EDITORIALS

Health for all by the year 2000

THE International Conference on Primary Health Care held at Alma Ata, USSR, in September 1978 was an event that made almost no impression in Britain. The *Lancet* printed it in full (Declaration of Alma Ata, 1978), hailed it as "one of the significant events of a cheerless year" (*Lancet,* 1979) and published a long paper about it by an Edinburgh physiologist (Passmore, 1979) which was angrily attacked in the only contribution (Frey, 1979) printed on the subject in its columns from anyone in British primary care. The *British Medical Journal* ignored it completely, as did the College and this journal (and, to be fair, British general practitioners as a whole). Why should this have been so? Is primary health care in these islands really so advanced or so different, or so far removed from the problems of the poorer countries of the world, that what went on at Alma Ata seemed irrelevant? If the silence of 1978 seems like assent to this question, perhaps the time has come to break it, and to start a debate on matters certainly less parochial, and probably more important, than some of those of current interest in our College.

The Declaration

What did the Declaration say? Perhaps the best way of paraphrasing it is to repeat the words of one commentator who, like several others, disliked the high-flown verbiage which so often cloaks the good intentions of the World Health Organization: "In some parts of the world, people are much less healthy than in others. That is unjust; it is also dangerous, because health, peace and economic development depend worldwide on one another. If we are to put things right by the end of the century, we must all work and plan together in freedom and equality, governments and individuals alike. By spending less on guns, we can spend more on caring for the ill, but also on eradicating disease, feeding and housing people properly, and teaching them how to live in a healthy way" (Dukes, 1978). What Dukes left out is the Declaration's emphasis on primary health care, which was described as "essential health care . . ., the first level of contact . . . with the national health system". A good definition of the characteristics of primary health care was provided by yet another of the *Lancet*'s correspondents (Fendall, 1978): "Primary and intimate contact with the community; an adequate range of services; co-ordination of those services; a capacity for health assessment of both the individual and the community; continuity of care; a progressive care support structure; a family orientation; and a non-institutional outlook."

A journal for the Declaration

To prove that it is a body with active limbs as well as an eloquent voice, WHO has started a journal called *World Health Forum,* whose specific aim is to provide a platform for the international exchange of ideas in primary care. In its columns *World Health Forum* returns constantly to the need to implement the Declaration of Alma Ata, to find ways of helping everyone to attain "by the year 2000 a level of health that will permit them to lead a socially and economically productive life" (Declaration, paragraph 5).

Implementing the Declaration

What can doctors do? As rich people in a rich country, could we not state in public our view that global economic inequality and the spending of grotesquely huge sums on weapons of destruction are interlinked causes of ill health in most of the countries in the southern hemisphere? As a practical expression of our beliefs we can work in these countries ourselves, either to shed a little moss (Brown, 1981), to see if the grass is greener (Daynes, 1981), to extend our education (Peppiatt, 1981) or simply from an altruistic feeling that people in developing countries stand in greater need of medical care than the self-indulgent bourgeoisie in what passes for the civilized world. The British organization Voluntary Service Overseas and the Bureau for Overseas Medical Service have both developed ways of getting doctors to the places where they are needed and where their skills will be most appropriately applied. And if we cannot work abroad, we can certainly pass on some of what we know: teachers can cross continents (Metcalfe and Varnam, 1981), especially if they take the trouble to find out what the learners need to know. It will almost certainly be true that what British primary health care does is not what primary health care in New Guinea should be doing, but Essex (1980) has shown that plans made by foreigners and geared to the appropriate level can be made, and can work.

The College's good reputation in the developing world (Pearson, 1980) brings with it two advantages: able people in the UK can be persuaded to work for it and influential people abroad are likely to adopt its

suggestions. Why, then, do we not capitalize on this good reputation? Why have the College's extending overseas contacts (see our reports on Council meetings, *passim*) been largely confined to the oil-rich countries of the Middle East? Is there no sort of advance that we could make to Tanzania, say, or Honduras, where the prospect of any kind of return to the College would have to be measured for the foreseeable future in terms of goodwill only?

There is a saying that people are what they do. We are doing very little. Don't we care?

S. L. BARLEY
Editor

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Notes

1. *World Health Forum: An International Journal of Health Development* is a quarterly journal with a subscription of Sw Fr 40-. WHO publications may be obtained, direct or through booksellers, from HMSO bookshops in London, Edinburgh, Cardiff, Belfast, Manchester, Birmingham and Bristol.
2. The address of Voluntary Service Overseas is 9 Belgrave Square, London SW1X 8PW (tel: 01-325 5191).
3. The address of the Bureau for Overseas Medical Service is London School of Hygiene and Tropical Medical, Keppel Street, London WC1 (tel: 01-636 8638 or, evenings and weekends, Ansaphone service 01-455 6332).

What is this PMS?

IN 1980 the Sixth International Congress of Psychosomatic Obstetrics and Gynaecology concluded that "premenstrual syndrome (PMS) must be regarded as an endocrinopathy . . . deserving of a place in the future, not only at psychosomatic meetings but also at scientific conventions" (Van Keep and Utian, 1981), thus recognizing the hormonal element in PMS. Nevertheless it is only general practitioners, observing patients in health and sickness, who are the most likely doctors to recognize the changes in mood during the menstrual cycle, so characteristic of PMS; only they know the impact it has on the patient's family, neighbours and workmates. The general practitioner also has the clinical competence to make the diagnosis and supervise treatment. PMS is thus the specialty of general practice.

Frank first described premenstrual tension in 1931 as "a feeling of incredible tension from 10 to 7 days preceding menstruation, which in most instances continues until the time the menstrual flow occurs". Later it was appreciated that many other symptoms may be involved, such as headaches, nausea, vertigo, joint pains, skin and mucosal lesions, rhinorrhoea, asthma, epilepsy and mastalgia. In 1953 the term 'premenstrual syndrome' was introduced "to prevent missing the diagnosis when tension was absent or overshadowed by a more serious complaint" (Greene and Dalton, 1953). PMS was defined as "the presence of recurrent symptoms in the premenstruum or early menstruation with complete absence in the postmenstruum". It must be emphasized that Frank's definition and this one are the same, and depend on the timing of symptoms, not on their type. They are themselves commonplace, and also occur with great frequency in men, children and postmenopausal women. Greene and Dalton insisted on the minimum time of recurrences of symptoms as three menstrual cycles, with an absence in each postmenstruum. Today some investigators consider that self-rating questionnaires used by women in only one premenstrual week are sufficient for a diagnosis (Clare, 1977). This is not good enough.

PMS covers a wide spectrum from normality to gross abnormality. It has been studied by sociologists, psychologists, psychiatrists, gynaecologists, endocrinologists and physicians, and is a popular subject in the medical and lay press, but too often definitions are absent or incorrect so that comparisons cannot be made. A recent review of PMS by Reid and Yen (1981) describes it on the basis of symptoms: "The patient with severe PMS develops breast swelling and tenderness, abdominal bloating and a variable degree of oedema in the extremities in the luteal phase", but fails to define PMS. This again is not enough; there must be evidence of timing of symptoms, and a symptom-free phase in the postmenstruum or pre-ovulatory phase.

Earlier doctors limited 'symptoms' to those complaints severe enough to require medical attention. Today's psychologists administer self-rating questionnaires to identify premenstrual complainers in a healthy