Round Table

John H. Bryant

Health for all: the dream and the reality

What has happened in the ten years since Alma-Ata? What has been the progress? What have been the success stories and the failures? Is the concept of health for all still alive and being worked into the fabric of health services? Is it still evolving in the face of new problems and insights, or has there been a fading of vision, a crumbling of resolve?

What has been the experience with health for all? The answers are mixed, depending on where one looks, whom one asks, and what one expects. To be sure, there have been naïve hopes and false promises, but there have also been clear vision and careful progress. Our world is not so simple that work with highly complex problems can be summarized with “yes” and “no” answers, and we should not reach for such easy generalizations.

What has become obvious is the global dichotomy of the health “haves” and “have-nots”. Of course, the division is not a neat one; there is a spectrum of countries strung along the gradient from poorest to richest, from highest under-fives mortality rates to lowest—but there is a key point to be made. It has to do with a country’s capacity for coping with its health and development problems.

Many countries are moving along the gradient at a pace that can be measured with familiar indicators: increase in per capita income, increase in literacy, decrease in maternal and under-fives mortality rates, and so forth. There is a rough predictability about the process, though there are many exceptions in which countries are moving either more rapidly or more slowly in health than would be expected from their socioeconomic levels, and we can learn from these exceptions. Progress in other countries is slower, as depicted by very high maternal and under-fives mortality rates: 64 countries representing 40% of the world’s population suffer more than 80% of the world’s under-fives mortality and more than 90% of the world’s maternal deaths. Looking at projections to the year 2000, under-fives mortality rates will be substantially reduced for most countries but will remain

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unacceptably high, more than 100 deaths per 1000 live births, in Africa and southern Asia. The reasons for these extremely high death rates are generally known and widely discussed. While our knowledge is not complete, it is substantial, and we are familiar with the terrain on which the problems need to be worked out.

But the most fundamental problems are solution-resistant. The global health machinery in its current state is not adequate. Progress has been slow despite growing understanding of the problems, and despite the continued development of health systems and the emergence of new technologies. It would be a serious mistake to believe that these problems could be solved with more of the same. Their persistence is saying something to us if we have ears to hear: what is being done is not enough.

The experience of the industrial countries

An important development has been the emergence of a European region-wide strategy for health for all. In 1980, the 33 European Member States of WHO agreed to a European strategy. They set 38 targets and chose 65 indicators for systematic and routine monitoring by countries of national progress towards the targets. An evaluation of the strategy was carried out in 1985 (1).

It should be kept in mind that Europe, like North America, has been having serious problems in implementing the promotive and preventive aspects of health in the face of burgeoning clinical technology, rising costs, and the depersonalization of medical care. The question remains open of how much can be accomplished without a radical reorientation of health perspectives away from the medicalization of health. The scepticism that existed before 1980 has given way to increasing confidence in the regional health-for-all strategy. Many Member States have made strong efforts to evaluate progress at the national level and in a number of cases have used the opportunity to formulate a national strategy in line with the regional one.

Now that the developed countries have taken serious steps towards a health-for-all strategy, it is curious to look back and realize that it was once questioned whether the matter even applied to them. This shows how far the health-for-all effort has come conceptually, methodologically, and politically since the time of Alma-Ata. It is a tribute to WHO that it has been able to bring about such a process.

Europe is not alone in the developed world in taking this direction. Canada’s historic Lalonde report on health promotion and disease prevention (2) preceded Alma-Ata by several years. While implementation of the concepts in that forward-looking document moved less rapidly than had been hoped, Canada has made great progress in the organization of its health services. The United States Public Health Service has developed its own Health objectives for the nation (3) along lines similar to the European targets for health for all and has pursued them systematically as a national effort. Many problems are on the health agenda of the USA, including particularly that of dealing with inequities in the availability of services to people in lower socioeconomic groups.
Two final observations may be made about the European strategy for health for all. One is that the targets represent a deliberate attempt to change the course of health development and not simply to document what is happening in health in each country. The second is that evaluations are carried out with quite remarkable honesty and candour. They are not whitewashed, presenting merely the good side of health development. The shortfalls and the inadequacies are described as openly as the gains.

Those who live and work in the poorest parts of the Third World need not only be impressed that this process is possible. One of the truly great contributions the developed world could make to the developing world would be to provide guidance on how to avoid progressing into the diseases of maladaptation, from which the industrial nations are now trying to extricate themselves. Collaboration in this field would be intellectually exciting and of great practical significance.

Some developing countries on the move

A phenomenon that has attracted many observers of health development in the Third World is the exceptional progress made by a few countries, well beyond what might be expected from their levels of economic development. A cogent analysis of this phenomenon has been carried out by Caldwell (4), who identifies superior health achievers and poor health achievers in terms of the extent to which their levels of infant mortality are above or below that expected in relation to per capita income. The superior health achievers have only a ninth of the per capita incomes of the poor health achievers, but they have managed to reduce their infant mortality rates to half the levels prevailing among the latter.

Caldwell examines the characteristics of the two groups, focusing particular attention on Costa Rica, Sri Lanka, and the State of Kerala in India, as examples of societies that have achieved major breakthroughs in health, and concludes from the experiences of these three that unusually low mortality can be achieved if the following conditions hold.

- There is a reasonable level of female education and sufficient female autonomy for the mother to act with some independence in caring for her child and herself.
- The society is of a kind that generates a continuing political activity, especially if stemming from a dominant populist or radical element, which hastens the spread throughout the community of adequate educational and health systems.
- There is ready access to health services providing universal coverage, with emphasis on maternal and child care, immunization, family planning, home visiting services, and the maintenance of an adequate level of food availability.

What is clear is that low mortality will not come as an unplanned spin-off of economic growth.

The poorest countries

It could have been predicted at Alma-Ata. Some countries, having adopted the concepts
of primary health care and health for all, put forward policies, mobilized resources and implemented programmes that slowly and surely have led to improvements in the health of their populations. But other countries have not. They have not been able to establish the political base for action, or put together the necessary resources, or fashion effective programmes. Substantial efforts may have been made but progress has been slow and painful. The reasons for these shortfalls are examined in the following paragraphs.

**Politics and policy-making**

At the political level, policies have not been strong enough, budgetary commitments not full enough, the management of health services not effective enough — any one or all of these. A familiar story is that the policy commitment is made, with the best of intentions, but health is not given the priority it should have in the budget, and the financial resources slip away in the give-and-take of cabinet-level decision-making. Health does not usually have strong leverage in national councils of power, and shifts in budgetary priorities involve shifts in power. Vision is needed at the policy-making level, and indeed the vision may be there — but not the leverage. Hard data may be required to solidify the argument, but the data are not at the policy-maker’s hand, and there is no one to provide them. The opportunity passes, lost to an option of another ministry.

**Stagnation**

Some countries appear to have stagnated in the development process. In the classical demographic transition, high birth rates and high death rates proceed into the transitional stage in which death rates come down but not birth rates, and population growth rates increase. The transition is completed when birth rates are brought down and population growth rates accordingly decrease as well. Things go wrong when countries get trapped in the transitional stage (5).

Scarce resources, weak infrastructures, and limited management capabilities weigh heavily on these countries. In the past it might have been expected that such problems would be overcome, given time and luck. Now, new forces appear to be working, and a strong tide runs the other way. A series of interlinked demographic, ecological, economic, and political events are coalescing in some regions to produce a frightening scenario: uncontrolled population growth leads to increased pressures on land, landlessness increases, internal migrants flow from rural to urban areas, and society becomes politically and economically unstable. Once populations expand to the point where their demands begin to exceed the sustainable yield of local forests, grasslands, croplands, or water systems, they begin to consume the resource base itself. Forests and grasslands disappear, soils erode, land productivity declines, wells go dry.

Since 1973, when oil prices increased, the growth of the global economy has slowed markedly. During the 1970s, Africa became the first region since the great depression to experience a decade-long decline in per capita income. Latin America is likely to join Africa in that trend, and even Asia is not immune. An important part of this
global slowdown has been the loss of momentum in agriculture. Per capita grain production is now declining in some 40 developing countries.

For many Third World countries the demographic trap is becoming the grim alternative to completing the demographic transition. In the long term there may be a return to the equilibrium of the first stage—with both high birth rates and high death rates. Such a regression is already evident in Africa, where famine has raised death rates on two occasions since 1970. In short, some countries may already have lost the chance to escape from the demographic trap.

**Health services at the periphery**

When policies and budgets supportive of health for all are passed along for implementation at the periphery of the health services, there may be a lack of ability to turn the policies into effective programmes. The problems can be manifold—bureaucratic inefficiency, organizational structures that work against integration and decentralization, and lack of managerial experience. The staff involved may not be prepared for the roles they must fill, or the support systems may be inadequate.

A broad look over the health arena shows that district health systems and their management present a special problem and an important opportunity.

**Health of the urban poor—a growing dilemma**

The health problems of the urban poor seem to represent many of the worst problems of Third World underdevelopment—patterns of disease that are a mosaic of both developed and developing societies, health services that are an ineffective mixture of high-technology care for patients who can afford it and few or no services for the burgeoning squatter settlements, all contained uneasily in cities whose growth is economically and ecologically unsound.

In these settings, the urban poor live with or die from their burdens of disease and despair. Urban health problems are both easier and more difficult to manage than in the rural settings: easier because of access, greater readiness for change, and more resources; more difficult because of social fragmentation, heavily contaminated environments, and political instability.

**The community in health development**

Health programmes seldom extend beyond curative services at health centres and dispensaries and rarely reach the family level where the critical changes must take place if the health of mothers and children is to be protected. There are relatively few community health workers to identify mothers and children at risk from preventable and treatable problems, and

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The ordinary people are seldom involved in the development of health programmes, beyond being expected to bring their children for immunizations and to passively accept a thin offering of services.

Their resources are usually overlooked, yet communities have a capacity for cooperation, for convincing one another to change health behaviour, for supporting local health workers, for sharing in the costs of programmes, and for guiding local decisions towards the most serious problems.

**Manpower development in relation to health needs**

A pervasive problem in the Third World is health personnel whose preparation is inadequate to enable them to function effectively in community-based or district-level health services.

This is true of workers at all levels but is most damaging among doctors. Typically, the medical education of the doctor is curative-oriented and hospital-based, provided in an institution where public health and community medicine are given little attention. Such health professionals are unlikely to be good at relating to communities, assessing needs, and planning, managing and evaluating programmes. Worse, in his role as a leader the doctor obstructs the functioning of the rest of the health team.

It is probably fair to say that nursing education is less remote from these issues. Nursing leadership has been generally responsive to the problems and possibilities represented by health for all. In the field, where there is an orientation towards public health and primary health care, nurses are often the mainstay of the service.

**Fresh strategies for a new era**

Considering the progress made towards health for all, as well as the persistent problems, especially for the least developed countries, fresh strategies are required as we move towards the turn of the century and beyond. Described below are the problems that need to be addressed and some strategies for doing so.

**The uncertain commitment to health for all**

There is no doubt that WHO has been highly successful in eliciting formal statements from all Member States in support of the meaning and intent of health for all. Indeed, a surprising number of countries have gone well beyond endorsement and are actually shaping their own national strategies in accordance with this precept. The troublesome questions have to do with the extent and effectiveness of both commitment and implementation. We can rightly worry that the concept of health for all may simply solicit responses in support that are, in reality, lip service without deep commitment to the values and actions that are called for. Let us look at these problems of limited commitment, first at the international and then at the national level.

What is the international climate of support for health for all? All too often it is ice-cold. There is little concern with equity, a lack of confidence in the processes of development, and sometimes even a contemptuous attitude towards the developing countries. These views find their way into development policies. In addition, during the recession of the 1980s, health has fallen victim to shifts in policy, the focus now being almost exclusively on economics as opposed to the broader aspects of social development.
Turning to the national level, one way of probing the depth of commitment is to examine the budgetary allocations to health. The health budget is often tiny—from 1% to 5% of total national expenditure—and even the published budget may be a political figure and not reflect the funds actually available for expenditure. While the health budget may be small, the part committed to primary health care and related efforts is often disproportionately smaller. Efforts to move resources from hospitals and specialty services to primary health care for the urban and rural poor often run into powerful opposition. Of course, even when the resources are there, allocated for primary health care, they may not be well used—a dismal story in itself.

Political commitment is an uncertain commodity. Well-meaning political figures may have little freedom of action within their party or administration. Political constellations of power may be transient, and what is solid support for primary health care today may evaporate tomorrow.

**Searching for new resources and mechanisms**

The vital question is: how can we mobilize the interests, commitments, and resources of a broader constituency of support for the poorest people and poorest nations? It is as clear as crystal that the current approaches that have been proposed—all the plans, programmes, resources, and time-frames—will not break through the hard shell of this most intractable of problems. The need is to move with different partners, to find different sources of support, and to use different mechanisms to bring all pressures to bear on the problem.

What other directions can be explored? To begin with, it is important to appreciate the substantial contributions made to health and well-being by the nongovernmental sector: voluntary organizations, universities, religious organizations, industry, philanthropic foundations, and numberless individuals. An interesting development is the emergence of very large numbers of such institutions in the developing countries. Literally thousands of socially oriented indigenous groups exist, many of them waiting for indications of useful directions in which to apply their energies and resources. Social and political activism is not new, to be sure, but it can be put to new uses at local, national, and international levels, enabling concerned people and organizations to bring their views and the power of their positions to bear on ineffective, misguided, and exploitative agencies and officials.

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At an international political level, why should it not be possible for some of the larger nations to join in a collaborative effort to assist some of the poorest countries? The USA and the USSR have long-standing agreements for cooperation in biomedical science, with exchanges of scientific delegations and collaborative research. This cooperation has weathered a number of diplomatic conflicts between the two countries, because each wants to keep this relatively nonpolitical interaction alive. Thus far, the exchanges have not extended directly to interaction with the Third World. In view of the recent disarmament treaties, and with prospects for further steps in
disarmament, it would be a significant gesture for the two nations to explore the possibilities of joint assistance to some of the poorest countries. Here would be a symbol of immense importance—the two most powerful countries not only agreeing to joint action but declaring that the resources involved would be taken from the reduced expenditures on arms.

**Health manpower demoralized**

At the centre of the weakness of primary health care is manpower. So often, in so many places, there is a lack of local professional leadership that could guide and shape these health services, and there are serious deficiencies too in the material and psychological support given to health workers at the periphery. They often feel that they are working in isolation—that no serious efforts are being made to provide them with the basic amenities required for living in a remote setting, that there is little concern to provide them with elementary materials and support, and, most damaging of all, that they and the work they do are not respected. The result is a severe demoralization, and, when such despondency occurs, loss of dependability and integrity are not far behind. The problem is not one of system design, nor is it necessarily inherent in primary health care systems. Rather, it is a matter of management practices and personnel support systems that are sensitive to human needs.

This bleak picture is not universal, but it is widespread enough to warrant careful attention. It makes no sense to preach social sensitivity and self-reliance for communities when the same sensitivity and support are withheld from the peripheral health personnel on whom the system depends.

**Selective programmes versus comprehensive care**

There has been a long-standing debate over two approaches to providing health services in poor countries—namely, selective or vertical programmes versus integrated or comprehensive primary health care systems (6). The selective side of the debate begins with the observation that the comprehensive approach is too idealistic to be implemented by most governments. Instead, it is held to be more realistic to direct scarce resources to the control of the diseases that account for the highest mortality and morbidity, particularly where low-cost technologies are available for prevention and treatment. The other side of the debate, put forward in favour of integrated or comprehensive primary health care, involves establishing a community-based infrastructure and tackling the health problems through primary health care programmes as an integral part of overall development, the communities themselves being actively involved in planning and implementation (7).

One of the reasons for concern about these issues is that the selective approach fits the technological and political orientation of some donor agencies, which look for concrete objectives and measurable outcomes achieved in a relatively short period of time. Such selective programmes, however, might...
ride roughshod over the fundamental principles of community-based primary health care.

Pursuing an individual disease problem might require a specialized infrastructure that could not be incorporated into the more general primary health care structure and could not be continued after the withdrawal of the donor’s support. Selective programmes are usually imposed from outside by the donor agency, and this tends to bypass community involvement in the selection and implementation of programmes. Moreover, selective programmes tend to focus on short-term processes when some of the important community development processes are necessarily long-term.

The development of a primary health care infrastructure is critical. Developed side by side with the local community, it provides a mechanism for involving the community, for responding to community needs and concerns, for adding or subtracting programmes according to decisions made with the community, and for introducing appropriate technologies.

**District health systems**

WHO’s recent emphasis on strengthening district health systems is well placed to have a critical impact on the health-for-all effort. The district can play a pivotal role in matching local needs and priorities with national policy guidelines and resource allocations. Playing this role effectively requires adequate decentralization of both responsibility and resources to the district.

District health systems provide a mechanism for investigating difficult areas such as maternal and young child mortality and the interactions of population growth and ecological deterioration. Studying the latter problem, of course, will call for special choices of geographical and ecological conditions, but there will still be overlapping interests and methods. In particular, the nexus of family life and environmental circumstances—how couples make decisions about the spacing of children and the size of families and how mothers care for their children—is central to both sets of problems.

One of the most difficult linkages to establish among the various levels of health services is that between primary health care systems and hospitals—especially district hospitals. Without close interaction, the primary health care services are on their own, without direct support and uncertain about referral, while the hospital functions in traditional isolation with no way of knowing how relevant and effective its services are. In the development of effective services this linkage is missing, and the district health system is an ideal place to pursue it.

**The roles of communities**

There is a puzzling feature about the role of the community in primary health care: the importance of community involvement in...
health services is widely expounded, but
much less practised.

The involvement of the community in
primary health care is not a social nicety, it
is a technical necessity. Primary health care
programmes cannot achieve coverage and
effectiveness without the full involvement of
the community. The key advances in the
health of communities depend on the
decisions of individuals—whether or not to
be immunized, to feed children differently,
to use family planning, to use oral
rehydration therapy, to seek and use clean
water, to control environmental
contamination, or to alter their life-styles.
Services that are “delivered” from the
outside will have limited effect unless
absorbed and taken over by the community.
How long have physicians and nurses been
sitting in health centres, seeing patients, and
waiting for the health status of the
population to improve?

Community participation is similarly
essential in dealing with the interaction
between population growth and ecological
deterioration. Personal and community
decisions are at the heart of effective attacks
on that set of problems too. Consider, for

and, where possible, should actually be
involved in seeking information. They
might, for example, carry out community
surveys. The community will also be a
leading party in deciding what is to be done.
The relevant information and the issues
requiring a decision must of course be put
forward in ways the community can
understand. Indeed, an important part of
management information systems is
adjusting the nature of the information to
those who will make the decisions.

The involvement of the community is all
the more pertinent because it is an essential
partner in paying for health services and
thus has the leverage to demand relevant
and effective services.

The role of women in the effective
implementation of primary health care
programmes is vital. The critical focus of
primary health care is the home, where
families live in ways that are either healthy
or burdened with risk, where behaviour is
influenced by neighbours, and where
decisions that affect health are made. The
mother must have the knowledge, as well as
the autonomy, to act as necessary in order to
promote and protect health within the
family.

High technology—a two-edged sword

The capacity of science to address problems
is at the heart of modernization, and its
potential for contributing to the
development of even the poorest countries is
very large. But science can be costly to
pursue and apply, and the costs can be
measured in terms of money, programme
distortions, and positive harm.

There are some relatively simple
applications of science that have produced
very practical technology for the Third
World: cold-chain technology that helps
ensure protection of vaccines against
temperature extremes; oral rehydration
therapy for diarrhoea, including use of
cereal-based solutions; diagnostic methods
that can be applied in peripheral health
centres, such as dipstick and blotting-paper
tests; durable but accurate equipment such
as the battery-powered X-ray machine;
microcomputers; and a simple but reliable
method for determining haemoglobin levels
in blood.

But the main problem in improving the
health of people in the poorer countries is
not lack of technology—it is the failure of
the services to reach people. The technology
is now at hand to reduce great burdens of
death and disease, but the delivery systems
are not in place. It is the strengthening of
health services that holds the key to
successful applications of science and
technology. This calls attention to the
importance of field-based research on health
services and on the applications of
technology within those services. Local
policy-makers need the guidance that
research on such matters can provide.

The complexity, sophistication, and cost of
diagnostic and therapeutic procedures have
become so dominant as to push aside the
more personal and humanly sensitive side of
medical care. In the developed world, this is
a matter of rising concern. In the Third
World it borders on disaster. The transfer of
technology has often been indiscriminate
and the costs scandalous. Moreover
advanced technology has attracted resources
away from priority needs. This is not to say
that it must be excluded from the Third
World, but the medical profession must
exercise keen judgement on priorities in the
use of resources. Making decisions in this
arena is complicated. What is essential today
must be balanced against what is necessary
as a base for tomorrow. Is excellence in
health care to be defined in terms of
sophistication of procedures or in terms of
equity? Obviously the health-for-all
philosophy would steer us towards the latter.

Professionals trained to use high-technology
equipment understandably want to use it to
further their professional development,
whether or not it is appropriate to local
circumstances. Those who are advising, or
selling, from the developed world have a
difficult role. They are at their best when
they help their partners to select judiciously
the things that are appropriate to Third
World settings and budgets. They are at
their worst when they promote their own
interest.

Most of the problems of the Third World
cannot be solved by technology transfer.
They require solutions developed on the
spot by scientists indigenous to the country
concerned. Fortunately a substantial science
base already exists in the Third World, built
up over the past few decades by a number of
developing countries working together with
internationally oriented institutions, but
there is clearly a need for considerable
expansion of this base.

**Leadership for health for all**

Without effective leadership, the
health-for-all movement will founder. The
question is: how is it to be developed and
enhanced? There is a paradox about
leadership in the Third World. Formally
trained and experienced leaders are in short
supply and often over-used. At the same
time, there are vast numbers of people with
leadership potential who are untrained and
unexperienced. There is much to be done,
therefore, in supporting existing leaders
while at the same time establishing
opportunities for others. In addition, new
paths for advancement of leaders, both
trained and untrained, should be created so
that they can avoid reaching a dead end in
their careers.
Universities have a critical role to play in leadership development in the health sector, but it must be seriously questioned whether many universities can or even want to play that role. Is it not odd to have to put it that way? The training of leaders is one of the primary responsibilities of the universities, yet in the health sector there is a distinct lack of confidence that many of them will undertake the task. This may be due to disdain for the concept of health for all, but it is probably deeper, arising from conflicts of purpose—between pursuing further advances in medical science and responding to social needs. Whatever the case, it is an issue that needs to be better understood.

Health for all—a living reality

It is now clear that the concepts and principles of health for all provided ethical precepts, political imperatives, and technical directions that have become critical guidelines for health and development throughout the world. The meaning of health for all has not, of course, been appreciated by everyone, but what is surprising is how widely it has been accepted and used, in whole or in part, by health policy-makers, programme planners, funding organizations, politicians, health personnel, schoolteachers, newspaper reporters, professors, mothers, and schoolchildren.

A further surprise is how influential it has been in the policies and programmes of the industrial countries, given the initial concern that it would be considered relevant to poor countries only. In fact, it has become a basis for national health strategies of many of those affluent countries. This is not to say that there are not serious problems to be overcome, stemming mainly from burgeoning clinical technology, rising costs and the depersonalization of medical care.

No less gratifying has been the general acceptance of the health-for-all strategy by the poorer countries. Here indeed is the acid test. Given a commitment to equity and a priority to the poor, can the precepts, commitments, structures, and resources guided by the health-for-all strategy make a difference in the health and well-being of the poor of the world? The answers will not be found in the simple application of present approaches. Residual problems from the past and emerging new problems are too complex and resistant. Therefore new approaches are needed—new methods, new partnerships, new resources, and particularly intersectoral resources—if these problems are to be effectively addressed. The key factor is the sense of social morality in health and development that Alma-Ata brought to the world. If that grows stronger, the obstacles—political, technical, economic—to health for all can be overcome.

References


Attiya Inayatullah

—Human development is the thread linking health, family planning and economic progress

The Alma-Ata Declaration brought into being a global public health movement. Professor Bryant’s article brings into focus the enormity of the tasks still confronting those concerned with the achievement of health for all. There can be no doubt that these tasks will be continuing long after the year 2000.

The increased emphasis placed on prevention has led to the expansion of rural health infrastructures; these could be rendered useless if not accompanied by policy changes and improved management.

Emphasis is being or should be given to immunization, oral rehydration therapy, child-spacing, rational drug policies, efficient health information systems, effective supervision of personnel, the development of community health workers, and incentives to attract doctors into preventive health careers.

Although a high proportion of the population in many countries is under the age of 15, the teaching of paediatrics is often neglected; it is necessary to strengthen medical education by making paediatrics a separate examination subject, including field practicals in community medicine and the teaching of simple management practices. Gains should be consolidated by institutionalizing primary health care and establishing innovative arrangements that do not compete with other activities.

Grant programmes for child survival activities should be instituted for nongovernmental organizations, the private sector, and local bodies.

Strong outreach teams should be established to deliver primary health care at the village level; health workers should be recruited in the community and trained so that programmes can be sustained; retraining and the updating of short courses in primary health care should be based on the concept of continuing education, in conjunction with the registration of doctors, paramedical staff, dispensers, hakims, homoeopaths, dais, and so on; and maternity waiting homes or halfway houses should be established so that there is an alternative to home delivery, which accounts for over 60% of births in developing countries.

Although some 75% of health workers are women, only rarely are women in a position to take decisions on health policy or its implementation. This situation needs to be remedied.

In 1985 over 700 million people did not get enough food to support an active life, and 17 million children died of malnutrition or disease, in a world of apparent plenty. Many who needed food were too poor to buy it.

Rapid population growth is a major cause of hunger. Large families are no longer the key to survival in traditional agrarian societies, and the nutritional reserves of mothers are so depleted as to bring about low birth weights and poor nutrition of nursing infants.

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The green revolution in many parts of the world is failing because of overgrazing, desertification, removal of topsoil, deforestation, and other factors.

Slum populations are increasing, unemployment has reached staggering levels, and shaky governments dampen urban unrest by keeping food prices artificially low, to the detriment of the agricultural sector.

In Pakistan there are seven births and two deaths a minute, and even if the average family size drops to 2.2 it will take something like a century to stabilize the population. Although considerable improvements have been achieved, important problems remain. There is neglect of family planning in the primary health care programme. In view of the demographic situation the political will to mount a successful family planning effort is essential. It is estimated that proper birth-spacing could bring a 10% decline in infant mortality.

The rural health centres and basic health units in Pakistan are underutilized because of the low quality of services, shortage of drugs, poor attitudes of doctors and other staff, and shortcomings in overall management supervision and discipline. Health management should therefore be decentralized.

Although Pakistan’s proposed health investment programme represents a substantial increase over previous capital expenditure in this sector, it is still inadequate. Furthermore, there are inequities in that about six times as much is spent per person by the public sector on health services in urban areas than in rural areas. It is necessary to examine how and where private involvement can be strengthened; this calls for innovative financing in the private sector, assistance for nongovernmental organizations, and an assessment of the social security system in health care. Equally important is the need to examine the application of user charges and cost sharing in the public sector.

By mid-1986, 75% of the world’s children aged up to 5 years had been fully immunized; this means that 100,000 children’s lives have been saved and that 45,000 additional children have escaped disablement. During 1983 and 1984, under the Child Survival Programme in Pakistan’s Punjab Province, containing 65% of the country’s population, 98% of children were reached by the Expanded Programme on Immunization and the Oral Rehydration Programme, thanks to good outreach work, highly motivated and effective workers, intensive mass media campaigning, and efficient supply chains. Many lessons can be learnt from this experience; for example, the school health service was found to be weak or nonexistent, nutrition received low priority, maternal and child health services were fragmented, intersectoral collaboration was weak, and community involvement at the health centre level was minimal.

In Pakistan today the overall health and well-being of the people owe much more to disease prevention than to doctors, hospitals, sophisticated equipment and drugs. However, although 70% of the population is rural, primary health care and community medicine are not given the prominence they merit in the medical curriculum.

Much more could be said and much more needs to be done in the interest of reaching the health-for-all goals. In the words of William Jennings Bryan: “Destiny is not a matter of chance, it is a matter of choice. It is not a thing to be waited for, it is a thing to be achieved. Lives of millions wait to be reached out to—we must remain on course”.

□
Rose J. Ndlovu

—The momentum is being maintained

There can be no doubt that the requirement for acceptability, affordability and accessibility, as embodied in the primary health care strategy, has proved vital in both developed and developing countries, which are now more aware than previously of the similarities of their problems in matters of health. The health-for-all movement has demonstrated that health has less to do with medicines and hospitals than with where people live, what they eat, where they work, and so on: good health is not a commodity to be dispensed in bottles but something that people create and sustain for themselves.

In the years after Alma-Ata, most Member States of the World Health Organization made declarations of total support for the health-for-all strategy. A set of indicators of progress gave policy-makers a vision of the intended targets. Each country was to devise its own routes for achieving them.

In many developing countries, large numbers of community health workers were trained and it was believed that the strength of this approach was that it fostered community participation. It has given a degree of success in some areas but the important question is whether this system can continue as a mainstay of community health services for the next 10-20 years.

There are contradictions in the approach. In selecting community health workers we look for people who are respected in the community and have leadership qualities, initiative, and motivation. At the same time we expect them to work on a voluntary basis for several years. If we train people with the qualities described, we are not likely to keep many in the community for an indefinite period.

Another weakness of the primary health care strategy is that there are no clear proposals for ensuring that more is spent in rural areas. Many activities designed to support the strategy are expected to be undertaken with minimal financing from health budgets. Thus, community health workers are expected to work on a voluntary basis or are given token allowances; and toilets and protected wells are expected to be constructed by voluntary labour from community members. As Professor Bryant says, the part of the health budget committed to primary health care is often disproportionately small. Many policy-makers give the impression that, while sincere about their declarations on primary health care, they have difficulty in overcoming opposition to the transfer of resources to rural health services.

I agree with Professor Bryant that nursing leadership has generally responded well to

The challenge is to educate people so that they can obtain and appreciate value for money.

the orientation towards primary health care. Nursing education has taken the study of the social sciences much more seriously than the other health professions, except that of medical social work, and nurses are therefore probably better equipped to appreciate the impact of social factors on

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health and illness than many of their colleagues.

Unfortunately, most national health systems fail to make serious efforts to recruit nurses and to ensure their retention and career mobility. At present there is an acute shortage of nurses in both developed and developing countries, and whereas many countries are losing doctors from state to private practice, nurses are being lost to other professions.

As many nurses see it, the challenge is to educate people so that they can obtain and appreciate value for money. Regrettably, it is still commonly felt that community health workers should be accepted where there are not enough nurses, and nurses only where there are no doctors.

It should be stressed that optimum care can be provided by the various grades of health worker where they are properly placed and supported. Health workers at each level should be able to identify and sort out problems that are within their domain and to refer those that are beyond them. If all the linkages in a system are strong and work effectively, people’s confidence in what the various grades of health worker stand for tends to be consolidated.

In recent years, much attention has been given to strengthening the district as a unit where many problems can be sorted out. In this connection there is a great need to strengthen linkages between the district and the health centres. Perhaps this is an area that policy-makers could look at in terms of moving the health budget to the periphery. Linkages between the district hospital and its tributaries are still among the most rudimentary in many countries. This applies to telephone communications, roads and transport. Policy-makers will be quick to point out that these are responsibilities of ministries of telecommunications and transport, not of health ministries. The point is, however, that accessibility, acceptability and affordability are determined by the extent to which communities can receive appropriate care when they need it most: that may mean some of the health budget being used to provide accessibility through improving communications and transport.

Ten years after Alma-Ata, the momentum of health for all is being maintained, particularly in developing countries. Although there is still a lot of room for improving intersectoral collaboration, ministries of health have gained substantial support for many of their health-promoting activities from other ministries. Progress towards health for all seems likely to continue at an impressive pace during the years to come.

Peng Ruicong

—Medical schools can play a major role in health manpower and leadership development

In relation to Professor Bryant’s comments on the inadequate preparation of health personnel in the Third World for work in community-based services, it may be of interest that, in China, great attention has been given to the reform and reorientation of medical education. During a national workshop in 1986 on medical education for the twenty-first century, it was noted that there were 0.35 qualified doctors per 1000 population in rural areas, whereas in urban

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areas there were 3.35 per 1000. In recent years some medical schools have reserved a proportion of places for students from rural areas; newly trained doctors are thus familiar with local cultures, customs and language. The assignment of students to work in regions remote from their homes is likely to meet increasing resistance, particularly in view of the one-child family policy.

It was decided to introduce three-year medical courses; these shorter and less costly than the normal courses, met the urgent need for qualified doctors at the grass roots. The intention was that the curriculum should be of value for the implementation of primary health care in rural areas.

Twenty years ago, more than a million “bare-foot doctors” worked in villages throughout China; some ten years later they were retrained and about half of them passed a provincial examination to qualify as “village doctors”. In the future, “village doctors” may work cooperatively with medical doctors.

It was also decided to reinforce support for rural health care from medical schools, urban hospitals, and other institutions. Teachers and students who contribute to rural health care have the opportunity to develop an understanding of the problems involved and a commitment to tackling them. The government encourages medical schools to send medical teams to remote areas and to admit doctors from these areas for continuing education.

There is now a marked tendency to integrate health promotion, disease prevention, treatment, and rehabilitation. Strong encouragement is given to university hospitals to contribute to various aspects of primary care, for example the prevention of cardiovascular diseases. Some students are assigned to field work for a month, and at the same time universities can nominate primary health care workers as part-time teachers. When clinical professors take part in primary care activities their students are stimulated to become interested and involved in working in the field.

With regard to leadership development, special lectures on primary care have been given for mayors, magistrates and community leaders, and strategies and programmes for achieving health for all at county level have been worked out. Schools of public health and departments of public health in medical schools should become involved and act as resource units. Once medical schools have become involved their professors may discover shortcomings in training programmes and social provision. The result may be more effective action to influence the development of values and attitudes reflecting concern for equity and social justice. In this way, medical schools could make an increased contribution to leadership development.

Emil Salim

—Primary health care belongs in the mainstream of development

Although there have been significant achievements in primary health care, many developing countries are still suffering high mortality rates, particularly among infants. More needs to be done to remedy this situation, but in many developing countries the necessary funds and skills are lacking.

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An awareness among the general public of the need for better health is noticeable in many developing countries. Increased educational levels and improved communications have raised people's aspirations and induced them to demand better health care. This, however, has to compete with demands for improved roads and many other things. Clearly, economic infrastructures, agricultural projects and factories obtain higher rates of return on investment than do health schemes. Furthermore, they raise incomes and produce benefits that are directly visible to the general public. If social projects are to be financed, they often have to satisfy the condition of visibility, as with schools and hospitals. Some planners and politicians identify social development with the acquisition of sophisticated equipment.

Most social projects have to satisfy short-term considerations, covering five-year terms of duty of elected officials. Long-term implications are pushed into the background because of political factors. Primary health care is not politically attractive because it takes a long time to show results and because the benefits are not easily calculated. Consequently, primary health care is among the first activities to be cut when government revenues decline.

In the 1980s most developed and developing countries have experienced rates of growth about half those of the 1970s, and the depreciation of the US dollar has raised the prices of imports in most developing countries. Slow growth rates in many industrialized countries have reduced world economic activity. Most developing countries are therefore being squeezed between reduced prices for their exports and increased production costs due to inflation.

When government revenues drop, priority goes to expenditure on food. If the production of staple food is insufficient, foreign exchange is used to import food. Next in order of priority is the basic economic infrastructure, including roads, transportation facilities, electricity and irrigation. Only after all this spending has been secured can consideration be given to social development projects, among which educational schemes are given pride of place because of pressures deriving from the population explosion affecting most developing countries. Health may then receive attention: the needs of hospitals are met first, so that they can be seen to be functioning. Finally, primary health care may be given an allocation, in most cases one that is inadequate. The more severe the decline in the economy, the more cuts are made in primary health care.

Why has more not been done in primary health care? Clearly, it has not been brought into the mainstream of development, and it needs to be expressed in terms understood by politicians, planners and economists. It should become a main consideration of those involved in the agricultural, mining, transportation, construction and other economic sectors, who should be convinced that health care can quickly raise productivity and contribute to increases in benefits and reductions in costs. Not enough is made of these factors in Professor Bryant's article.

Proponents of primary health care should be able to prove that there is a positive correlation between health inputs and
economic outputs, that health care can produce short-term as well as long-term gains in various sectors, and that it helps to improve the cost-benefit ratio by adding to benefit and reducing cost. For example, Indonesian tea workers suffering from iron deficiency were given iron tablets and quickly improved their working performance to a degree that far outweighed the cost of treatment.

Improved conditions in economic sectors do more than raise productivity: healthy workers are community members, and their families and others around them are also beneficiaries. Health extension workers should make this clear to all concerned. By working through heads of families employed in agriculture, mining, transportation and so on, it is possible to have a favourable influence on large parts of communities, and, by involving neighbourhood groupings, practically whole villages or cities can be covered. Thus a primary health care constituency can be developed, which may have a significant bearing on the politics of fund allocation.

It may be useful to concentrate efforts on diseases against which dramatic results can be demonstrated, e.g., significant reductions in mortality rates, which in turn show the effectiveness of preventive measures.

Crucial in a new primary health care strategy is the local health extension worker, who should bring its achievements to the public's attention. These include reduced absenteeism, increased output, and reduced company expenditure on curative measures. Also important in this context is the identification of diseases or nutritional deficiencies that markedly affect workers' productivity.

Efforts should not stop here, and the primary care approach should be applied to workers' families and their neighbourhoods so as to form health peer groups and a constituency that could affect political decisions on budget allocations. Local health extension workers should constantly aim to enlarge these groups.

John Vattamattom

Setting priorities is vital

India's traditional health practices probably began to decline in the sixteenth century with the arrival of the Portuguese and their introduction of allopathic medicine. Much later, however, efforts were made to revive them. In 1928 the National Congress passed resolutions favouring the widespread use of indigenous systems of medicine, in an attempt to extend medical aid to the masses. In 1946 the Bhole Committee recommended that there should be a community-based approach to health care and district-level planning. Although independence was achieved immediately afterwards, the recommendations have still not been implemented.

In developing countries there is commonly a discrepancy between stated policies and the political will to implement them. A feeble political will cripples the best of policies and nips enthusiasm in the bud, leaving the ordinary person no better off than before.

Some 80% of India's people live in villages. For the vast majority, food, safe drinking water, clothing and shelter are inadequate. Every 20 seconds an Indian child dies of diarrhoea, which is easily preventable; every year there are three million new cases of malaria;

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13.5 million people have tuberculosis; and 85% of children suffer from malnutrition. And there are many other killers, none of which we seem able to control. India has over half a million villages with altogether 624 million inhabitants, for most of whom the very basic necessities are lacking. It is estimated that there are more than 300,000 doctors and 535,000 hospital beds. However, 80% of health care facilities and 90% of health care personnel are concentrated in urban areas, while 80% of the people are in rural areas.

Although India is basically a village-based agricultural country, its economic policy seems to favour industrialization: by 1986 India was already in fifteenth position in terms of manufacturing output. In the eagerness to take the country into the twenty-first century there is a grave danger of neglecting the masses. The development of any country should be judged on the situation of all its citizens, not merely on that of the affluent few.

Professor Bryant makes the point that budgetary commitments to health are inadequate. Many developing countries are forced to spend a substantial amount of their resources on defence and allied matters, while their budgetary allocations for health care are at best about 2%, as is the case in India, where most of this is spent on the affluent sections of society, particularly in urban areas. In such circumstances, can health for all be achieved by the year 2000? For the vast majority of people, will it become a reality, or will it remain only a dream? Unless we rethink budget allocations, unless the big powers refrain from interfering in the affairs of other nations, unless countries are allowed to set aside a substantial portion of their resources for the overall development of their citizens, particularly the poorer sections, health for all will be only a pipe dream.

It is estimated that, to provide primary health care, including water, sanitation, trained workers, control of communicable diseases, and essential drugs for everybody in the world, the additional cost would be US $50 billion a year for the next twenty years. This is only two-thirds of world spending on cigarettes, half that on alcohol, and a fifteenth of global military spending. The drive towards primary health care requires a careful determination of priorities. Clean water is needed before antibiotics; food before vitamin pills; vaccination before kidney machines; breast milk, therefore more food for mothers, before baby foods; basic literacy and education before computers; homes before prestige projects in cities and towns; basic health care facilities before expensive hospitals and nursing homes; culturally relevant and appropriate technology before sophisticated modern technology; and so on. The priorities should be such as to create healthy nations comprising health-conscious individuals, families and communities that are free from social, economic, cultural and political ills.

A hopeful sign is that there is an increasing tendency for ordinary people to see health as a right and a responsibility.

A hopeful sign is that there is an increasing tendency for ordinary people to see health as a right and a responsibility. If sufficient are political will, courage, and commitment are maintained, this should do much to convert the health-for-all goals into reality.
Julia A. Walsh

—Health systems must support people in their efforts to become more self-reliant

Recognition of many of the obstacles to primary health care led to the suggestion that efforts to provide it should begin on a small scale, focusing on particular areas, and then gradually expand and evolve on the basis of initial successes (1). The original priorities of immunization, oral rehydration, breast-feeding and malaria control were feasible, effective, inexpensive, interim, and non-exclusive, and they conformed to the spirit of Alma-Ata.

Programmes such as the Expanded Programme on Immunization, spearheaded by the World Health Organization and the United Nations Children’s Fund, have worked within national health systems, thus strengthening them and heightening social awareness and commitment. The success of these campaigns has stimulated effort and morale among health workers in many areas. The twice-a-year national immunization days in Latin America provide opportunities to initiate and complete immunization, to bring families into the health care systems, and to identify them for further outreach. In several places this work has broadened to include the giving of vitamin A, iodine supplements, oral rehydration solution, and hepatitis B vaccine.

Such programmes as those for immunization and family planning have taught several lessons. These technologies improve well-being when applied appropriately and effectively. However, lack of community and family commitment to them renders them useless. People need knowledge and support so that they can make correct decisions regarding health. Social networks should lend support. Communities need assistance in utilizing health and family welfare services. Health professionals require reorientation and retraining so that they can work effectively with families and communities. Community leaders and policy-makers should be influenced to make family welfare a priority. This whole process of organization strengthens primary health care.

As mentioned by Professor Bryant, the availability of health services has improved enormously in the last 20 years. Nevertheless, health status has not improved as expected. Of great importance in this connection are individual choice and behaviour. Knowledge is required so that sound decisions concerning family, personal, and community welfare can be taken. Without knowledge, action, and commitment to health-promoting behaviour and the use of health services, little progress can occur.

During the twentieth century, medical research has transformed our knowledge about causes of ill health and has provided efficacious tools for prevention and treatment. In the industrialized countries, individuals have become largely responsible for their own health. Intensive health education efforts in the USA have led, among other things, to increased use of seat belts, declines in cigarette-smoking, alcohol consumption, and cholesterol intake, increased screening and treatment for hypertension, cervical cancer and breast cancer, and changed sexual practices among many of those at greatest risk of acquiring and transmitting AIDS.

When informed of the options and supported in their choices, individuals in developing countries can also become more responsible for their own health. Many

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kinds of health-promoting behaviour do not require enormous resources. Breast-feeding, oral rehydration, family planning, personal hygiene, sanitary disposal of excreta, and the use of immunization services are not extremely costly for families or society. Communication programmes have increased knowledge, influenced decisions, and changed behaviour in these areas. Responsibility for health goes beyond individual behaviour and self-reliance, to include community action and policy decisions on priorities, choices, and the planning and implementation of strategies.

The role of health workers is apparently to provide access to health services and, more importantly, to give information and support so that people can look after themselves to the greatest possible extent. Ultimately, responsibility for health lies with individuals, families and communities as well as with health services.

Reference


Barbro Westerholm

—Success comes through persuasion and adaptation

As Professor Bryant implies in his opening paragraph, countries vary in their approaches to health for all because of differing circumstances, including needs and resources. My comments are based on experience gained in Sweden, a rich industrialized country that has lived in peace since 1814. Since 1977, between 9% and 10% of its gross national product has been spent on health care. The life expectancy of a newborn boy is 77 years, that of a newborn girl 83 years.

After 1945, health care became increasingly hospital-based and highly technical. Patients disliked this, not wishing to be considered merely as biological entities but rather as human beings. Good nursing became a matter of honour.

Politicians and administrators reacted against rising costs. The need for prevention came into the picture. When the oil crisis occurred the need for financial restraint became obvious. The Declaration of Alma-Ata was therefore very timely: the public was to obtain health care that was more “human” and the politicians were to save money because outpatient care was thought to be less expensive than hospital care. Furthermore, efficient health education was expected to cut down morbidity.

Everyone was given a legal right to health care under the national health service. Care was to be of high quality, easily accessible, and subject to patients’ choice. Much weight was put on prevention. Primary health care was to be the basis of health care, with hospital services in support.

What has happened since these decisions were taken? The number of general practitioners rose from 813 in 1977 to 2358 in 1987. The number of hospital beds decreased from 117 per million inhabitants in 1973 to 111 in 1986. The mortality pattern has not changed dramatically over the past ten years; 51% of deaths are caused by cardiovascular diseases and 21% by tumours. Lung cancer is decreasing in men and increasing in women. The former have decreased their smoking over the last ten years, whereas among young women the habit has increased in prominence.
Between 80% and 90% of patients are content with the health care they receive: 20% to 30% are willing to pay extra for improved inpatient services. All this suggests that health care is reasonably satisfactory.

The mass media, however, report long waiting-lists for hip surgery and lens operations; patients who die while waiting for coronary by-pass operations; overcrowded wards in hospitals; rapid turnover of personnel, mainly in the big cities; and staff shortages, especially of physicians in rural areas. When decision-makers lay down priorities, antagonism arises between different groups of patients.

Clearly, in a rich industrialized country, progress requires investment and the benefits cannot be expected instantly. One cannot take away services and not replace them with something equally good. Initially the old and new systems have to operate in parallel so that adaptation can occur. Allowance has to be made for the possible introduction of new technology. In Sweden, this happened in surgery, leading to requirements for hospital beds, operating theatres, and trained personnel. If the services needed and asked for cannot be offered, some patients will seek treatment in the private sector or abroad, thus thwarting the goal of equity. The needs of an aging population have to be met: an increasing number of elderly people with senile dementia and other handicaps need 24-hour services. And it has to be realized that 85% of adult women work outside their homes and have limited time to look after children and elderly relatives.

In order to achieve the health-for-all goals, different groups in society have to be persuaded of the value of the strategy. Politicians have to be won over. They should not only pay lip service to legislation and parliamentary decisions but should have the courage to convert decisions into action. This sometimes means taking steps that politicians may fear because they wish to be re-elected.

The health care professions have to be won over. This presupposes information, education, motivation and active involvement in decision-making. Health care personnel tend to defend the interests of patients, and any move that threatens the well-being of patients is therefore likely to fail. Redundancy among doctors and heavy cuts in expenditure may put such pressure on the health care system that group interests and antagonisms develop. Change may be hindered by poor communication between politicians on the one hand and the public and health care personnel on the other, between general practitioners and specialists, between hospital nurses and community nurses, and between hospital social workers and community social workers. A lack of consensus about the functions of the various disciplines in specific situations may also be a stumbling block.

Without good communication between all the parties involved there is likely to be misunderstanding, disagreement and disappointment, leading to obstacles that will be difficult to overcome.

Teachers in universities and nursing schools have to be persuaded to accept the strategy. Information, education, motivation and active involvement in curriculum-planning and decision-making are prerequisites for success among these professionals.
Other sectors of society have to be won over. This presupposes strong leadership in the health care sector in order to convince them that health is a top priority.

Finally, the public at large has to be won over. Very clear explanations have to be given as to why and how changes are introduced. It is necessary to be honest about possible drawbacks. When it comes to a change of life-style, the rights of individuals have to be respected. It is very important that politicians, other decision-makers, health care personnel, and teachers should live in accordance with the principles they enunciate, thus setting a good example.

Decision-making requires competence; in the field of health care, decision-makers far too often lack training and experience in working with patients and therefore have difficulty in foreseeing what their decisions might lead to. Courage is necessary to carry through changes with consistency, avoiding restiveness and maintaining an awareness of new demands. Without good communication between all the parties involved there is likely to be misunderstanding, disagreement and disappointment, leading to obstacles that will be difficult to overcome. Staff continuity at all levels is necessary in times of transition.

Whatever activity is initiated, it will go through a number of phases, the first characterized by enthusiasm, the second by the discovery of obstacles and the emergence of disappointments and doubts, the third by reorientation in order to achieve the goal, and the fourth by success—or failure. Sometimes, of course, projects are abandoned during the second phase. The health-for-all strategy is at present in phase two; we must now be keenly aware of new demands and we must adjust our methods so as to achieve success.

A forthcoming issue of *World Health Forum* will continue this discussion on primary health care.