LEAD SPEECH

by Dr. John R. Evans

Strengthening Management of the Health Sector

In 1978 your countries joined others throughout the world in endorsing the goal of health for all by the year 2000. Some five years have passed and although I think it is too early to judge the outcome of that proclamation it is not to early to ask what progress has been made in the march towards the goal of health for all. On the positive side, ministries of health of most governments have adopted this goal and in many instances have developed a plan for implementation. There has been considerable progress in developing simpler and less expensive techniques to control the principal causes of morbidity and mortality in children - for example, immunisation against the childhood infectious diseases, oral rehydration therapy and related aspects of the management of diarrhoea, and other simple and effective measures. Furthermore, through intensification of research on diseases previously neglected by the international scientific community, there is now promise of dramatic new control measures for malaria, onchocerciasis, leprosy, hepatitis B and other common and important diseases.

On balance, however, progress has been much slower than expected. The world-wide economic recession has placed a sector such as health under extreme financial pressure in nearly all countries. The current economic circumstances are disproportionately harsh on the least developed countries and the poor within those countries. Although health for all has been adopted as a policy in many countries, there is scant evidence of effective implementation. Visits to rural areas in developing countries indicate that large segments of the population still do not have access to the most basic services of health, water supply and sanitation. Where health posts do exist, they are often under-utilised because of lack of credibility of the health workers and uncertainty of supply of essential drugs and vaccines. At the same time, the limited resources available in developing countries tend to be drawn into further hospital development in urban areas and ministry of health staff are fully occupied attempting to solve the problems of maintaining these services. The most telling evidence of lack of progress of the primary health care movement is the health status of the population in the 34 poorest developing countries of the world, many of which are members of the Commonwealth. Life expectancy is still on average 20-25 years less than in industrialised countries, chiefly because infant and child mortality rates are 10-20 times higher than in the industrialised countries. In these developing countries and in the poorer regions of middle-income countries, one child in four will die in the first year of life and one in three during the next four years. These statistics illustrate the distance that remains to be travelled to reach the goal of health for all by the year 2000.

Why is progress so much slower than expected? Some believe the goal may be too ambitious. Others blame the limited financial resources. Review of health programmes in a number of countries at different stages of development suggests two more acceptable explanations: first, the difficulty that countries have had in selecting from the rich array of possible health programmes the ones most important for the health needs of their population; and second, deficiencies in day-to-day management of programme implementation at all levels of the health system. Your conference addresses these two problems: the problems of planning and management of the health system.

First, with respect to the matter of selecting the most important programmes in relation to the health needs of the population of a region or a country, it may be useful to think in terms of three states of development in health.

The first stage is dominated by acute infectious diseases with high infant and child mortality and morbidity and a low average life expectancy of 40-50 years. The slow improvement which occurred in industrialised countries was related to economic progress, improved nutrition and standard of living and public health measures. In spite of gloomy economic prospects for less developed countries, rapid progress is possible in these countries by application of simple control measures which are now available and which could reduce mortality by more than 50 per cent at a cost which can be met by even the poorest country. It is critical that countries with first stage problems should give priority to these rather than dissipating their resources in attempting to cope with many of the diseases and problems of the second stage.

With the control of acute gastro-intestinal and respiratory infections, infant and child mortality drops, life expectancy increases to the 60s and 70s and the second stage of development in health is characterised by diseases of the adult and ageing population: cardiac and cerebro-vascular disorders, cancer, chronic lung disease, arthritis, diabetes and mental disorders.

The response in industrialised countries has been a dazzling array of expensive diagnostic and therapeutic interventions, many of which are of doubtful value, delivered almost exclusively through the personal medical care system. In some of our countries over 25 per cent of expenditures are on terminal illness with marginal, if any, benefit in extension of life. There has been very limited attention to preventive strategies as a means of making a greater impact on health with limited resources.

Two priorities emerge in the second stage of development: first, the need to select the small number of diagnostic and therapeutic interventions which are really cost-effective; and second, to develop preventive strategies for the chronic diseases of stage two to avert disease or minimise disability that results from it.

It is useful to think in terms of a third stage of development in health, reflecting a shift in emphasis from preoccupation with the intrinsic disorders of structure and function of the body as the cause of disease to awareness of extrinsic health hazards arising from environmental factors - personal habits, diet, life style and social conditions at home, in the community and work-place. The personal health care system deals with the consequences of such processes. It is increasingly recognised that new approaches in health are needed to detect potential hazards, identify population groups at high risk due to genetic susceptibility or other factors, and to establish mechanisms to promote protective interventions. Industrialised countries have only recently come to grips with the concept of the third stage, as illustrated in Canada by the Lalonde Report in 1974. To make progress with third stage problems, however, countries will need to adapt health systems to give greater emphasis to health promotion and preventive measures at individual and community levels.

Industrialised countries have evolved through the three stages of health development over more than a century. In contrast, developing countries face the challenge of coping with all three stages simultaneously. The rural and peri-urban poor who constitute a majority of the population are still at the

first stage; the influential and more affluent urban dwellers are at the second stage; and the need for third stage responses is already apparent because of the environmental hazards, life style changes and social disruption associated with urban migration and unemployment. Furthermore, developing countries must cope with the three stages with just a fraction of the financial and human resources available to their industrialised counterparts - $10 or less per person devoted annually to health in these countries compared with over $1000 in many industrialised countries. In any circumstances, but particularly under these conditions, the strategy to improve health must be highly selective. Success will depend heavily on identifying correctly the most important problems in each population group, selecting the most cost-effective interventions to deal with those problems, identifying gaps in health infrastructure which must be corrected without trying to overhaul the whole system, and rearranging financing within existing constraints. This is the sequence of planning questions associated with problems of scarcity and choice.

First, what are the most important health problems of the target population? This question can be answered by epidemiological techniques including sample surveys, reviews of institutional records and semi-quantitative approaches that provide answers which are roughly right and which can be obtained inexpensively and rapidly.

Second, which interventions actually correct the health problem or control the disease? What impact can be expected, at what cost and how difficult is it to implement? Are there opportunities to reduce the cost of implementation by combining interventions which can be delivered by the same infrastructure?

Third, what are the strengths and gaps in the current system of delivery of health services? In order to implement the interventions that have been selected, what key elements of the health system need to be strengthened rather than trying to overhaul the whole system?

Fourth, who pays? What is the existing revenue by source, and the expenditure by function? What costs are involved in the proposed changes? Should the costs be met by reallocation of existing resources or new revenues in the form of taxes or user fees or should the proposals be revised?

The combination of these four steps in project and programme management results in a strategy which is likely to address the most important problems, invoke feasible solutions and avoid imposing impossible burdens on health infrastructure or financing. While the questions may seem self-evident, it is uncommon for managers preoccupied with fighting the fires of daily administration to ask themselves these questions about their programmes, to know how to obtain the evidence to answer the questions and to be able to review it critically. If managers in the health system are able to adopt this approach, the health system will make substantially greater strides towards the goal of health for all within existing resource constraints and, at the same time, present a much stronger case for new resources when these are possible.

To cope with problems of scarcity and choice and to make "informed choices", health personnel need better technical and analytical skills to cope with the four questions noted. Until recently, these skills have not been given prominence either in training for health services administration or in medical education. The development of training for these aspects of management, and of health services research capability to provide evidence on which to base

planning and management decisions, is a top priority to strengthen health sector management.

Why must each country develop its own capability to evaluate the health of its population and carry out health systems and health services research? Information on the efficacy of scientific interventions is transferable from country to country, but the priorities for programmes and the effectiveness of these interventions are different in each country, depending on the profile of disease in the population, the health infrastructure, the supply of health personnel such as physicians, political policies and social and economic circumstances. With such a wide range of national situations and policies, each country must develop its own approach suited to its own conditions and circumstances. Equally important, a managerial team must build confidence in its capability not only to select the most suitable health investments for the population but also to solve the inevitable problems of implementation.

Medical schools have an important role in training personnel in the new skills and in contributing to health services research. By developing capability in training and research, medical schools can be much more helpful partners in national health development than in the past. Since training programmes for these skills are well-developed in only a few countries, this represents an ideal opportunity for technical collaboration among member countries of the Commonwealth in pursuit of the common objective of health for all.

The second major challenge is to strengthen day-to-day management to improve the implementation of the programmes selected. According to the World Development Report just released by the World Bank, deficiencies in management are a serious impediment to development in all sectors. Reports from WHO and other sources confirm that health is no exception.

The health sector presents a formidable challenge to management. Some of its objectives depend on co-operation with other sectors such as agriculture, industry, environment, water supply and sanitation, education and community development. Even the services for which the ministry of health is directly responsible are incredibly diverse: health services in widely dispersed communities; numerous categories of personnel; self-governing professions and specialities; general and specialist hospitals; vertically organised programmes to control individual diseases such as malaria, tuberculosis, leprosy or venereal disease, each with its own personnel and support services; community health care programmes with multi-purpose workers; and often a system of indigenous medicine with traditional healers and birth attendants. The different elements need to be organised to reduce conflict and duplication between programmes and to provide a coherent system to screen and treat patients according to the level of care required and to refer patients with difficult problems. Key aspects are supervision and in-service education of health workers, logistics and supply to maintain credible services, personnel policies to motivate staff, and policies and financial arrangements that encourage rational use of health resources both by the public and by physicians.

Faced with this challenge, what can be done in practical terms to improve the effectiveness of implementing health programmes? I have five suggestions.

The first is to **simplify the task of management.** This is a key factor to improve performance, particularly in weak organisations. Rather than attempting to implement a large number of activities in a programme, it is better in the first instance to concentrate resources on a limited number of

activities of high priority in terms of health impact. The choice among activities should emphasise short-term targets for which effective interventions are currently available and affordable and which are not too difficult technically to implement. Success with the initial limited programme will build confidence of the health personnel responsible for the programme and credibility of the system with the communities served.

In no area of health is the need to simplify the task more evident than in the implementation of primary health care for the rural and peri-urban poor. Primary health care is difficult to implement since it depends on collaboration and shared financial responsibility with communities, delivery of services by health workers who have the minimum basic education and limited health training, and maintenance of essential support services such as technical supervision, transportation and supplies, drugs and vaccines, for a widely-dispersed network of service points. Breakdown of the entire system can be precipitated by failure of any component and the chances of breakdown are multiplied by the number of different activities which the primary health care worker is expected to perform. Training and supervision of health workers and supply of drugs, for example, is manageable for 5-10 interventions in a new primary health care programme, but most countries have attenpted to introduce three of four times that many interventions to deal with a wide variety of health problems with the result that none has been handled effectively.

Developing countries with first-stage health problems, short life-expectancy and infant and child mortality have as their highest priority in primary health care the extension of basic maternal and child health services to under-served populations. Simple, inexpensive techniques of proven effectiveness are now available to control the common health problems which kill over 15 million infants and children each year in the developing world.

Diarrhoeal diseases account for nearly six million deaths of infants and children each year. This mortality can be reduced by one-half to two-thirds by simple oral rehydration therapy.

Standard childhood immunisation programmes for measles, whooping cough, diphtheria and polio will dramatically reduce mortality and long-term disability from these diseases which now account for nearly five million deaths per year.

Neonatal tetanus still claims the life of one in ten babies in certain Asian and African countries, and this hazard can be prevented completely by tetanus toxoid immunisation of mothers.

The high mortality from severe respiratory infections and pneumonia in infants and children can be greatly reduced by prudent use of antibiotics.

Moderate or severe malnutrition, which may affect as many as 30 per cent of children in the poorest developing countries, is an associated factor in half the deaths from infectious diseases and diarrhoea and an important factor in physical and mental stunting of the survivors. Many of the severely under-nourished children would benefit from food supplementation; however, even in the absence of these programmes, the use of weight charts to help mothers recognise malnutrition and the promotion of breast-feeding have been shown to dramatically improve the nutritional status and health of the children.

Low birth-weight, a key factor in high infant mortality, is five times more common in developing than in industrialised countries. Rapidly repeated

pregnancies, pregnancies in mothers under 20, anaemia and intrauterine infection are important causes of low birth weight which could be substantially reduced by simple prenatal health care and sensible family planning services.

For populations at the first stage of health development, these six interventions alone have the potential to reduce infant and child mortality to less than half current levels in a very short time and at an annual cost of only a few dollars per child. No other health investment can provide comparable benefits. However, the records indicate that less than half the population in most developing countries have access to these services and less than 20 per cent of the 80 million children born each year are immunised.

Even in those countries that have made the political commitment to health for all through primary health care, serious difficulties are being encountered in organising and maintaining a system to deliver the services. A first step towards overcoming these difficulties is to simplify the management task by limiting the primary care programme to a small number of interventions such as those described. Once confidence is gained with successful implementation of the core programme, other high priority interventions can be added.

Simplifying the task is equally important for management of other health programmes. The probability of success can be greatly enhanced by selecting those elements of the programme of greatest importance and giving priority to their implementation.

My second suggestion for improving the effectiveness of health programmes is drawn from the World Bank Report. It is to **limit the management burden of the public sector.** A corollary of simplifying the task of management is to avoid overwhelming the management capability of the ministry of health with responsibility for too many programmes. The recent World Development Report points out that the development process in nearly all sectors has been hampered by relatively weak institutions and by the limited organisational and management capability of a vastly-overloaded public sector. The report notes that governments are tempted to take on more and more responsibilities but suggests that governments need to take more into account the limits of their own management capacity. These observations apply in full measure to the human service sectors such as health which, the report acknowledges, pose special management problems.

Governments should evaluate which functions and activities should be undertaken by the public sector and conserve their limited management capacity for these activities. If managerial skills are really in short supply, then new functions which are taken on will almost certainly fail to be effectively discharged and at the same time will weaken the management of existing public sector programmes.

Limiting public sector involvement implies either doing less or delegating more to the private sector. In fact, both directions are appropriate. For the ministry of health, success with a small number of shorter-term, high-priority programmes will have a salutary impact at all levels: the planning and finance ministries responsible for the health budget; the management and staff of the ministry; and most important, the health of the people.

In most countries, the ministry of health has not taken full advantage of the opportunity to delegate administrative responsibilities to the private sector. Services such as transportation, supply of drugs and servicing of equipment

may be more efficiently handled by contracting out to private firms than by expanding the public administration to provide these services. Private management is not without its weakness but unsatisfactory private contracts are more readily terminated than internally-administered public services, and competition and financial failure are powerful incentives for private enterprises to strive for efficiency of operations.

In addition, there is the opportunity in many countries to harness the potential of non-governmental organisations and community groups which have an active interest in providing hospitals and community health services. Few ministries of health, however, have succeeded in establishing an appropriate mechanism for administrative interaction with private sector organisations which also preserves the independence of the private sector organisations. It is reasonable to anticipate that some of the private ventures will fail, but experience indicates that many achieve better results with less in the way of resources than can be achieved in the public system, and the relatively small scale of their individual operations permits innovations which, if successful, can be adopted subsequently by the publicly-administered system.

My third suggestions is to **decentralise management.** The weakest link in the chain of public administration in most countries is at the periphery. Management capability at local and district level is of the greatest importance, since this is the lowest tier of the health administration which on the one hand communicates with central institutions and on the other is in contact with communities, sensitive to their changing needs and in a position to encourage community participation. It is at this level that the best opportunity exists to match resource allocation on health needs.

No single formula for decentralisation is likely to meet the variety of circumstances in different countries or in regions of a country but several generalisations may be valid. First, decentralisation implies different roles for different levels of government, not a dismantling of the central institutions. In a decentralised system, the central institutions must retain strong capability in policy, planning, finance and evaluation, and be in a position to mobilise and adapt nationwide resources for training, logistics and supply to meet changing local needs.

Secondly, career development in the public service concentrates the most talented managers in central institutions. If a decentralised system is to function, high-quality managers must also be attracted to the periphery, otherwise the ministry will not have the confidence to devolve responsibility to the local level and the local managers will be reluctant to accept the responsibility.

Thirdly, devolution of responsibility may be undermined by financial practices which unfortunately are all too common. Central authorities often release appropriations only on a monthly or quarterly basis because of budgetary uncertainties, and this makes it extremely difficult for managers to plan the most effective use of resources. Furthermore, when budgets are cut, if the decisions on what is to be cut are taken centrally the leadership of the local manager is undermined, particularly if the budget cuts are across-the-board and priority programmes are dropped and effective performers penalised.

Finally, decentralised administration requires timely, relevant information for all levels of the system. The local manager should have direct access to the national health information collected from his jurisdiction and this can be supplemented by inexpensive, sample surveys of populations or administrative records to answer specific planning and management questions.

My fourth suggestion is to **strengthen the technical capability of managers.** Management capability of experienced health administrators is limited by lack of the quantitative analytic skills necessary for critical review of evidence. Without a population-based perspective, the administrator tends to become more concerned with the health of the institution which employs him than with the health needs of the population to be served. Without a clear understanding of efficiency and effectiveness of programmes, the administrator's efforts are focused on efficiency of operations without questioning the usefulness of the expensive interventions which comprise the operations. What is needed, however, is not more epidemiologists and health economists in a back room but more epidemiological thinking and concern with cost-effectiveness on the part of those actually responsible for planning and operating health programmes. These skills are important not only to ensure rational decisions but also to convince health professionals to co-operate in their implementation.

Priority should be given to mid-career training of individuals who have already demonstrated leadership and have field experience. Excellent programmes have been designed for this purpose combining theoretical knowledge and analytical practice and using case studies of problems from the trainees' experience.

Management responsibility is widely dispersed in the health system. The clinical decisions of doctors have profound implications for the use of expensive resources. Each of these individuals without regard to rank is a manager in terms of assessing health needs and deciding on the use of resources. Most practising physicians give relatively little weight to the consideration of the efficacy of the procedures they use and almost no attention to the real cost and foregone opportunities in terms of resources consumed. Abel-Smith estimated that the consequential costs generated by the average medical specialist in Great Britain are of the order of £500,000 per year. If eliminating unnecessary procedures succeeded in reducing expenditures by only 10 per cent, the savings nationwide would be enormous. In developing countries, the costs generated by physicians are smaller in absolute amount but the implications are equally serious because of the limited total resources available for health. A key issue in management development, therefore, is training in medical education and a reward system in medical practice which promote discriminating use of scarce resources for diagnosis and treatment.

As noted in the Fifth Commonwealth Medical Conference in Wellington in 1977, "the most pressing need in the developing countries is for more trained personnel capable of measuring problems, of devising possible, practical solutions and of evaluating their application". The shortage of personnel with these qualifications is not confined to the developing countries, however. A high priority for all countries is the establishment of programmes to provide this dimension in training of health managers and clinical leaders and to establish units capable of providing expert advice on design, measurement and evaluation. Ideally, the capability should be linked to planning and management at all levels of the health system. Both the training and research functions are opportunities for collaboration between ministries of health and medical colleges and universities.

My fifth suggestion is that there should be **performance incentives for health managers.** Most health ministries are plagued by the shortage and high turnover of managers. The lack of continuity of management caused by high turnover is particularly disruptive in developing countries without well-established institutions. What can be done to make career opportunities in the public

sector more attractive, not only to recruit and retain staff but also to stimulate performance of those who accept these important responsibilities? First, a consistent policy position - political commitment - by government is a key factor in reinforcing management. Secondly, clearly-stated objectives provide managers with unambiguous terms of reference and objective criteria by which to judge their performance. Thirdly, substantial performance bonuses can be given to compensate for the low civil service salary as a reward for achievement, rather than premature promotion which tends often to move the individual to different responsibilities. Equally important, poor performers should not be rewarded, otherwise holding the job becomes more important than meeting the objectives and the effect on staff morale is damaging.

Managerial positions in the public sector carry with them the satisfaction of service to the public, broad responsibility and public recognition. These rewards alone, however, are unlikely to attract and retain the substantial core of good managers needed in the absence of competitive remuneration, proper recognition of performance and a professionally satisfying work environment.

In conclusion, all countries face the triple threat of rising public expectations, increasing technological complexity of health services and rapid escalation of costs. At the same time, the pressure to cut back public expenditures and to give priority to sectors of the economy with more immediate impact on generating wealth and employment means that ministries of health will have to work hard in the coming years just to maintain their current share of national resources. It is in this context of making the most effective use possible of existing resources that the challenge is presented to improve management of the health sector. In developing countries, the management of primary health care warrants special attention because primary health care represents the best return on health investment and because the existing disparity in access to health services for the rural and peri-urban poor will be further exaggerated by any other health investment unless the primary care programme succeeds.

The longer-term future holds out hope for renewed economic prosperity which will raise the standard of living throughout the world and the promise of spectacular scientific advances in the control of disease. But substantial progress can be made now towards the goal of health for all by the year 2000 with the financial resources and scientific techniques currently available. The challenges are to sharpen our planning to identify the most important health programmes and to strengthen management capability to implement these programmes. Both challenges can be met. Both provide a fruitful opportunity for sharing experience and technical collaboration among Commonwealth countries.

LEAD SPEECH

by Professor O. O. Akinkugbe

Of Stated Goals and Proved Performance

I approach this adventure today with considerable trepidation, for two reasons.

First, to be procured from academia to hold forth on a theme as socio-political and practical as Health Planning and Management is to invite deep circumspection as to the wisdom of such a course. I can almost hear sotto voce reactions in the audience as to how this inmate of the ivory tower can expect to elevate his subject from the usual rhetoric and conventional wisdom that are the stock-in-trade of his guild!

Second, to follow in the wake of such an eminent colleague as John Evans, who is not only at home in this subject but is on his home ground, almost makes me feel that Health Ministers are indulging, albeit unwittingly, in the traditional scientific approach of "control" and "test dose", even with lead speeches - an experiment that I fear might be a little extravagant. But seriously, I am immensely flattered to have been invited to share some thoughts with you on this ponderous subject. If some of my submissions appear iconoclastic, it is because I am an unrepentant provocateur in matters relating to health. Although this is a gathering of Commonwealth Health Ministers, I hope you will forgive me if the substance of my remarks gives disproportionate attention to the developing world situation. With hindsight and listening now to John Evans, my message should probably have been addressed to the more developed areas of the Commonwealth.

The issues Your Excellencies will be addressing in the ensuing days have been succintly outlined in your pre-circulated annotations: the political will, intersectoral and interministerial relationships, socio-economic imponderables, paucity of resources and poor permeation of services from centre to periphery. All this is symptomatic of your deep concern that the health care which most of your populations receive does not appear effectively to be answering the problems they have. Add to this the outmoded hierarchical structure in most health ministries and the demonstrable apathy of a large section of the consumer public, and we find we can no longer escape the charge that the issue of health has now become too important to leave to health professionals and administrators. Despite professed commitment to the ideals of equity and social justice, many Third World governments have failed to build political institutions and administrative structures capable of ensuring a fair distribution of health services and other resources through their populations.

Yet there are lessons crying out for application. The Commonwealth is a

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*Views expressed herein are personal and in no way represent official opinion of the World Health Organisation.

fascinating conglomeration. Affluent and indigent, populous and sparsely peopled, technologically advanced and on-coming (not to say backward!), large and small, politically influential and of modest political weight - I hope you will permit me to assert that these are descriptions you will find not too inappropriate in typing its various member states. It is, ironically, this diversity and seeming conflict in endownment and opportunity that constitutes its main forte, for it poses a tremendous challenge to the inner instincts of man in endeavouring to redress glaring inequities.

Consider for a moment these ten, somewhat disparate observations, which read like a catechism of inequities. They are data that are probably "old hat" to many in the audience but they do throw our present predicament into bold relief:

1. 400 million people in today's world are on the brink of starvation.

2. There are 500 million episodes of diarrhoea in the world every year, resulting in at least 5 million deaths.

3. 270 million people are exposed annually to malaria, of which over one million children die.

4. One per cent of all mankind is blind, either wholly or partially.

5. Three-quarters of all the world's population live in developing countries.

6. Three-quarters of people in all developing countries live in rural areas.

7. Three-quarters of all the skilled health personnel in developing countries live and work in the cities.

8. Three-quarters of all health expenditure in most of the developed and developing world is spent in curative (as opposed to preventive) medicine.

9. In per capita terms, a typical industrial country already spends more on health alone than the entire income of many developing countries.

10. The total global expenditure is now one million dollars per minute. The world's military expenditure for half a day could finance the World Health Organisation's entire malaria programme from beginning to end.

Some of these tragedies are entirely avoidable, others constitute a challenge to self-reliance, yet others derive from the innate selfish instincts of humankind. I know of no developing country, Commonwealth or other, in which national health plans have not extolled the virtues of investing a substantial percentage of capital and recurrent resource allocations to health in the areas of prevention and promotion, and I know of no nation in which such investments have been given full practical expression. It seems preposterous to stand before Health Ministers to make this vigorous claim, but before I am charged with heresy, I would beg leave to offer some plausible explanation.

It is the way in which health has been woven into the conventional social fabric that makes it difficult for many national leaders to comprehend fully its implications for other sectors of the economy. The acceptance by all nations, for instance, of primary health care as the main engine of implementation of the World Health Organisation's mandate for "Health for All" immediately implies the redefinition of interrelationships, and the re-ordering of priorities as between the different sectors of the national economy. We now have to see how health, agriculture, housing and environment, education, science, industry and technology can move together on a broad front, in the crusade of ensuring in the coming decades "the attainment by all citizens of the world of a level of health that will permit them to lead a socially and economically productive life".

It has often been contested that the key to progress in the field of health lies in skewing educational input towards the neglected rural majority in a given population. There then follows a general emancipation, with attendant improvement in the major socio-economic indicators of development. Those who hold this view go on to argue that a society which lacks a clear understanding both of its rights of access to public services (including health) and of the political process is easily manipulated and by-passed, thus becoming powerless to enter into, let alone attempt to influence, the system.

There are parallel aphorisms of special relevance to the developing world scenario: mortality rates are now more closely associated with income, education and broad nutritional levels than with the spread of health services per se; and given the level of income, the ability to allocate it in such a way as to meet minimal requirements improves with the level of education.

One might thus envisage a flow chart in which mass education leads to political consciousness which itself leads to political participation with resultant equitable distribution of resources, including health. The Kerala experience in South-west India presents us with a vivid example of the socio-political dividends of increasing educational awareness.

Next is the assertion that exploitation of intersectoral relationships might lead to a clearer understanding of the role of health in human development. This can hardly be contested, for it seems so obvious that, by quantifying the benefits that could accrue from alternative programmes per unit of funds expended, it is possible to put health care needs into a framework that could be appreciated by economists and decision-makers. But cynics say that the relatively poor allocation of resources to the health sector is often a deliberate political decision, innocent of rationale or any well-reasoned supplication. Stripped of the usual euphemism, the position of health in the cabinet pecking order is not infrequently the crucial factor in deciding the fate of health care services in the life of that government. You will not want me to elaborate further on that theme.

Even when education has generated an awareness of the benefits that could flow from good health, even when a reasonable sectoral allocation has been made, and even when the government is poised to implement its laudable and loudly canvassed health provisions, certain problems still stubbornly obtrude.

The present organisational structure of governmental ministries (not peculiar to health alone) works hardship on mutual co-operation and collaboration as between government itself, manpower and research institutions and various non-governmental organisations. It is common knowledge, for instance, that in many countries the suspicion with which universities are regarded by ministry

officials is only matched by the intellectual disdain of government functionaries by the academic world. The fracture of confidence and communication thus makes it difficult, on the one hand, for health ministries to solicit input from academia in developing and monitoring national health programmes, and on the other hand, for the universities to train adequate, relevant manpower and develop appropriate technology to assist the government in dealing with the compelling health problems of the day.

The extent to which this seeming divorce can affect the delivery of health care in a given country does vary, but the subject has sufficiently exercised the attention of the World Health Organisation for it to decide to devote its next Assembly's technical discussions to the role of universities in Health for All. But much more is needed than mere alignment of these two sectors into dialogue. A profound change in both systems is a necessary prelude. The attitudes, the approach and, above all, the organisation of health programmes in the ministries need drastic rethinking. It would be a great step forward for all to see (both government and academia) that the introduction of primary health care has led, or will lead, to a much greater improvement in the quality of life than an equivalent expenditure on the extension of a hospital-based system. I will develop this theme a little later but for now let us look to see how much a reorganised ministry, geared to problem-solving, can achieve.

A good deal of the ministry's activity, at least in prevention, relates to the mobilisation of resources other than health. That is why interministerial consultation becomes a sine qua non, but this must be both "in word and deed". All too often, such interdepartmental links are left to junior personnel unable to understand the implications of joint programmes, not to talk of committing their ministries. Such an intersectoral forum must have the imprimatur of government itself and must be given considerable initiative in operating together on issues of mutual concern. But again this is not enough, for the health ministry must find means of monitoring the progress of programmes in the field and the various modalities of health services offered to the community. This calls for frequent visits to the periphery and regular dialogue with front-line field workers in the entire health industry. It is through such practical initiatives that ministry officials can rightly claim to be serving the best interests of communities in their charge.

What has been said here of the need for close liaison with all cadres of health care personnel, serving both the centre and the periphery, applies with even greater force to private health professionals. In countries where the bulk of health services are still provided by traditional practitioners, there can be no excuse for excluding them from the mainstream of the health delivery process. A means must be found of incorporating them into the overall health care system, not condescendingly, but in a positive and pragmatic manner.

We now come to what is perhaps the greatest area of challenge to health in what is left of this century if we are going to be able to alter convincingly and in a durable way the attitudes and approaches to health care in our various communities. I refer to the role of health manpower institutions and how they can be effectively mobilised by government and society. We inevitably look to the universities, for it is in them that we expect to find the kind of leadership that will, once convinced of the merit of a concept, run with it and catalyse change through its immense influence over several categories of manpower in health and health-related disciplines. The university, at least in the developing world, is as important a forum for the "studium generale" as it is for the training of tomorrow's leaders in the

various sectors of the economy. Its tripartite functions of teaching, research and service thus make it eminently suited to help the ministry in its many endeavours to prepare personnel to deliver health care to the entire populace.

Health ministries could solicit through universities a change in the curriculum for training in the health professions. In their turn, universities could assist in developing specific skills for defined categories of health manpower in the field; they could be enlisted to research into problems of health needing urgent solution and they could be encouraged to interact with those of their numbers in health-related disciplines so that health can be conceptualised and promoted as an exercise in social justice and human development.

The Commonwealth Secretariat seems to me to have demonstrated a profound understanding of the issues involved in this vexed university/ministry interface. It has done this well in advance of most organisations that I know of and, what is more, has taken definite steps, through its Sri Lanka workshop almost a year ago, and through other impressive activities, to underpin the need for such sectoral efforts to be coterminous. Surely the least Commonwealth governments can do is to respond positively to such clear initiatives.

Those who advocate that curative health services should be supplanted by preventive and promotive measures are not doing the cause of primary health care much good. It does not need the gift of prophetic wisdom to see that in most societies, developed or developing, medicine will continue to serve the individual, however much we might attempt to skew that service towards the community. The critical problem is that of the present criminal neglect of preventive measures reflected in the allocation of meagre resources. The redress of that imbalance will come not by decapitating the pyramid and doing away with the ultimate tertiary referral centre, as some naively think, but by strengthening its base and reorganising its effectiveness.

Manifestos in social services, particularly at times of electioneering, are replete with promises of utopia in the area of health. These promises infrequently vanish with the counting of the final vote. Proved performance then becomes a poor relation of stated goals. The iniquities of inequity receive full embrace and yet we note the dictum of that remarkable French philosopher, Decartes, who once said of health:

> "Si l'espèce humaine peut être perfectionnée, c'est dans la médecine qu'il faut en chercher les moyens."

which in my pedestrian translation means:

> "If the human species is to be perfected, it is to medicine we must turn to find the means."