Target 2000

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Health for all: the way ahead

The attainment of health for all requires that a complex range of political, social, managerial and technical problems be overcome. To this end it is necessary to produce a sufficient number of health-for-all leaders throughout the world, possessing the conviction and knowledge that will allow them to galvanize the masses into taking action on their own behalf.

Since the World Health Organization came into being in 1948 various approaches have been tried for providing optimal support to countries in their struggle against major public health problems. There has been a progression from the epoch of malaria control in the 1950s to the development of basic health services in the 1960s and, in the 1970s and 1980s, to the much broader approach of primary care and health for all with emphasis on intersectoral collaboration and community involvement.

The problems that threaten the attainment of health for all are very complex. In order of importance they can be categorized as political, social, managerial and technical. No amount of development or improvement of national managerial or technical expertise can produce major breakthroughs until solutions are found to complex political and social problems. Health for all has to be achieved by countries and in the context of the social structures in which people live.

Political problems

There is no universal blueprint for a health-for-all strategy but there can be a broad understanding of what health for all means. The underlying principle is that in the pursuance of the objective of improving the health status of populations, countries must ensure that every individual in every community has access to primary care and consequently the ability to lead a socially and economically productive life. It follows that health for all will have different practical implications for different countries and even for different parts of particular countries, depending on their economic and sociocultural characteristics, morbidity patterns, and the degree of development of their health systems; however, the universal theme must always emphasize social equity.

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If people in the developing world are to have radically improved lives, it is first of all necessary to teach them to be dissatisfied with the present situation and at the same time make them appreciate how they can work towards a better future. People with leadership potential in each country have to devise ways and means of getting the rural masses to understand health development, create health cooperatives, set up district health and/or development committees, construct their own outreach health facilities from locally available materials, and select from among their own people suitable candidates for training as primary care workers. When the rural masses have been so mobilized there will be pressure from them for concerted and coherent action by the policy-makers. This is the real litmus test of political commitment.

An important obstacle exists wherever there is a lack of appreciation of the need to perceive health development as an integral part of economic and social development. Health development is not the exclusive concern of health ministries, which tend to

**Health ministries—and the others**

For several decades it has been the policy of the World Health Organization to strengthen ministries of health with a view to improving their capacity to promote new thinking about health development, especially in the areas of health promotion and disease prevention. The Organization’s country offices, headed by WHO Representatives, have in the main been strategically located in these ministries. This has not paid off, largely because ministries of health have little political leverage in the Third World, a fact that should be urgently confronted by developing countries if health for all is not to become an empty slogan.

The grouping of all health-related ministries and departments under one umbrella at the highest political level, advocated by the World Health Organization a decade or so ago, has not been seriously tried. National health councils can exist as separate entities or become functional subcommittees of national planning commissions. Coordinating committees comprising representatives of the Organization and national government, or similar arrangements confined exclusively to the health sector, should not be allowed to supplant genuine intersectoral councils for health development, whose mission and functions they can never fulfil.

In order to ensure that these councils function efficiently and effectively in coordinating activities concerned with the different components of primary health care and the inputs from bilateral, multilateral and nongovernmental organizations, serious thought needs to be given to the assignment of responsibility for running them. In view of their very important advisory, consultative and coordinating role, they should meet at least quarterly under a

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suitably senior chairman, e.g., a national vice-president or a deputy state governor. An alternative would be to assign the responsibility to a ministry of finance, planning and economic development, whose minister would take the chair. The ministry of health, jointly with the ministries of local government and/or rural and community development, should take on the functions of a secretariat. Depending on the country, nongovernmental organizations and other political, economic and sociocultural groupings should be represented on the council. This proposal should not be construed as an attempt to encroach on the traditional duties of a ministry of health. Its purpose is to impress on the minds of those holding power at country level that there is an imperative necessity for an intersectoral approach to health development.

**Technical and other support**

The world economic crisis has raised doubts about the prospects of attaining health for all. In the developing countries, adverse climatic conditions and other calamities have made a bad situation critical. Against this background the fight for new financial and technical support for health-for-all strategies has to be waged. Emergency aid is not a panacea; unless accompanied by long-term support for health development, it fosters negative attitudes and an endless dependence on external assistance. The same critical economic situation has led to the idea of technical cooperation among developing countries, which raised high hopes in the second half of the 1970s but has so far failed to produce the results expected of it. In addition, cooperation between developed and developing countries in the form of direct technical assistance or through groupings such as the European Economic Community is beginning to slacken.

The establishment of the mechanism of country planning figures for technical cooperation with Member countries started in the World Health Organization’s 1980–81 financial period. It is perhaps time to embark on a full-scale appraisal of its merits and demerits. In any event, the question should be raised as to whether it has brought about a better working relationship between the Organization and the Member countries and, in particular, whether it has proved an efficient and effective way of fulfilling the Organization’s technical cooperation role. This question requires an in-depth study with a view to ensuring that funds are being disbursed judiciously and in support of health-for-all strategies.

Not only has this cooperation failed to provide the much-needed transfer of technological know-how, but there is a growing suspicion that the greater part of the financial outlay returns to base either as exorbitant salaries and allowances paid to “experts” or in the purchase of supplies and equipment. The donor countries seem to have come to appreciate the need for a new approach to food aid: the emphasis should be on the requirements of the developing countries, not on the food surpluses the donor countries would like to unload.

**Social factors**

The beliefs, attitudes and behavioural patterns of people as well as the social
structures they live in affect the degree of acceptance and the implementation of the essential components of primary health care. The implementation of plans of action that give effect to health-for-all strategies requires the preparation of policy-makers, planners and health personnel so that they will accept changes of attitude and behaviour. These changes call for a study of the group dynamics of the consumers and providers of service. Indeed, over the last decade or so, there has been a growing awareness of the significant contributions that social anthropology and its related disciplines can make to health development. Health promotion and disease prevention are inextricably linked with changes in human behaviour.

The extent to which cultural practices and beliefs can influence the perpetuation of insanitary habits and environmental pollution is now fully recognized. There is a pressing need for social research to throw some light on how to overcome this difficult problem, and on how the consumers of service can be made to appreciate their prime responsibility for the maintenance and improvement of their health. It may be extremely difficult, if not impossible, to effect behavioural changes in the elderly. However, as the populations in most developing countries are comparatively young, vigorous programmes of public information and education aimed especially at the young should quickly produce rich dividends. Well-thought-out, practical health education programmes in schools will not only motivate the young but can also indirectly affect older people.

How can customs, beliefs, behaviour and social organization be exploited to enhance the political commitment of the masses to health development? How can cultural taboos on food items that are necessary for the protection and promotion of health of specific population groups, e.g., pregnant women, be overcome? How can knowledge of existing health patterns, practices and services be increased with a view to effecting change? How can local financial support for health development be mobilized? Until answers are found to these and other burning questions there can be no significant extension of primary care.

The fundamental resource of all health work is the community itself and full community involvement should form the basis for the expansion of health care systems. To maximize community involvement means that:

- coverage has to be improved in ways that are acceptable culturally, especially in rural and periurban areas;
- communities have to be provided on a continuous basis with information and education about health systems and the ways in which their functional efficiency and effectiveness can be sustained;
- the dynamics of community mobilization have to be given pride of place in health systems research conducted in parallel with programmes in other priority areas.

Managerial considerations

Health infrastructure

The most important managerial obstacle to the attainment of health for all in many developing countries is the absence or poor development of a health system infrastructure. In many of these countries, health infrastructures lack the managerial competence to deliver existing health technologies in a satisfactory manner; if this state of affairs could be adequately improved there would be a great advance towards health for all. The ideal approach involves
the proper planning and programming of health-for-all strategies. Most countries have experienced various aspects of a national health planning process, but hardly ever in a systematic or interrelated manner. Because of the crucial importance of the initial planning process in the development and optimal functioning of a health system infrastructure based on primary care, the World Health Organization has devised a managerial process for national health development. It includes health programme evaluation and the closely related national health information systems, and provides several entry points in order to cater for the situations in different countries. Unfortunately, very few countries have yet used it correctly.

Training in health development

Appropriate training in health planning and management at all levels is vital if the capabilities of the manpower required to formulate and implement national policies, strategies and plans of action are to be developed and sustained. Training programmes at the Organization's regional and subregional health development centres should be intensified to support countries' efforts. In a typical country setting, training in health planning and management should take place at the national, provincial and/or regional, and district levels. In the national context, training must be conceived as a continuous process and not as a one-time exercise, since some training in management can be undertaken at every stage of the planning cycle.

Information on health

Another important managerial obstacle is presented by the almost complete absence of reliable health information. The World Health Organization should stimulate, encourage and actively support national efforts to develop or strengthen central planning and statistical units. The Organization should make it conditional for the granting of a country planning figure that a fixed percentage thereof will be disbursed in support of a central planning office in the ministry of health.

A country's central planning and statistical unit should progressively develop and strengthen its antennae at provincial, regional and district levels, where it is responsible for the training of personnel. At a very early stage the unit should prepare a list of priority tasks, at the head of which should be the development of mechanisms for the collation and analysis of the right kind of health information from all categories of health facilities. Also included should be the provision of information feedback to intermediate and peripheral units and the use of health systems research as an important managerial tool for the strengthening of the health system infrastructure.

Central control versus decentralization

A health system is composed of different levels in a pyramidal structure whose base is where primary care is administered. The central and intermediate levels are
responsible for supervision and the provision of support for the facilities at the base. This support includes the provision and maintenance of technical and logistic equipment and supplies, the organization of in-service training, the dissemination of information, and the provision of referral facilities. However, restrictive and unimaginative central control should not be allowed to stifle creativity at the periphery.

**Location of WHO's country offices**

In order to facilitate direct and permanent collaboration with national health administrations, the offices of the WHO Representatives have always been located in ministries of health or as close to them as possible. However, in the light of what has been said about the political leverage of these ministries, serious reconsideration should be given to this matter.

Clearly, the main reason for the World Health Organization to maintain an office in a country is to activate and enhance technical cooperation. This includes the provision of support for national administrations in the preparation of health-for-all strategies and plans of action for implementing them; the coordination of inputs into the health sector from different sources; the identification of areas where the Organization’s inputs can have optimal multiplier effects; and the provision of information and technical support during programme implementation. These activities have great political implications and call for policy decisions at the highest national level. In almost all developing countries this means the ministry of finance, planning and economic development, with which the United Nations Development Programme (UNDP), the World Bank, the International Monetary Fund, and the regional economic commissions and development banks have to deal. This ministry coordinates all inputs from abroad, regardless of the sectors for which they are destined, and the preparation of national development plans. Obviously, therefore, the World Health Organization’s office should be located here in order to give the politics of health a hearing in the real corridors of power. In national contexts where this would create serious problems, a suitable alternative would be to attach the Organization’s office to that of the UNDP Resident Representative who is the overall coordinator of United Nations activities in countries and therefore has a hearing in important government forums. Matters of a purely technical nature would continue to be handled in the ministry of health or in related ministries and departments.

**Technical matters**

If countrywide health systems based on primary care are to function optimally, the following points require serious consideration and constant vigilance: the appropriateness of the health infrastructure; the correct mix of the different categories of health manpower at each level; the technical content of programmes; and the appropriateness of health technology, support and management. Guided by the peculiarities of its political, administrative and cultural setting, each country should take into account the following key factors in order to ensure that actions at different levels are technically coherent and mutually supportive:

- the geographical and demographic characteristics of the various parts of the country;
- the quantity and quality of manpower;
- the definition of the function, scope and degree of sophistication of the work to be undertaken at different levels;
— the definition of the lines of demarcation within the health infrastructure of the primary, secondary and tertiary levels of care, remembering that primary care must remain at the hub;

— the first referral level or district hospital in primary care must be strategically located in view of its important coordinating, training and supervisory functions.

When devising health-for-all strategies and formulating plans of action, governments should give serious consideration to the technical content of programmes and the appropriateness and social relevance of the technologies to be used for delivering them; for example, with reference to: the storage and distribution of drugs and vaccines; equipment (pumps, syringes, material for sterilization, transport, radio communication systems, etc.); expendable supplies (cotton, gauze, bandages, etc.); medical appliances, refrigerators, deepfreezes and their sources of energy; the small-scale manufacture of equipment in the countries concerned, using locally available material; and the regular, local maintenance of all equipment.

**Health manpower**

Each country will have to decide on its manpower requirements for each level of service and on the degrees of sophistication of service to be delivered, taking into account the useful role of traditional healers and birth attendants where applicable. It will be necessary to organize reorientation courses for existing health workers, training courses for new cadres of health personnel, and in-service training for all categories of staff. Apart from logistic support, manpower training will require the most extensive inputs and is thus an area where the World Health Organization can supplement national and other external contributions to the greatest possible effect. If it is accepted that the delivery of primary care is best installed on a phased basis rather than as an experimental demonstration or a pilot project, then manpower requirements will call more for a deployment of personnel than for a major increase. Lastly, incentives should be devised to encourage experienced staff to remain at their posts for considerable periods of time.

**Support from the centre**

The support provided by the higher levels of the health system for primary care is vital. It embraces the planning of health care delivery in its multiple dimensions, the definition of appropriate curricula for training programmes for all categories of personnel, the establishment of a carefully planned schedule for the provision of supplies and equipment, the provision and maintenance of the right type of logistic support, and the development or strengthening of an adequate two-way referral process. All this calls for leadership.

**Leadership potential can be encouraged, enhanced and strengthened by means other than formal educational activities.**

**Leadership development**

An innovative approach to foster the build-up of a critical mass of health-for-all
leaders throughout the world was approved by the Thirty-eighth World Health Assembly in 1985. Its success will require the combined, dedicated and tireless efforts of the whole Organization, and of all the bilateral and multilateral agencies and nongovernmental organizations whose activities have direct or indirect implications for health development in Member countries.

Three important questions will have to be answered at the very outset in order to put this leadership development effort on the right footing.

- What are the principal objectives of the scheme?
- Who should be the target groups both from the national and international points of view?
- Can some of the operational aspects of the development scheme be specified even at this initial stage?

Others will, of course, come to light as a result of further analysis and research as well as through the process of learning by doing.

Clearly, the first objective in leadership development should be the acquisition of an improved understanding of what health for all is about. There ought to be much common ground, although there will be a need for national and regional variations in emphasis as well as in modes of application. Armed with a good understanding of and faith in the health-for-all concept, the selected leaders will be expected to revolutionize the thinking of the masses. The crucial point here—and this is another key objective of the development process—is that the capacity of the leaders to influence their compatriots must be considerably strengthened.

The national target groups should include: policy-makers at ministerial and parliamentary level; senior managers from health and health-related sectors, not forgetting those in ministries of information and the mass media; heads of municipal, provincial and district councils, religious leaders and schoolteachers; and the heads of cooperatives in the rural areas. As far as international target groups are concerned, the most important individual is the WHO Representative. Others are the senior staff of all bilateral and multilateral agencies and international nongovernmental organizations.

The traditional type of classroom training is inappropriate for aspiring health-for-all leaders. It can even be argued that leaders are born, not made. However, once leadership potential has been identified it can undoubtedly be encouraged, enhanced and strengthened by means other than formal educational activities. The development of efficiency in the advocacy of health for all and in the planning, implementation and management of health-for-all strategies should occur against the background of the everyday lives of the people in the different target groups. And as the WHO Representatives are in daily contact with potential candidates, it is clear that they, together with other senior staff of the World Health Organization who are stationed in or frequently visit countries, should be the first to submit to the developmental process, using the briefing sessions organized regularly for their benefit. These sessions should more and more take the form of simulation exercises depicting live country settings, using visual aids and other modern communication techniques.

In countries, the same type of developmental process, where applicable, should be spearheaded by the WHO
Representatives, supplemented as necessary by other senior staff, including consultants, from headquarters and the regional offices. In most cases, however, this type of training will be unsuitable; motivational and developmental activities that can be fitted in and tacked on to demonstrable realities in country settings are likely to be more productive. As any target group (religious leaders, schoolteachers, parliamentarians, etc.) will be heterogenous, some selective criteria will have to be instituted with great tact and diplomacy. Whatever form the motivational exercises take, they must be in line with and scrupulously respect the cultural traditions of the population groups concerned. Leadership qualities, including skills for dealing with policy issues, managerial capacity, personal authority, and willingness to take decisions, should receive careful consideration. Development and training in countries will, by and large, take the form of round-table discussions, colloquia, symposia, and visits to field activities where there are demonstration items and facilities for continuous dialogue, all supplemented with modern communication techniques.

The development of health-for-all leadership can be made the subject of technical discussions at the World Health Assembly and Regional Committee meetings, not on a one-time basis but at intervals, to allow for the monitoring of progress. The choice of collaborating institutions for research and the development of suitable instructional modules and films constitute another area well worth exploring. Such instructional material can be used to great advantage at regional and subregional health development centres and in faculties of health sciences for the training of health manpower.

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Some of the above proposals for action are new, others reflect those put forward previously in different forums but not applied in many developing countries. It should not be forgotten that the approaches to these issues are likely to vary widely between countries and that considerable amounts of emotional energy will probably be expended as solutions are debated. Provided that this process remains constructive, in the sense that the broad health needs of people are kept in mind, it seems reasonable to expect that useful practical results will emerge.

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Said at the First World Health Assembly

Spirit of harmony

Several speakers have stressed the fact that they would like very much to avoid discontent and struggle between Members in this Assembly. I would venture the statement that this World Health Assembly up till now has been characterized by an international spirit which you very seldom find in large international gatherings in our time.

—Dr K. Evang, Norway
Eleventh Plenary Meeting, 10 July 1948.