3 the Medicalization of Health Care and the challenge of Health for all

by David Sanders

The Global Health Situation

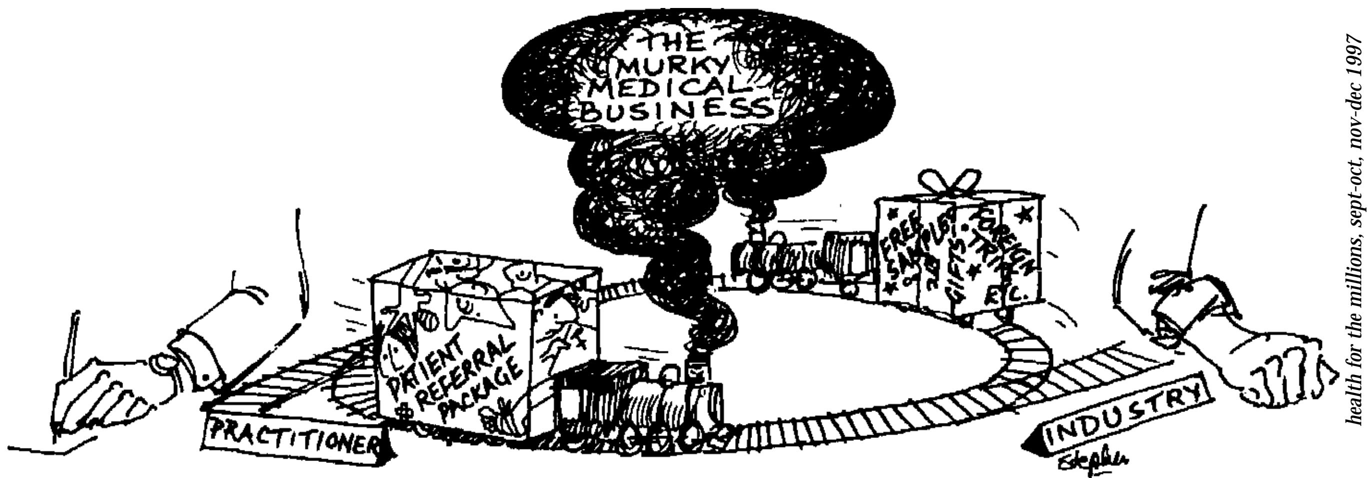
Over the past 50 years, considerable gains in health status have been made. Globally, life expectancy at birth has increased from 46 years in the 1950s to approximately 66 years in 1999 and the total number of young children dying has fallen to approximately 12.5 million instead of a projected 17.5 million. Substantial control of certain communicable diseases, notably poliomyelitis, diphtheria, measles, onchocerciasis (river blindness) and dracunculiasis (guinea worm) has been achieved through immunisation and specific disease-control programmes, and cardiovascular diseases have decreased in males in developed countries, partly because of a decline in smoking.

Despite these gains, there have been setbacks. In step with the widening disparities in socio-economic status, disparities in health have also increased between poor and rich countries and within both. Although child mortality and life expectancy have improved in aggregate terms, a breakdown of the numbers reveals that the gap in mortality rates between rich and poor countries has widened significantly for certain age groups: the relative probability of dying for under-five-year-olds in developing countries compared to European countries increased from a ratio of 3.4 in 1950 to 8.8 in 1990. Furthermore, in a number of sub-Saharan African (SSA) countries, infant mortality rates (IMR) actually increased in the 1980s under the impact of economic recession, structural adjustment, drought, wars and civil unrest and HIV/AIDS. In countries that did experience major health gains, health care interventions cannot be credited as the only or the main factor; these improvements could be mainly or at least partly due to a general improvement in living standards as a result of social and economic development.

It is recognised that health care services worldwide are often **inaccessible, unaffordable, inequitably distributed** and **inappropriate** in their emphasis and approach. Indeed, these problems have, in many situations, worsened over the past decade, with erosion of many of the gains of the 1970s and early 1980s.

While government expenditure on the health sector as a percentage of the GNP had increased in most countries by the early 1990s, the percentage devoted to local health services has been increasing in developed countries, been stagnant in developing countries, and has decreased in the least developed countries. This has resulted in the recent deterioration of services in the latter group.

health for the millions, sept-oct, nov-dec 1997



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In the poorest 37 countries, public per capita spending on health was reduced by 50% in the 1980s. In some third world countries, cutbacks in spending on health and education have been even more drastic. For example, in 1991, Peru spent roughly US$12 per capita on health and education, one-fourth of what it had spent a decade before—and half the amount it was spending on debt payments to Western banks.

This situation has resulted from a number of related problems, which in turn have underlying causes ultimately rooted in a complex of political and economic factors (see background paper on "The Political Economy of the Assault on Health").

The health care sector has not been given sufficient importance in national planning. Public services in general, and health services in particular, have become increasingly starved of national resources, resulting in deterioration and even collapse of these services at all levels.

These problems are rooted in a complex of factors, which result from particular fiscal policies including inadequate financial allocations for capital and recurrent costs. This has led to a decline in the quality of health care facilities and shortages of equipment, drugs and transport. The deteriorating conditions of service have further resulted in a decrease in the performance of health personnel.

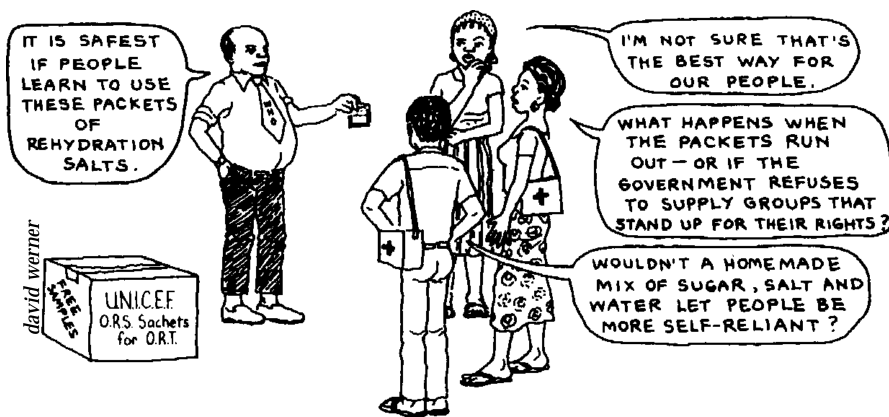
The underlying causes of these problems are both economic and political. Neoliberal economic policies, dominant internationally over the past decade or two, have reduced state funding of health and social services, and resulted in its increased privatisation. This decline in political commitment to social provisioning reflects, in many cases, reduced accountability of governments to their populations. The 1960s and 70s were a period characterised by optimism and popular mobilisation, reflected in Third World countries in a basic needs approach to social development of which the Comprehensive Primary Health Care (PHC) approach was part. This has been replaced by apathy and fragmentation of popular initiatives as a result of growing disillusionment with conservative and corrupt governments and the dismantling or absence of structures for genuine political participation.

Health care services have become more inequitably distributed in relation to need.

Historically, health services—both private and public—have been concentrated in urban centres and often in better-off areas: this has been summarised in the "Inverse Care Law", coined for Britain in the 1970s by Tudor Hart but shown to have universal application.

Health sector reforms**,** which are introducing radical management change into fragile district systems, often make the situation worse. In developing countries, reform strategies are being directed at inefficient use of scarce public funds on inappropriate and cost-ineffective services with poorly functioning systems; poor coverage by inadequately planned and managed services; and low quality services rendered by unmotivated, poorly trained staff in poorly equipped facilities.

Although its aims appear rational in their conception, the reform process has evolved at different rates and to different extents in different countries, and it is difficult to generalise about the success of its implementation. It appears that in many, especially developing, countries the rhetoric of implementation often masks the truth that fundamental change has not occurred. Policy-makers have tended to concentrate on 'quick fix' solutions rather than on the sustainable development of public health services and improvements in quality of care. There is all too often a major separation between policy formulation and implementation, with little focus on the realities of putting policies into practice, and an eagerness to shift and redefine policies frequently.



The definition and control of health care by medical professionals has resulted in its commodification—its configuration as a product, which can be sold or exchanged for profit. The commodity nature of health care has resulted in an overwhelming emphasis on the curative aspects and a stunting of the preventive and especially the promotive aspects, since the former are more likely to be purchased in the face of acute illness and the latter are perceived as less needed due to the less direct and less immediate impact on current health problems.

While decentralisation of management, a common feature of health sector reform, has the potential for being a mechanism to improve the efficiency and accountability of health services, it has often meant decentralisation of responsibility without real decentralisation of power or resources. It has, in effect, frequently become a mechanism for further withdrawal of central government from financial responsibility, and a means to decentralise conflict and criticism of services to an under-resourced and disempowered local level.

Alternative approaches to health financing, another common component of reform programmes, have also promoted privatisation, which instead of serving as an instrument for change has frequently become an end in itself. Growth in private health care has often resulted in: the shifting of costs to households by increasing cost sharing; in priority setting decisions about the choice of services (or packages of care) to be publicly funded; and in the creation of competing private insurance schemes and informal payment mechanisms. Because of differential ability to pay, all these new financing approaches undermine equity-oriented health policies. This suggests that privatisation is based on ideological commitment rather than sound evidence of its effectiveness.

These initiatives, together with the lack of human and other resources from an under funded public sector, have led to the rapid growth of private health care and have further aggravated inequity in the distribution of public services, leaving increasing numbers of poor people with little or no access to health care. For example, in Latin America there is an increased tendency to develop managed care organisations. This has become an important investment area for the main multinational insurance companies such as Aetna, Cigna, American International Group (AIG), International Medical Group (IMG), Prudential, International Managed Care Advisors (IMCA) and Blue Cross Blue Shield.

Health care is becoming increasingly inappropriate in its emphasis and organisation.

The dominance of the curative aspects has been reinforced by a number of factors. These include, most importantly, the health care industry, the education of health professionals and new and influential approaches to developing cost-effective health interventions.

Over the past decades, the health care industry—pharmaceutical, medical equipment, baby food—has developed dramatically and has significantly increased its influence. Many studies have shown that research investment into diseases dominant in developing countries is minuscule when compared to that allocated to health problems predominating in the industrialised world. Additionally, investment in researching and developing preventive interventions is dwarfed by that allocated to developing pharmaceuticals and cosmetics for middle class consumption.

The medical equipment industry has experienced massive expansion with the advent of computer technology. Although this has increased the efficacy of diagnosis and treatment of some conditions, it has also significantly raised the costs of medical care worldwide and has aggravated the predominance of (often inappropriate) curative approaches and of disparities in access.

The agreements of the World Trade Organization, especially those concerning Trade-related Intellectual Property Rights (TRIPS) threaten the economic sovereignty of poorer nations and are likely to undermine their already fragile food security situation, as well as their ability to undertake indigenous technological development, including in the area of essential pharmaceuticals.

Curative, biomedical approaches are still the focus of health professionals' education. Notwithstanding innovations in a number of educational institu-

tions internationally, most health sciences curricula have not integrated the principles of public health and PHC into their core subjects. PHC has often remained separated off as a small component of a marginalized public health course, rather than informing the whole curriculum. Attempts to educate health science teachers about PHC and its relevance and application to their own disciplines have been limited.

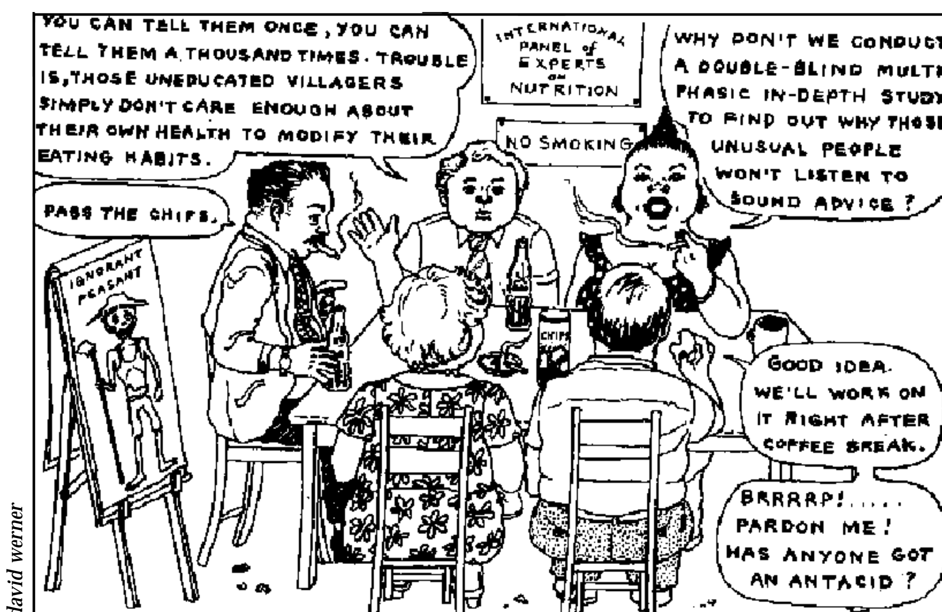
The tendency of the PHC approach to be restricted to, or focus overwhelmingly on, the medical technical interventions such as in the Child Survival Initiative that promoted UNICEF's GOBI package, has been reinforced recently by new methodologies designed to promote cost-effectiveness in health. Furthermore, the focus on cost-effective and efficient 'delivery' of 'health care packages' reinforces the excessively technical emphasis seen in selective PHC and to result in further neglect of the process of health development. In the economically conservative climate of the 1980s, GOBI, an acronym for growth monitoring, oral rehydration therapy, breastfeeding and immunisation, was adopted as a streamlined, cheaper, more feasible set of interventions in primary health care. While superficially a compelling idea, GOBI ended up being a way for governments and health workers to avoid tackling the social, economic and political causes of poor health. Health interventions remained resolutely within medical control where simple evidence-based results could be observed. There was little appreciation of the myriad roots through which a social intervention, as opposed to a strictly medical one, could improve health.

Similarly today, the development of the DALYs (disability adjusted life years) as an index to quantify the burden of disease, and to cost the effectiveness of certain interventions, inevitably results in a focus on selected medical technologies at the expense of broader social interventions. Hence, oral rehydration therapy for diarrhoea management is proposed as an essential component of a core health package while water and sanitation, which have an indirect and less easily quantifiable impact on diarrhoea, are deemed 'cost-ineffective' and therefore not recommended as an area for public sector investment. The DALYs approach, promoted by the World Bank and enthusiastically embraced by WHO, also has the effect of devaluing important aspects of health care, such as caring, which cannot be easily evaluated for their cost-effectiveness.

The institutional mechanisms to implement comprehensive PHC have been relatively neglected.

In addition to inadequate attention to the reform of health personnel education and its institutions, insufficient thought, resources and activity have been allocated to important aspects of PHC such as the development of intersectoral action and community involvement, and the incorporation of lessons learned from innovative experiences in a multitude of community-based health projects. It is also clear that the dominant technical approach described above inevitably results in medically driven, vertical and top-down initiatives, which discourage intersectoral collaboration and community involvement.

These vertical programmes may be effective in specific situations and in the short term, but are ultimately ineffective at providing steady and consistent care. For example, the Expanded Programme of Immunisation (EPI) launched in Togo, Senegal, Ivory Coast and Congo only sporadically increased the number of children vaccinated because the immunisations were not an integrated component of the health services. In contrast, significant reductions in infant and child mortality were achieved in Zimbabwe, Botswana and Cape Verde when immunisation and maternal and child health services became the responsibilities of the permanent health services.



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This emphasis on medically-driven programmes is reflected in the internal organisational structure of many ministries of health and WHO itself: such arrangements reinforce the tendency towards vertical technical approaches and militate against implementation of comprehensive PHC.

Health care continues to be an instrument of social control.

Overtly unethical behaviour and human rights violations by health personnel are, unfortunately, not only a disgraceful part of health history, but persist, particularly in situations of war and political oppression. However, health care as an instrument of social control is much more subtle and widespread. Central to this is the mystification by the health professions of the real causes of illness, which is often attributed to ill-considered individual behaviour and natural misfortune, rather than to social injustice, economic inequality and oppressive political systems. Examples of such individualised and conservative approaches range from the promotion of family planning, in isolation from social development, as a means of population control, to oppressive forms of health education that neglect the social determinants of certain 'lifestyle' factors linked to ill-health.

Guiding values and suggested action

The vision of the Peoples' Health Assembly is of an accessible, affordable, equitably distributed, appropriate and sustainable health system, based on the principles of comprehensive PHC and responsive to its users. Mechanisms for popular participation in the health system should ensure its accountability and also contribute to the movement for participatory democracy in society at large.

In order to achieve such a vision the following broad types of action are suggested:

Advocate at national and international levels for prioritisation of and investment in health.

There is accumulating evidence that investment in the social sectors has not only contributed to social development but has also often led to economic development. The 'Good Health at Low Cost' examples of Cuba, Sri Lanka, China, Costa Rica and Kerala State in India demonstrate that a commitment to broad-based, equitable development, with investment in women's education, health and welfare, has a significant and sustainable impact on the health and social indicators of the whole population. To realise the equity essential for a healthy society, evidence suggests that a strong, organised demand for government responsiveness and accountability to social needs is crucial. Recognition of this important challenge informed the Alma Ata call for stronger community participation. To achieve and sustain the political will to meet all people's basic needs, and to regulate the activities of the private sector, a process of participatory democracy—or at least a well-informed movement of civil society—is essential: analysts have noted that such political commitment was achieved in Costa Rica through a long history of egalitarian principles and democracy, in Kerala through agitation by disadvantaged political groups, and in Cuba and China through social revolution. 'Strong' community participation is important not only in securing greater government responsiveness to social needs, but also to mobilize an active, conscious and organised population critical to the design, implementation and sustainability of comprehensive health systems.

Good Health at Low Cost

Despite the dismal living conditions and health situation in many poor countries, a few poor states have succeeded in making impressive strides in improving their people's health. In 1985, the Rockefeller Foundation sponsored the 'Good Health at Low Cost' study to explore why certain poor countries with low national incomes managed to achieve acceptable health statistics. More specifically, they asked how China, the state of Kerala in India, Sri Lanka, and Costa Rica attained life expectancies of 65–70 years with GNPs per capita of only US$300–1,300.

Upon completing the study, the authors determined that the increased life expectancies were due to a reduction in child and infant mortality rates (IMR) in the four states and were accompanied by declines in malnutrition and, in some cases, in the incidence of disease. These remarkable improvements in health were attributed to four key factors:

- political and social commitment to equity (i.e. to meeting all people's basic needs);
- education for all, with an emphasis on the primary level;
- equitable distribution throughout the urban and rural populations of public health measures and primary health care;
- an assurance of adequate caloric intake at all levels of society in a manner that does not replace indigenous agricultural activity.

The importance of factor one, a strong political and social commitment to equity, cannot be overemphasised. While the course of action may vary, equitable access to health services necessitates breaking down the social and economic barriers that exist between disadvantaged subgroups and medical services.

Of the four regions investigated, China was the most exceptional in terms of equality. Whereas in the other three states, the decline in IMR was largely due to better social services (improved health care coverage, immunisation, water and sanitation, food subsidies and education), China's improvements were rooted in fairer distribution of land use and food production. The population was encouraged to become more self-sufficient, rather than to become dependent on government assistance.

While all four regions developed cooperative, community-oriented approaches to resolving problems and meeting basic needs, in the 15 years since the Rockefeller study, China has had the most success in maintaining its advances towards 'good health at low cost'.

Source: Werner, D. and Sanders, D. (1997) Questioning the Solution: The Politics of Primary Heath Care and Child Survival. Palo Alto: HealthWrights, p.115.

Concerted action should be taken to persuade individual governments to invest in health. WHO needs to be lobbied to assume a stronger advocacy role. It should take the lead in analysing and publicising the negative impact that globalisation and neoliberal policies are having on vulnerable groups. It should spearhead moves to limit health hazards aggravated by globalisation, including trade in dangerous substances such as tobacco and narcotics. It needs to strongly assert health as a Human Right and publicise and promote the benefits of equitable development and investment in health. The extent to which WHO and governments play such roles will depend on the extent to which popular mobilisation around health occurs. Communities have to be active and organised in demanding these changes.

Demystify the causes of ill-health and promote an understanding of its social determinants.

Since 'health' and 'medicine' have become virtually synonymous in the popular consciousness, it is important to communicate the evidence for the fact that ill-health results from unhealthy living and working conditions, from the failure of governments to provide health-promoting conditions through policies that ensure greater equity. It then becomes obvious that health problems are the result of structural factors and political choices and that their solution cannot lie in health care alone, but requires substantial economic reform as well as comprehensive and intersectoral health action. Mechanisms to disseminate this message, including the use of the mass media, must be identified and exploited.

Advocate and promote policies and projects that emphasise intersectoral action for health.

Government health ministries and international health agencies need to be pressed to engage as partners with the sectors, agencies and social groups critical to the achievement of better health. Policy development must be transparent and inclusive to secure broader understanding and wider ownership of health policies. Structures involving the different partners need to be created at different levels from local to national, or within such settings as schools and workplaces. The priority should be to focus on geographical areas with the greatest health needs and involve communities and their representatives at local level. Subgroups with responsibility for health, within local, provincial or national government (e.g. health committees of local government councils) should be promoted and should have links to the above structures. This has occurred in some of the Healthy Cities projects in both industrialised and developing countries. Currently the Brazilian law requires different groups to discuss the health policies to be promoted, and includes community and consumer participation.[1]

Intersectoral action to reduce traffic accidents

In the early 1970s, Denmark had the highest rate of child mortality from traffic accidents in Western Europe. A pilot study was started in Odense. Forty-five schools participated in an exercise carried out with accident specialists, planning officials, the police, hospitals and road authorities, to identify the specific road dangers that needed to be addressed. A network of traffic-free foot and cycle paths were created as well as a parallel policy of traffic speed reduction, road narrowing and traffic islands. Following the success of the pilot study, the Danish Safe Routes to Schools Programme has been implemented in 65 out of 185 proposed localities and the number of accidents has fallen by 85%. Accidents can, and must, be avoided. It is the responsibility of each one of us, but many initiatives can and should come from local authorities.

Source: Walking and Cycling in the City. WHO, 1998E, p. 64

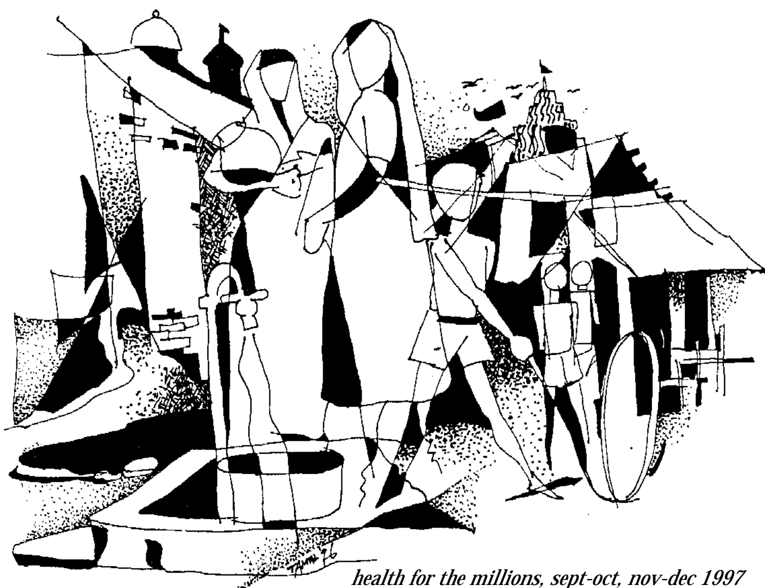
A process of engaging the public in a dialogue about public health problems and in setting goals for their control can both popularise health issues and become a rallying-point around which civil society can mobilise and demand accountability. It can also create the basis for popular involvement in implementation of health initiatives.

Actively develop comprehensive, community-based programmes.

Most programmes addressing priority health problems start from a health care or services perspective. While curative, personal preventive and caring actions are very important and still constitute the core of medical care, comprehensive PHC demands that they be accompanied by rehabilitative and promotive actions. In addressing priority health problems comprehensively, by defining and implementing promotive, preventive, curative and rehabilitative actions, a set of activities common to a number of health programmes will be developed as well as a horizontal infrastructure.

The principles of programme development apply equally to all types of health problems, from diarrhoea to heart attacks to domestic violence. After the priority health problems in a community have been identified, the first step in programme development is the conducting of a situation analysis. This should identify the prevalence and distribution of the problem, its causes, the potential resources to address them,, including community capacities and strengths that can be mobilised and actions that can be undertaken to address the problems. The more effective programmes have taken the above approach, involving health workers, other sectors' workers and the community in the three phases of programme development, namely, assessment of the nature and extent of the problems, analysis of their multi-level causation and priority actions to address the identified causes. Here, partnerships with NGOs with expertise in various aspects of community development are crucial.

Clearly, the specific combination of actions making up a comprehensive programme will vary from situation to situation. However, there are certain principles that should inform programme design, one of which is the deliberate linking of actions that address determinants operating at different levels. So, for example, in a nutrition programme any intervention around dietary inadequacy (immediate cause) should also address household food insecurity (underlying cause). Clearly the principle of linking curative or rehabilitative (feeding), preventive (nutrition education) and promotive actions (improved household food security) should be applied to health programmes other than nutrition, together with addressing basic causes in the political and economic realm.



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A Comprehensive Approach to Under Nutrition in Zimbabwe: The Children's Supplementary Feeding Programme (CSFP)

The existing community-based popular infrastructure that had developed during the war permitted a more rapid and better-organised implementation of the nutrition programme than would otherwise have been possible. Mothers evaluated the children's nutritional status by measuring and recording their upper arm circumferences. Those with mid-upper-arm circumferences less than 13 cms were included in the programme. The reasons for this cut-off point were explained to all parents, both those of children admitted to the programme, as well as those considered not at risk. They then established locations for supplementary feeding (which the mothers preferred to be located close to their homes and fields), and themselves cooked the food and fed the underweight children.

The design of the programme was informed, on the one hand, by an understanding of the most important factors underlying rural child undernutrition in Zimbabwe and, on the other, by knowledge of rational dietary measures and identification of locally used and cultivable food sources (analysis). By deliberately selecting for use in the programme foods that were highly nutritious, traditionally used in weaning and commonly cultivated, and by reinforcing their value with a very specific message in the form of a widely distributed poster asserting the importance of groundnuts and beans in addition to the staple, it was possible to shift the focus of the intervention from supplementary feeding towards small-scale agricultural production programme. This was aimed at reinstating the cultivation of groundnuts— culturally a 'women's crop'— which had been largely displaced as a food crop in Zimbabwe by the commercialisation of maize. The provision by the local and the national government of communal land, agricultural inputs and extension assistance, together with the policy of collective production on these groundnut plots, contributed to improving poor households' food security. The joint involvement of ministries of health and agriculture in this project led to the development of intersectoral Food and Nutrition Committees at sub-district, district and provincial levels.

The programme design therefore allowed the linking of a rehabilitative measure (supplementary feeding) to preventive and promotive interventions (nutrition education and food production), thereby displaying the features of a comprehensive primary health care programme. This comprehensive approach to child undernutritiongreatly influenced the management of this problem within the health sector. It resulted in a changed approach of health staffto the dietary management of the sick child and to nutritional rehabilitation. It also created a community-level infrastructure of feeding points and food production plots/child care centres to which recuperating undernourished children could be sent. Thus the sequenced addressing of immediate (dietary) and underlying causes (household food insecurity, inadequate young child care and inaccessible health services) by the feeding,the communal plots and pre-school centres respectively, was made possible by both careful design based on a prior analysis and by the presence of a well-organised and motivated population. Intersectoral action and structures for nutrition and food security developed around the project, from the bottom-up. and were supported at higher levels of government.

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Source: Sanders in Werner, D & Sanders, D. (1997). Questioning the Solution: The Politics of Primary Health Care and Child Survival. Palo Alto: HealthWrights.

In other health programmes – such as the Safe Motherhood Initiative, the programme for Integrated Management of Childhood Illness and Tuberculosis management (DOTS) – as also in technical guidelines for the management of common non-communicable diseases, similar minimum or core service components can be identified. Standardising and replicating these core activities in health facilities is helpful in reinforcing their practice throughout the health system, but does not guarantee the implementation of a comprehensive PHC programme, which must involve other sectors as well as communities in promotive actions.

Promote the use and dissemination of appropriate health technologies

The use of appropriate health technologies can have a number of positive effects, which include spreading health care more widely and increasing its cost-effectiveness. One of the less obvious, but

very important effects of appropriate technology is in demystifying health care by giving lower-level health workers and, through them, community members better understanding, skills and effective technologies forhealth care. Thus the medical professions' monopoly of knowledge and expertise can be challenged. A good example is the use of homemade cereal gruels, which have been shown to be very effective in rehydration during diarrhoea.

Similarly, if certain appropriate health technologies become widely incorporated into standard health practice, their use can stimulate a critical approach to the expanding range of inappropriate, sophisticated and expensive technologies. A good example is that of pharmaceuticals. Encouragement of the use of a standardised, short list of inexpensive drugs (essential drugs lists) known by their own name (generics), not a trade name, can reduce bad prescribing practices and begin to undermine the operations of the pharmaceutical industry. Evidence that such an initiative has succeeded in challenging the forces that historically have dominated health care has been the extent of the opposition by the pharmaceutical industry to WHO's essential drugs programme.

Increasing the visibility and role of community-based health workers.

In the early years of the PHC movement an important and effective role was played by community health workers (CHWs) in the implementation of PHC. One of the strongest features of CHWs is that they are predominantly women who can often identify and gain access to those households and individuals with the greatest health needs. Indeed, many of the 'model' PHC initiatives relied extensively on CHWs for their successful operation. Further, the role of CHWs was seen not merely as a technical one of extending basic health care to peripheral communities and households: it was also, importantly, frequently an advocacy and social mobilising role, enlisting the conscious involvement of communities and other sectors in health development.

The conservative economic and political environment of the late 1980s and 1990s has contributed to the demise of many CHWs programmes: policy-makers seldom advocate the retention of this cadre, and communities are economically unable to support them.

Given the very positive past experiences of CHW programmes in diverse situations, and the increasing need for community-based workers given the international health crisis, aggravated in many countries by the HIV pandemic, it is urgent that the progressive health movement advocate and campaign for the reintroduction of this cadre and look for innovative ways to care for their communities.

Advocate for equity in health and health care.

Equity is core to the policy of Health for All. Socio-economic inequalities are growing everywhere, at a more rapid rate than ever before. Together with reductions in public health and social services in many countries, this is leading to growing inequities in health. To advocate equity in health and health care more successfully amongst international organisations, governments, donors and professional organisations, we have to demonstrate the social differentials in access to health resources and in health outcomes. The progressive health movement needs to press for the monitoring of equity in health through advocacy and information dissemination.

Promote more appropriate health personnel education and better management.

The primary health care approach needs much more strongly to inform the content of health sciences curricula as well as the learning process and choice of venues for learning. The aim is to equip learners with competencies spanning a broader range than has traditionally been the case. There is accumulating evidence that problem-oriented and practice-based approaches result in more relevant learning, and in the acquisition of problem-solving skills, both necessary attributes for the successful development of the PHC approach. If health workers are to contribute to a health system that enables people to assume more responsibility for their own health through an emphasis on preventive and promotive measures

Table: Key indicators for monitoring equity in health and health care

Indicator categories	Indicators measuring differences between population groups
Health determinants indicators	Prevalence and level of poverty Income distrivution Educational levels Adequate sanitation and safe water coverage
Health status indicators	Under 5-year child mortality rate Prevalence of child stunting [Recommended additional indicators: maternal mortality ratio; life expectancy at birth; incidence/prevalence of relevant infectious diseases; infant mortality rate and 1–4 year old mortality rate expressed separately]
Health care resource allocation indicators	Per capita distribution of ***qualified*** personnel in selected categories Per capita distribution of service facilities at primary, secondary, tertiary and quaternary levels Per capita distribution of total health expenditures on personnel and supplies, as well as facilities
Health care utilisation indicators	Immunisation coverage Antenatal care coverage % of births attended by a qualified attendant Current use of contraception, percentage

Source: World Health Organization (1998). Final report of meeting on policy-orientated monitoring of equity in health and health care. 29 September–3 October 1997. Geneva: WHO, page ii.

integrated with curative and rehabilitative measures, then their training must expose them to good practice at district level and to the social issues at community level. There is also an urgent need for teaching staff in the health sciences to upgrade their skills to carry out such a reorientation of the curricula.

The above suggestions for education reform apply equally to all categories of health personnel, as well as to undergraduate and post-graduate training. It has long been acknowledged that nurses play a pivotal role in the PHC team; in addition, they constitute the largest category of health personnel in many countries. Endorsement of such educational reforms and their fuller implementation and promotion by the nursing leadership within individual countries is critically important for progress towards Health for All.

In most countries, health education institutions have not carried out curriculum reform along the lines described above. Although there are indications that some have embarked or will embark on such a course, there will probably still be a significant delay before sufficient 'new' graduates are available to work in and transform the health system. Clearly, if the implementation of comprehensive PHC is to be achieved during the next decades, the process of curriculum reform in the educational institutions needs to be accelerated and accompanied by a massive programme of capacity development of personnel already working in the health system. In short, the current Health for All imperative demands the rapid expansion of continuing education activities in most countries. Some of this in-service learning should take place in multi-disciplinary teams to promote better teamwork.

Similarly, education in PHC needs to involve personnel from other health-related sectors as well as community members: capacity development for these constituencies has generally been neglected and has weakened the growth of both community participation and intersectoral involvement in health development.

Health personnel management also needs to be greatly strengthened through the development of incentives, appropriate regulations and improved support and supervision. The technocratisation of health care that has been a feature of the past decade has resulted in increasing inequities in service provision and reduced accountability of service providers. The progressive health movement needs to lobby strongly for greater investment in human resources for health, since people are the key to more appropriate and accountable health services.

CONCLUSIONS

- It is clear that progress towards Health for All has been uneven and is increasingly compromised. Gains already achieved are under threat from a complex and accelerating process of globalisation and neoliberal economic policies, which are negatively impacting on the livelihoods and health of an increasing percentage of the world's population and the large majority in developing countries. Although the global PHC initiative has been successful in disseminating a number of effective technologies and programmes, which have reduced substantially the impact of certain (mostly infectious) diseases, its intersectoral focus and social mobilising roles – which are the keys to its sustainability – have been neglected, not only in the discourse but also in implementation.
- Government health ministries need to be pressed to enter into partnerships with other sectors, agencies and communities to develop intersectoral policies that address the determinants of inequities and ill-health. The policy-development process needs to be inclusive, dynamic, transparent and supported by legislation and financial commitments.
- The time is long overdue for more forcefully translating policies into actions. The main actions should centre around the development of well-managed and comprehensive programmes involving communities, the health sector and other sectors. The process needs to be structured in well-managed district systems, which need to be considerably strengthened, particularly to effectively reach the household, community and primary levels. Here, PCH centres and their personnel have to focus onthe reinstatement of community health worker schemes.
- The successful implementation of decentralised health systems will require targeted investment in infrastructure, personnel, management and information systems. A key primary step is a new capacity development of district personnel through training on the job practice and health systems research. Such human resources development must be practice-based, problem and community oriented and come after we reorient, educational institutions and professional bodies.
- Clearly, the implementation and sustenance of comprehensive PHC requires inputs and skills that demand resources, expertise and experience not sufficiently present in the health sector in many countries. Here partnerships with NGOs and their expertise in various aspects of community development is crucial. The engagement of communities in health development needs to be pursued with much more commitment and focus. The identification of well-functioning organs of people's organisations , whether or not they are presently active in the health sector, needs to be urgently pursued to make the necessary alliances that can multiply our efforts.
- In promoting the above move from policy to action, WHO needs to be pressed to play a much bolder role in: advocating equity and legislation needed for its achievement; pointing out the dangers of globalisation poses to health; stressing the importance of partnerships between the health sector and other sectors; integrating its own internal structures and activities to ensure that comprehensive PHC programmes are developed; entering into partnerships with and influencing other multilateral and bilateral agencies and donors, as well as NGOs and professional bodies, towards a common Alma Ata rooted vision of PHC; and advocating for major needed investments in health, especially in human resource development, without which Health for All will remain a mere statement of intent.

Suggested reading list

Sanders, D. (1985). The Struggle for Health. Hampshire, UK: Macmilliian Education.

Sanders, D. (2000) 'Primary Health Care 21 - Everybody's Business' in Primary Health Care 21 - Everybody's Business: An international meeting to celebrate 20 years after Alma Ata. Geneva: WHO.

Werner, D. and Sanders, D. (1997) Questioning the Solution: The Politics of Primary Heath Care and Child Survival. Palo Alto: HealthWrights, p.115.

World Bank (1994) Better Health in Africa: Experience and Lessons Learned. Washington DC: World Bank.

David Sanders has more than 20 years experience working in the health sector in Southern Africa particularly in Zimbabwe and South Africa and has been actively involved in the development of health policy and services with both the Southern African liberation movements and with the newly independent governments of Zimbabwe and South Africa. David Sanders has since April 1993 been Director and Professor of a new Public Health Programme at the University of the Western Cape, South Africa, which provides practice-oriented education and undertakes research in public health and primary health care. David Sanders is author of "The Struggle for Health: Medicine and the Politics of Underdevelopment" and co-author of "Questioning the Solution: the Politics of Primary Health Care and Child Survival" and has researched and written in the areas of political economy of health, structural adjustment, child nutrition and health personnel education.