INTRODUCTION: A NOTE ON HEALTH AND DEVELOPMENT

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I am neither a health researcher nor a practitioner. My exposure to the field of health development is limited. Nevertheless, as one engaged in development planning and fascinated by the concept of Primary Health Care, I decided to put down rather hastily some notes on my understanding of the dialectical interaction between health and development.

As many of us presumably recall, capitalist development theory in the 1960s (and for several preceding decades) was dominated by the growth models of neoclassical economics, e.g. Harrod Domar, Cobb Douglas etc. These models express output as a function of labour and capital, but conceive the relationship as only a technical or engineering one containing no element of social dynamics. The basic paradigm was, of course, the trickle-down theory, i.e. that the increased prosperity of the few would spill over and bring development to the majority.

Subsequent to their attainment of political independence in the 1960s, many developing countries were preoccupied with these growth models. Economic results were mixed; some countries had rapid rates while others grew more slowly. However, even those which they had relatively rapid growth rates of growth began to find themselves increasingly in debt to and dependent upon the industralized countries as a direct result of the particular form of growth which they has sustained. Equally significant were the gravely unequal distribution of the benefits of growth among different social classes within countries, and the growing international inequality of wealth. An increasing number of developing countries came to recognize that the free market path (allegedly) travelled by today's developed market economics was not necessarily the one be followed by themselves. Neoclassical models and their related development paradigm were questioned and there followed a shift from quantitative to qualitative indicators of development.

The 1970s witnessed radical changes in both global and national perceptions of development. The demand for the establishment of a New International Economic Order (NIEO) by the developing countries and subsequent attempts at financial, economic and trade reforms, coupled with the economic and social problems faced by many non-oil producing countries in the aftermath of oil price increases, compelled development planners and administrators to emphasize the need for strong internal project linkages - in several directions - within development programmes.

The health sector cannot be an exception to these changes. I assume that the slogan of "Health for All by the Year 2000" and the concept of Primary Health Care (PHC) were not introduced merely as novelties, but as logical outcome of the search for alternative development patterns. The phrase "Primary Health Care" can be deceiving. "Primary" tempts one to take it as an elementary concept referring to simple health care activities at village level. On the contrary, it is a complex concept requiring familiarity with the politics and processes of development as well as with the specific elements which require balancing within the health sector, e.g. preventive and curative medicine, hospitals and clinics, doctors and health assistants, etc.

Two of the basic assumptions underlying the PHC approach are stated in the Declaration of Alma Ata:

1. The PHC approach is a multi-sectoral one which involves not only the health sector, but also agriculture, animal husbandry, food and nutrition, industry, education, housing, public works, communication etc., and requires their coordinated effort;
2. Maximum community and individual self-reliance and participation are essential to the realization of PHC.

The PHC approach is a leap forward in thinking about health development in that it incorporates wider economic and social considerations basic to changes in national health status. First it redefines the discussion; health development is not an isolated, micro-level problem but one whose solutions require a comprehensive, macro outlook. This is significant because a strictly sectoral approach underestimates the importance to health of the interactions among the different sectors of society. Only a wider analysis permits one to address structural questions; this can be difficult, for economists at least, as long as macro-economic issues are considered of lesser interest than micro ones.

Secondly, the coordinated growth of the commodity-producing and the service (health, education etc.) sectors has been emphasized as an essential components of PHC. I take to be recognition of the multi-sectorality of health development and the role of national development planning in improving health status. Such recognition is important because it acknowledges the frequent failure of the market to allocate necessary resources to the health sector and to fairly distribute those resources and consequent services among consumers. The imperfections and indeed, failure of the market in many areas are well known. Such market failure is particularly evident in the health sector because of consumers' inability to make informed, rational choices about medical care. This inability is due in part to the complexity of medical problems and consumers' lack of specialized knowledge of specific disease problems. Additionally, consumers do not make independent decisions; physicians, who virtually monopolize medical knowledge, effectively control most patient choices. Consequently, in some market economics, the health care services are badly exploited. To avoid this, in many market economics (particularly in western Europe) the state has had to intervene between the providers of health care and its consumers in order to reduce exploitation and social tension. The conclusion can be drawn from this that strong sectoral and national development planning are indispensable tools in the realization of PHC.

Thirdly, as noted at Alma Ata, effective community and individual participation are essential components of PHC. There are two important points here. First, planning and administrative decisions must be democratic in outcome; second, all health policies must be directed to the problems of the cast majority of the population; i.e. in the developing countries, the rural masses and the urban poor. These points show the politics concealed in PHC, i.e. that decisions should be democratic and that PHC is not a class-neutral approach, but one positively biased towards the poorer classes.

I believe the Ethiopian revolution has established the necessary political, economic and social infrastructure for the realization of PHC. Social ownership of the major means of production and distribution, the establishment of a strong central planning organization (the National Revolutionary Development Campaign and Central Planning Supreme Council) with seven regional planning offices, the formation of peasant, workers', youth, women's and urban dwellers' associations and the promotion.

One important instrument for this purpose is the National Health Development Network and its journal, the *Ethiopian Journal of Health Development*. As a scientific journal created to advance the cause of PHC, it will be expected to remedy deficiencies of knowledge in the attitudes and practices of health development. Basic to an understanding of correct ideas about health is a recognition of the relationship between the production of material goods and their integration with the service sectors.

In our country, where PHC is an accepted strategy and an integral part of national and social development planning, the Ethiopian Journal of Health Development has a great opportunity to be useful. We have no doubt that it will succeed and we offer it our undivided support on its long and important journey.