control, have resulted in excessive costs and inflexible management. The deterioration of equipment has reduced the quality of service and pushed up running costs.

**New approaches**

The developing countries are in a demographic, ecological and food crisis. Public institutions are often ineffective and technological levels are generally low. The public has little faith in governmental institutions and programmes. If the health-for-all strategy is to retain broad international support, substantial progress will have to be demonstrable quite soon. Donors will have to be satisfied with the strategy, which is primarily concerned not with their problems but with those of the developing countries. Technical and managerial capabilities in developing countries will have to be improved; in this connection it is necessary to win credit with public institutions, something attainable by results but not by speeches.

The construction of integrated health care delivery systems based on primary care remains the essential precondition for health for all. This is the most economical formula: systems that are mainly commercial and curative always incur larger deficits. Systems predominantly rooted in the public sector
are, on balance, the most economical and therefore the most likely to allow the extension of services towards the periphery. Moreover, they are the only systems permitting positive discrimination, since they open the door to the specialized medical care needed among the most disadvantaged strata of society.

Unfortunately, such systems become unwieldy. In the developing countries, bureaucratic apathy is compounded by inefficiency resulting from shortfalls in operating budgets and a lack of motivation among poorly paid staff. Rigorous referral procedures are vital, since every case treated at too high a level attracts unnecessary costs. Referral levels, and the procedures for access to them, should therefore be standardized.

Formulae providing for free care or flat-rate charges should be shelved. Free curative care leads to waste and loss of credit with the public, while flat-rate charging discriminates against the poor. Payment systems should be based on surveys of the use of services by different social groups.

Other bodies than the state, including commercial firms, insurance companies, and nongovernmental organizations, should participate in the financing of health care, but this does not mean the dismantling of a unified institutional system.

These preconditions can lead to a gradual reduction in inequalities of access to health care and can allow positive discrimination by the state in tackling the greatest possible number of disease problems among the socially and economically most disadvantaged sections of society.

Concurrently, specific targets should be set and programmes launched for reducing the disease problems in the various social groups. The major causes of infant mortality in Africa, among them measles, malaria, acute respiratory infections, diarrhoea, malnutrition, and perinatal factors, could be tackled with increased effect using present technology through the institutional network. The same type of programming should be instituted with regard to maternal mortality, which remains stationary at a high level in most parts of Africa. The control of malaria, tuberculosis, leprosy, and certain other diseases that are major causes of mortality and low productivity could be improved, at least over limited geographical areas. Such programme packages require the creation of new technical capabilities in epidemiology, planning and health economics at national level.

Unfortunately, while financial difficulties and the deterioration of health status are compelling health authorities to assign programme priorities and rationalize resource management, there is a lack of skills and expertise. In this context, short-term consultants present more problems than they solve. Epidemiologists, planners and health economists can be effective in the long term only if they work as a national team and help to develop local capabilities.

Challenges, risks and opportunities

In the developing countries there is a clear connection between the economic crisis, the social consequences of structural
readjustment programmes, and the deterioration of health status. The developed countries should reconsider their position with regard to the international economic order and the exploitation of the resources of the Third World. Deteriorating living conditions can become a catalyst for social upheaval in the developing countries.

The efficient management of health systems requires the development of planning and health economics for both analysing cost-effectiveness and monitoring the output of institutions.

Different population groups have different disease profiles and social consumption habits. Public intervention aimed at redistributing wealth is necessary, including job creation, greater efforts to achieve social integration, and encouragement of the use of social services.

Internationally, there now appears to be particular concern to develop specific programmes of high cost-effectiveness for disease problems or risk groups and to achieve profitability in health care delivery systems and institutions. If pressure along these lines is applied to countries where there are no integrated health services, the following consequences are possible.

- The medicalization of systems could occur, leading to a loss of democratic control over their operation, and to foreign cultural and technological domination.
- There could be neglect of certain health problems and of the organization of basic services after the successful implementation of programmes favoured by funding bodies. Furthermore, the establishment of supporting structures for major vertical programmes could destroy the existing infrastructures. Verticalization also entails a risk of cost increases.

- There could be political manipulation of risk groups, who could be offered minimum programmes without access to the referral levels while having to survive as a manpower reserve.

International bodies are saying that publicly run health services are always inefficient and that the privatization of health care should be part of the solution to this problem. Regrettably, less prominence is given to the following realities.

- It is possible for publicly run health systems to be efficient, as is evident in several developed countries.
- Systems based on private medicine are sometimes less efficient than publicly run systems. Furthermore, to go down the privatization road would be to extend private medicine and magnify inequalities. Governments of developing countries would be obliged to finance health activities only for people who could afford to pay through being engaged in production and thus integrated into the world market. Anybody not in this position would receive little or no health care.

In order to develop specific, highly cost-effective programme packages for dealing with disease problems and risk groups it is firstly necessary to define social groups and identify their requirements. The efficient management of health systems requires the development of planning and health economics for both analysing cost-effectiveness and monitoring the output of institutions.
From this combination of disciplines is derived a capacity for strategic planning, something that is essential for obtaining short-term results that provide the stability and prestige allowing long-term progress, and for restoring the credibility of public institutions.

So as to minimize disparities between social groups brought about by economic rehabilitation programmes, greater scientific rigour should be deployed by government institutions dealing with intersectoral problems. The health sector should devise objective, quantifiable indicators of the need to readjust social policies.

The Editor would be pleased to receive readers' views on obstacles to applying the health-for-all strategies and ideas for overcoming them.