THE INTERNATIONAL RELATIONSHIP BETWEEN DEVELOPMENT AND HEALTH: AUSTRALIA IN CONTEXT

AIMS: To explain the meaning of the epidemiological transition and primary health care. To describe global and Australian health profiles. To discuss current international health goals and targets. To provide examples of health planning and promotion activities.

ECONOMIC DEVELOPMENT PROMOTES AN EPIDEMIOLOGICAL TRANSITION

If countries develop economically they usually go through what is called 'an epidemiological transition', which is a change in their population profile and in their related health and social needs. In developing countries, where many people still live off subsistence level agricultural production, many children are born and many die. Death is mainly due to poverty and infectious diseases which have become rare or been eliminated in developed countries. Adults also die comparatively young. Women tend to die before men, often as a result of childbearing related causes. The population profile contains many children and people in younger age groups and comparatively few older people. In such societies the provision of basic health care and education, especially for women and children, must be the earliest priority. Even more important is the establishment of sources of clean water, food and sanitation.

If countries develop economically and families stop trying to farm and are drawn to cities instead, the population profile usually changes, and so do health needs. Increasing inequalities may develop between industrial and rural populations. Urban slums may also develop. In general, however, economic development usually means that fewer children are born, health often improves and adults live longer. In developed nations the death of children is relatively rare. The number of children borne to each couple is often below replacement level, and men are more likely to die a few years before women. The population profile begins to have many older people and comparatively few young ones. The major health problems are non-infectious diseases caused primarily by lifestyle and over consumption. In these societies the means for self directed improvement of the comparatively disadvantaged should be a major health and sustainable development focus.

Much remains to be done since the WHO Alma-Ata declaration of 1978 in Soviet Kazakhstan, when representatives of 134 nations agreed that health is a fundamental human right. The WHO meeting stated that existing gross inequality in the health status of people, particularly between developed and developing countries as well as within countries, was politically, socially and economically unacceptable and therefore of common concern. Participants declared the social target of governments, international organizations and the world community should be the attainment by all people of a level of health that would lead to a socially and economically productive life. Improvements in primary care were declared to be key priorities. The Ottawa Charter was produced at a WHO conference in 1986 and stated that necessary supports for health include peace, shelter, food, income, a stable economic system, sustainable resources, social justice and equity. The Charter called for the development of public policy and the reorientation of health services as well as community action and education to support health goals.

Of the 5.8 billion people who inhabit the earth roughly 4.6 billion live in developing countries. According to the WHO, between a quarter and a third of all deaths in the world are from infectious and parasitic diseases, which have largely been eliminated in the developed world. This has occurred through the introduction of clean water, effective sanitation, adequate nutrition, immunization, family planning and other basic health and welfare services. Malaria remains one of the major causes of death globally, and about half of those who die are children. Millions of

children still die before the age of five in developing countries, despite the fact that the means exists to prevent most of the deaths. Approximately half of the world population lacks access to the most essential drugs.

However, considerable progress has been made in improving world health, and this has largely become possible as a result of economic development. The end of the Cold War has also offered new possibilities for nation building and welfare progress, despite the fact that the collapse of European and Soviet Socialist regimes, and the introduction of a market economy, has also sharply increased inequality and reduced health in these countries. New major health problems are emerging globally. In 1995 ten million people died from circulatory disease and three million from diseases related to smoking. WHO also estimated that during the year 2000 a total of forty million people would be infected with HIV/AIDS. Civil wars and violent conflicts have also escalated now that global Communist and Capitalist power blocs no longer face each other down. Recent wars have created an estimated 20 million refugees in the world. All these problems require solution through a general development approach which puts community health, education and autonomous decision making first.

PRIMARY HEALTH CARE

Because of the epidemiological transition the focus of the WHO is on supporting primary care in developing countries. Primary health care is essential health care, and is the first level of contact people have with the health care system. The education of women is the most vital aspect of effective health development because women are the ones bearing and caring for children. Because it focuses on health promotion in a community context, good primary health care is vital in developed as well as underdeveloped economies, and is particularly relevant where economic benefits have not reached particular population groups, such as Aboriginal Australians. According to the WHO it rests on the following eight elements:

- Education concerning prevailing health problems and the methods of preventing and controlling them
- Promotion of food supply and proper nutrition
- An adequate supply of safe water and basic sanitation
- Maternal and child health care, including family planning
- Immunization against the major infectious diseases
- Prevention and control of locally endemic diseases
- Appropriate treatment of common diseases and injuries
- Provision of essential drugs

In order to meet the primary health needs of any population one might start with finding out how adequately its health needs are met in regard to the elements described above. Adequate shelter and housing are also vital for good health. Respiratory problems and eye diseases are often major concerns which are exacerbated by the smoke from cooking fires. Self-reliance, self-education and self-determination are keys to the creation of healthy communities. Caring communities need to be able to provide the means to support the development of these characteristics, especially for individuals and communities who cannot get their needs met satisfactorily in the dominant culture of development. The Nobel Prize winning economist, Amartya Sen, has contrasted the vital aim of ‘human security’ and the related values of creativity and dignity with tradition notions of national security and defence. ‘Human security’ is seen as ‘the keyword to comprehensively seizing all the menaces that threaten the survival, daily life, and dignity of human beings, and to strengthening the efforts to confront these threats’. Sen argues that support

for the poor, freedom of speech and transparent management are all essential for effective operation of the market and for equality. This is consistent with holistic, risk management based approaches to health and communications, discussed in these lectures.

PLAN AND SUPPORT COMMUNITY DEVELOPMENT TO PROMOTE HEALTH

Although there is a generally positive relationship between economic development and health, the application of international market forces can often further degrade some environments, causing greater inequalities within countries, and a lower quality of life for future generations. Government policy should be aimed at preventing such environmental problems. Incentives should also be provided for environmental rehabilitation. The WHO recently declared that 'Countries need partnerships for health, not prescriptions' and its conference in Jakarta in 1997 had as its theme the development of health promotion through co-operation between government and the private sector. In Australia the government is gradually lowering its levels of protection to older industries. The tendency for this to create unemployment and related health problems, particularly among those already comparatively poor, needs to be accompanied by measures to promote environmental protection, rehabilitation and re-employment.

Many economists hold the view that there is nothing a tariff cannot do that a subsidy cannot do better. This is important in a context where all nations are committed towards a free trade direction, so that each may maximise their natural, trade related strengths. Beyond 2001 the focus of nations should increasingly be on the holistic management of health and sustainable development in regional community contexts. Health services, housing, education, income, crime prevention and other aspects of people's health and quality of life need to be planned and competitively delivered, in the context of a holistic and sustainable approach to community based work and environment management. This development is made more necessary by the decline of subsistence agricultural production and the trend towards a growing range of community needs being met either through the market or through the taxation and welfare systems. For example, in Australia, one in five people are currently dependent on some form of government welfare. Most would probably welcome the chance to keep healthy, to contribute to their community and environment, and to increase their skills, if the opportunities were there and they were encouraged to do so. There is failure of public management partly because systems of support do not deliver services in an effectively coordinated and planned way, to meet community and individual need.

FOCUS ON CONTROLLING THE WORST GLOBAL AND LOCAL RISKS FIRST

In 1992 the UN Rio Declaration on Environment committed signatories, including Australia, to sustainable development goals. The first principle states that human beings are at the centre of concern for sustainable development and are entitled to a healthy and productive life in harmony with nature. However, the UN Economic and Social Commission for Asia and the Pacific revealed a disturbing picture in its state of the environment report for 1985-2000. It estimated that by 2020 fifty percent of the Asian population and 75% of the Pacific population would live in towns and that rural growth would be slower. There would be large numbers of young and the elderly to support in these areas. It predicted very uneven growth and income distribution as well as major environmental degradation. It saw the major development need as being to expand planning and management to make urban and rural development mutually supportive. Resources and services would be necessary to meet requirements of urban populations. Congestion, poverty, and environmental degradation are all major concerns.

A holistic approach requires governments to work with market participants, including non-government welfare organizations, to ensure that an increasingly competitive global economy does not also lead to increasingly unsustainable development, environmental degradation, social inequality, lack of public amenities, and self-destructive consumption patterns. The need to reliably estimate the quality and cost of product and service provision is crucial for government and the community. Transparent competition may be an important means of ensuring that community services can be made more effective, available and affordable. However, in the absence of reliable, comparative information about production and service outcomes, competition may drive down service and community health standards instead of improving them, to the detriment of the individual and the community.

A study by the Harvard School of Public Health in cooperation with the UN and the World Bank provided a comprehensive and systematic overview of world health problems in 1990, presented on a nation-by-nation basis. According to the study, life expectancy at birth is expected to grow for women in all regions and will also grow for men, but much more slowly, primarily because of the impact of tobacco use. The average life expectancy at birth in the least developed countries ranges from 38 to 52 years, in comparison with a range of between 76 and 81 years for developed nations. In 1990 the people of Sub-Saharan Africa and India bore more than 40% of the total global burden of disease and made up 26% of the world's population. The rates of premature death were seven times higher in Sub-Saharan Africa than in the established market economies. China was the healthiest of the developing regions, with 15% of the world's population and 12% of total disease. It introduced a grassroots approach to health planning and promotion many years ago which was implemented by rural communities and 'barefoot doctors'. However, China's recent embracing of the international market economy threatens the certainty of health and education services that rural people could expect from government in earlier times.

The Harvard investigation of mortality, disability and risk factors indicated that a substantial proportion of international and national disease prevention planning should relate to controlling the ten principle risks of premature death, of which the most important continue to be malnutrition, poor water supply, sanitation and hygiene, unsafe sex, tobacco use, alcohol, and occupation. These risks accounted for more than one third of the global disease burden. Respiratory infections, diarrhoeal diseases, and conditions arising during the perinatal period were the three leading health problems, accounting for almost 25% of diseases internationally. In 1990, reproductive ill health, including unsafe abortion and chlamydia accounted for half of women's health problems. These concerns were primarily confined to the developing regions.

For four fifths of the world's population, non-communicable diseases such as depression and heart disease are likely to have replaced the traditional problems of infectious diseases and malnutrition as causes of disability and premature death. By 2020 noncommunicable diseases are expected to account for seven out of every ten deaths in developing regions compared with less than half today. Injuries, both unintentional and intentional, are also growing in importance. In 1990, unintentional injuries, on the roads and at work, were a burden which outweighed interpersonal violence and war. For men aged fifteen to forty-four, road traffic accidents were the largest cause of ill health and premature death world wide, and the second largest cause in developing regions. Unsafe sex was the third greatest risk factor for disease. In Sub-Saharan Africa it accounted for an estimated 30% of the total burden. By 2020 tobacco is expected to kill more people than any single disease, including HIV/AIDS. Tobacco and alcohol take their heaviest toll on men in the developed regions, where they account for more than one fifth of the total disease burden. Depression and suicide are major health problem for both sexes in developing and developed regions.

HEALTH IN AUSTRALIA

Australia is a developed economy with a high wage structure. Because of this it cannot compete globally in low wage, labour intensive manufacturing or service, so its major trade related development for the future must include high value added products and services in areas such as health, education, communication and insurance. This requires good public policy and management. Life expectancy at birth has increased throughout this century in Australia. Currently the average age of death for women is eighty-one compared with an average for men of seventy-six. Since the 1970s, improvements in life expectancy have been achieved by reductions in death rates at all ages, but particularly for people aged forty-five years or over. Diseases of the circulatory system, which include heart disease and stroke, are now the leading cause of death, followed by cancers such as lung, colorectal, prostate and breast cancer. For people under forty-five years old, injury accounts for around half of all deaths. The most common causes include suicide, motor vehicle accidents, drowning and falls. Injury is the fourth most common cause of death after respiratory illness, and men are much more likely than women to be injury victims.

It may surprise some to know that the most developed nations where people live longest may also report the highest rates of disability. Nineteen percent of the Australian population report having a disability, compared to 3% of people in China. The combination of genetic make-up, work, personal habits and the rising expectations that come with development all contribute to the fact that the rate of reported disability may increase sharply with age in developed nations. Arthritis and other musculoskeletal disorders are the most commonly reported disabling conditions. Diseases of the ear and respiratory diseases are major causes for concern. Poor general mental health is also a key problem.

SOCIO-ECONOMIC SITUATION AND HEALTH IN AUSTRALIA

There is a clear and consistent relationship between social class and health, whether the former is measured by income, education level, or occupation. For all age groups, men and women from less advantaged backgrounds have higher death rates and report higher levels of illness than the more affluent. The role of work in undermining health is not sufficiently recognised in statistics on work related injury because traumatic events are most easily identified as work related. The progressive effects on the development of chronic ill-health of a life-time of repetitive movement, heavy lifting, working with hazardous substances, or in noisy conditions, is hard to determine. There is also a greater prevalence of smoking and alcohol consumption in lower socio-economic groups, particularly by men. Physical inactivity and obesity are also more common. This may partly be related to the stresses of working long hours in jobs which are often boring, dangerous and/or poorly paid. Cheap pleasures accessed quickly can become very important when work is low paid, without breaks and unfulfilling.

There is also a strong relationship between unemployment and poor health. Unemployed young men and women are much more likely to report fair or poor health than employed people in the same age group. They also report more serious chronic illnesses, and are twice as likely as the employed to report being disabled or handicapped. They are also much more likely to have symptoms of psychological distress. Children whose parents are both unemployed have many more serious chronic illnesses than children with an employed parent. Conditions reported frequently include injuries, deafness, and bronchitis. Children whose parents are unemployed also visit the doctor more often, and have twice as many outpatient visits, but significantly fewer

dental visits than those in the general population. There is a pattern of worse health risk factors for single parents and their children and more visits to the doctor. Both boys and girls in single parent families are more likely to be handicapped or disabled than those in two parent families. This is partially indicative of the stress that the disability of any adult or child can place on all family members. Planned community development approaches which centre on supporting unemployed or disabled people in suitable education and work are of vital importance for health.

ETHNICITY AND HEALTH IN AUSTRALIA

Australia is ethnically diverse and in 2003 about 25% of its people were born overseas. About half of these were born in a non-English speaking country. The talents of such people need to be tapped more effectively to meet Australia's needs in a global economy. For the purposes of health comparison the Australian Institute of Health and Welfare puts immigrants into four broad regional groupings: the United Kingdom and Ireland, Other Europe, Asia and Other. These regional groups exhibit significant variation in their age structure depending on the recency of their arrival. Migrants from Asia and Other regions are mainly young, with large numbers between 20 and 44 years old. Migrants from the United Kingdom and Ireland and Other Europe have median ages around fifty years. Stringent health requirements for immigration ensure most migrants enjoy good if not better health than the Australian-born population. Immigrants have lower death and hospitalisation rates, as well as lower prevalence of certain lifestyle-related risks.

However, there are large variations in the health status of migrants according to birthplace, age, socio-economic status, fluency in the English language and satisfaction with their job and life in Australia. This is not surprising because migrants come from such a wide variety of cultures and have migrated for many different reasons, including business, family reunion, and as refugees. Comparatively good health status soon after arrival might be explained by factors such as health, education and income considerations which positively influence migrant intake. Underutilisation of mainstream health services in the early years of migration, because of cultural unfamiliarity, may also mean the health problems of new migrants are understated. Health may be affected negatively by the stresses of migration and resettlement, and by the pressures of unfamiliar work and lifestyle, particularly if people experience lack of access to the kind of jobs in which they had trained in their home countries and in which they had hoped to be employed.

RURAL HEALTH IN AUSTRALIA

About 36% of Australians live outside capital cities, half in major regional centres and the others in rural and remote areas. Their access to medical and related health services is poor in comparison with city dwellers because doctors generally find living in cities more attractive. The Australian Institute of Health and Welfare noted recently that relatively few studies of rural health have been undertaken and that the data is incomplete. Non-metropolitan residents have higher death rates for all major causes of death except cancers and mental disorders. They are more likely than metropolitan Australians to die from pneumonia/influenza, traffic accidents, diabetes, cerebrovascular disease and ischaemic heart disease. The death rate for men and women aged 25 to 64 in non-metropolitan areas is 15% higher for men and 9% higher for women than in the general population. Lack of job opportunities in rural areas may mean unemployment is a major problem, especially for the young. A co-ordinated community approach by government, employers and educational institutions to dealing with such problems is required.

INDIGENOUS HEALTH IN AUSTRALIA

Aboriginal people comprise around 2% of the total population and may live in remote communities or major cities. They die eighteen years earlier on average than the general population, and are much more likely to die from avoidable conditions, which should be wholly or substantially manageable with adequate medical care. Lack of essential services including housing, clean water, electricity, sanitation, health care and education are major factors which combine with unemployment, poor nutrition and alcohol abuse to explain the poor health of many Aboriginal people in rural and remote areas.

Improvements in Aboriginal life expectancy over the past two decades have generally resulted from reductions in infant mortality and infectious and parasitic diseases. However, Aboriginal infant mortality rates continue to be more than three times the rate for all Australians in some areas. Principal causes of Aboriginal deaths include diseases of the circulatory system such as ischaemic heart disease, cerebrovascular disease, injury and poisoning. Respiratory diseases, cancers, diabetes, infectious and parasitic diseases and mental disorders also extract a heavy toll. Aborigines are around 70% more likely to be handicapped than the general Australian population. In spite of these problems, which are keenly related to cultural dispossession, there is likely to be considerable potential to develop effective community based management approaches to improving health and environment. This is because indigenous leaders and their communities have cultural knowledge which everyone might benefit from understanding and promoting.

WHO PRIMARY HEALTH GOALS AND TARGETS

The WHO focuses its programs on assisting the poor in developing nations. The ninth general program of work of the WHO, which covered the period 1996-2000 outlined ten goals and targets for world health. The fact that these have not been met makes taking this direction even more urgent. The first goal was to increase the span of healthy life for all people in such a way that the health disparities between social groups are reduced. The targets which related to this goal were that life expectancy at birth would not be less than sixty years in any country, and for all population groups the difference between the highest and lowest values for life expectancy at birth would be reduced by at least 50%. The second goal was to ensure universal access to an agreed set of essential health care services of acceptable quality, comprising at least the eight essential elements of primary health care. Targets included that at least 85% of the world's population would have access (within an hour's travel) to treatment of common diseases and to essential drugs and vaccines, biological products and blood products of good quality.

The ten goals and targets of the WHO program were accompanied by four policy orientations. Their aims were to integrate health and human development in public policies; to ensure equitable access to health services; to promote and protect health and to prevent and control specific health problems. These orientations are reflected in Australian policy and program developments discussed in these lectures, but change is painfully slow so far, and health is still centred on hospitals and doctors rather than on broader community development approaches. A planned and community based approach to management is necessary which targets housing, education, employment and sustainable economic development as well as health services.

The international primary health care focus of the WHO has as major goals the spacing of children at least two years apart, and providing trained pre-natal and birth assistance. Health worker systems are to be established and promoted to ensure that children continue to gain weight, and receive necessary medications. Benefits of breast-feeding, good nutrition and hygiene are taught. The need for a supply of clean drinking water, good construction and use of latrines, and basic hygiene principles to protect against diarrhoea, are addressed. Education is

also provided in the handling of food to guard against contamination, and the importance of suitable liquids for a child who has diarrhoea.

Children should be immunized against tuberculosis at birth and against diphtheria, whooping cough, tetanus and polio at six weeks. Further immunization should occur at ten weeks and fourteen weeks. Measles immunization should occur between the ages of nine and fifteen months. In areas where malaria is common the emphasis should be on destroying mosquito lavae and preventing them from breathing. Anti-malaria tablets are needed throughout pregnancy and young children, in particular, need to be protected from mosquito bites. Since the advent of the global AIDS epidemic, the need to avoid promiscuous sexual behaviour and to use condoms in order to avoid AIDS has become an important aspect of the primary health message. The particular risks of anal intercourse, prostitution, and the dangers of injecting drugs should also be tackled in ways which recognize the particular development needs of poor communities.

RELATED HEALTH AND ENVIRONMENT DEVELOPMENT PRIORITIES

After the first five years of life, whether in industrialised or developing countries, the most common causes of death are cardiovascular diseases, cancer and accidents. WHO promotes action to fight these problems, and also tobacco. WHO also estimates that about 300 million people in the world currently suffer from mental or neurological disorders or from psychosocial problems such as those related to alcohol and drug abuse. These problems are thought to be the cause of two fifths of all disability in the industrialised world. WHO encourages the incorporation of mental health skills, knowledge and understanding within general health care and social development. Other major WHO priorities are monitoring air and water pollution, and contaminants in food, through cooperation with the UN Food and Agricultural Program, the UN Environmental Program and the International Labour Organization which has an international program on chemical safety. However, it laments that little attention is currently being given to sustainable development, which has major health ramifications.

The UN Economic and Social Commission for Asia and the Pacific state of the environment report for 1985-2000 clearly outlined the problems of development which need to be tackled through a community based planning approach. Increasing urbanisation often causes increasing income inequality. The poor in urban communities may face inadequate housing, live in marginal communities where crime is a major problem, and experience a lack of effective water supply and sanitation. There are often deficient solid waste collection, treatment and disposal systems. There is also growing pollution related to this. Traffic noise and congestion may be a major concern. Air, water, and noise pollution as a result of population pressure, manufacturing production and auto transport are also common problems. Oil and gas reserves are low and coal has a significant effect on air quality which contributes also to the effects of global warming.

The key to sustaining economic returns from land and preserving the diversity of resources lies in combining economic development with maintenance of ecological processes and conservation of biological diversity. Population growth, the limits of available agricultural land, and current land use practices may all be major causes of environment degradation. Land use planning should allocate priorities, distribute resources and undertake area protection. Deforestation resulting from agriculture and timber extraction is a growing problem throughout the world. Fuel wood remains an essential source of energy for the poor, and this also contributes to desertification, which affects half the world's population. Fertilizers and pesticides cause environmental degradation. There is likely to be increasing reduction in biodiversity as a result of this.

Water may be increasingly degraded by sewage, industrial waste, agricultural run-off and increasing erosion as a result of loss of trees. Countries which share rivers and natural reservoirs need to provide integrated management which protects all wetlands. Dams may flood valuable forest and farmland, destroying wildlife and displacing people. Irrigation schemes can also spread water-borne diseases or degrade farmland by drawing salts into the soil. A decrease in groundwater level can cause saline water to intrude. In inland and coastal waterways marine and aquatic resources are under pressure from intensive fishing practices and endangered species are increasing in number.

Marine environments play an essential role in population health and are degraded by settlements, transportation, fishing and harvesting, mineral and energy resource extraction or waste disposal. Marine management plans need to deal with problems arising from the exploitation of fish resources, as well as coastal waters which are polluted from domestic sewage, industrial effluent and agricultural runoff, or from tankers and oil exploration. All of this contributes to the destruction of marine ecosystems such as mangroves and coral reefs.

COMMUNITY DEVELOPMENT SHOULD BE PROMOTED

A 1997 report on the Australian overseas aid program recommended that aid should assist developing countries to reduce poverty through sustainable economic and social development. It advised investing in the human capital of the poor in areas such as health and population programs, education and training and research and technology transfer. Community management, like charity, should also be effectively designed, managed and supported, at home.

Feuerstein's book 'Poverty and Health' is full of practical suggestions for developing management systems in cooperation with subsistence-based communities who have little money and education. Many of her suggestions are probably appropriate for adaptation in more developed community contexts. She discusses the need to develop planning based on the main needs of any community. She lists these as physical, shelter and environmental needs, and also psychosocial and spiritual needs. She addresses the related requirement for personal and communal asset planning, especially in regard to management of land and water for home food production, livestock and grazing, and for recreational areas and opportunities. She discusses access to transport and markets, and to basic education, health services and productive employment in this context.

Feuerstein also addresses the community-based development of risk indexes so that agreement can be gained about how to identify high-risk families in order to design inputs around their needs. Poverty profiling blends existing information from government and academic sources with that generated by the poor themselves. For example, in social mapping a group of women may draw a map on the ground then, individually, stand at the place their house is located and talk of their problems and needs, such as having no food, caring for grandchildren, or having imprisoned relatives. 'Poverty and Health' discusses informal financial services and credit for the poor, including a variety of ways that small-scale savers and borrowers can get money and raise their incomes. It suggests schemes such as providing food stamps or coupons for the poor, low-cost restaurants, small scale agricultural extension, crèches and day care systems, and food for work systems for those without land or stable employment. Women who care for children are often seen as the best investment risks for micro-loans that allow them to purchase the means of developing an appropriate small business based on meeting local needs. For example, a poor woman might seek to purchase a sewing machine, bee keeping equipment or related productive tools, paying the loan back on a regular basis so that others take up related development loans.

CONCLUSION

Countries move through an epidemiological transition as they develop. In developing countries the major health risks are infectious diseases, which are primarily related to poverty. Major problems may be a polluted environment, lack of sanitation, inadequate food and lack of immunization. Children are most at risk. In developed economies adults have fewer children and people live longer. The major diseases relate primarily to personal consumption and lifestyle. Tobacco related diseases, accidents and mental health problems are increasing throughout the world. Environmental degradation is also a major risk for current and future generations of people. The focus of the WHO is on the development of primary health care, targeted to the basic needs of women and children in developing countries. Education, environment protection and sustainable development require coordinated management in this community context. Partnerships should undertake the holistic identification of major risks to community health, and the development of strategies to control them. A holistic approach to development requires teams of people who have a diverse range of skills, including cultural knowledge and leadership. Management and budget responsibilities should be allocated to meet the projected program of work in the community.

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