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30 Jahre nach Alma Ata: Die Zukunft von Community Health

Evolution of Global health policies since the Alma Ata Conference

A long way back towards Health for All

Von Eduardo Missoni

The history since the declaration of Alma Ata recounts about privatisation, fragmentation and confused global health governance. Because of the failure of different market approaches and the vertical programmes Primary Health Care is back again on the agenda of international health politics.

In 1948, the member states of the newly formed United Nations gathered together to create the World Health Organisation; the international community established the "attainment by all peoples of the highest possible level of health" as the objective of the new organisation which received the mandate to "act as the directing and co-ordinating authority on international health work".

By identifying health as a fundamental human right and defining it as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" it was implicitly recognised that the promotion of good health could not be pursued through medical care alone, nor through the sole control of diseases, but would require a much wider and intersectoral outlook. Recognising that the health of all peoples is an indispensable condition to the attainment of peace and security of the world, and dependent upon the fullest co-operation between individuals and between states, as well as indicating "unequal development in different countries in the promotion of health and control of disease" as "a common danger", both the global nature of health-related issues and the connection with international relations was made clear.

Naming the new organisation the World Health Organisation also raised sights to a worldwide "global" health perspective. The evolution of global health policies is largely coincident with that of WHO's role in the global scenery.

In its first period of existence WHO and world's health policies were strongly influenced by the politics of the Cold War and closely allied with the interests of the United States, especially until 1956 when the Soviet Union returned to the UN and WHO, that it had left in 1949. In

that period, action was largely focussed on the malaria eradication campaign and top-down interventions fitting into US Cold War efforts to promote modernisation with limited social reforms and support local governments and US supporters in winning "hearts and minds" in the battle against communism. In 1959, after the Soviet Union and other communist countries had returned to WHO, a new vertical programme – the global smallpox eradication programme – was launched, soon bringing together the interests of the two most powerful players and later ending up as the most successful disease control programme.

In the 1960s and 1970s the political context was marked by the emergence of decolonised African nations, the spread of nationalist and socialist movements and new theories of development. Among those, some (Dependency Theory) focussed on the structural position of so-called underdeveloped countries in the world economic system and the characteristics of those societies, with the interests of their élite convergent with those of the élite of dominating countries, others proposing a "basic needs approach" and other fostering a New International Economic Order. In this changing context also WHO shifted to a new approach, more attentive to the development of basic health services, community participation and the immediate health needs of the population.

It is under the leadership of Hafdan Mahler, the Dane, who served as a Director General from 1973 to 1988, that WHO was established as the "global health conscience" openly challenging the commercial practices of transnational pharmaceutical and food industries.

The spirit of Alma Ata and its quick betrayal

In 1977, the World Health Assembly adopted the goal of "Health for all by the year 2000" and the following year, with the Alma-Ata Declaration, Primary Health Care (PHC) was identified as the best strategy toward that objective, not only as an integral part of each country's health system, but of it's entire social and economic development, in a view based on equity and community participation, focussing on prevention and appropriate technology, with an integrated inter-sectoral approach to development. "For most, it was a true revolution in thinking", commented thirty years later Dr. Mahler, "health for all is a value system with primary health care as the strategic component. The two go together. You must know where you want your values to take you, and that's where we had to use the primary health care strategy".

With this broader developmental focus came new dangers. WHO had to face competing, and powerful interest groups and Mahler's leadership for change in policy direction also led WHO into much greater conflict than before.

The adoption of the new strategy and its holistic approach would have had relevant societal structural implications, thus immediately a number of governments and agencies pretended the PHC approach to be idealistic and pushed to reduce the spirit of Alma Ata to a practical set of technical interventions.

It is reported that on the following year a conference was held in Bellagio, Italy, sponsored by the Rockefeller Foundation and supported by the World Bank, with in attendance the vice-president of the Ford Foundation, the administrator of USAID and the executive secretary of UNICEF, giving birth to “selective Primary Health Care” low cost interventions, pragmatic and limited in scope. It was a quite reductive, centralist approach getting legitimated on the basis of some cost-effectiveness considerations, which with the advent and prevailing of neoliberal policies was to become dominant. Attention was drawn away from health and focussed on the control of single diseases. Under the strong influence of international organisations and bilateral agencies, this soon resulted in the reorganisation of health systems in “vertical programs”, the disarticulation of public health activities, along with a multiplication of costs and a waste of resources, not to speak of the complete detachment of these programs from development actions being implemented in other sectors (schools, production, etc). This disease- rather than health-oriented approach, was often more consonant with the political and administrative needs of main donor countries and organisations whose influence on choices made by beneficiary countries is well known. It adapted better to market strategies and to “social marketing” and, behind relatively cheap but highly visible campaigns, it often served to mask the lack of any real political will to improve people's health conditions.

In those years, public health was confronted by market forces also on another front. Consumer groups were growing in numbers and strength advocating for putting the marketing of baby foods onto the health agenda. In 1979, an international meeting jointly hosted by WHO and UNICEF and involving representatives of governments, health organisations, companies and campaigning groups, called for the development of an international code of marketing. Two years later the International Code of Marketing of Breast-milk Substitutes was adopted by the 34th World Health Assembly, the sole opposing vote coming from the United States of America, which perceived the code as interference in global trade and marketing practices.

WHO had to face the market logic also with its “Essential Drug Program”, a fundamental component of the PHC approach. In part as a protest against that programme, which was opposed by leading US-based pharmaceutical companies in 1985 the United States decided to withhold its contribution to WHO's regular budget. Three years earlier the World Health Assembly had already frozen WHO's regular budget.

The financial challenge that WHO had to face, gave start to a significant change in the way global health priorities were defined. A crucial shift took place from predominant reliance on the regular budget – drawn from member states' assessed contributions defined on the basis of population size and gross national product – to greatly increased dependance on extrabudgetary funding, i.e “voluntary” contributions from “donor” countries and external contributors including the World Bank. The World Health Assembly had no say over the use of extrabudgetary funds which were pledged by “donors” according to their own priorities, giving soon rise to a number of vertical programmes, with a variable degree of independence from WHO's institutional decision making structure. By the beginning of the 1990s

extrabudgetary funds already represented 54% of WHO's total budget, and that percentage would progressively grow over the years to reach 79% in 2007 becoming the most visible obstacle to WHO autonomy.

Yet, the spirit of Alma Ata was still inspiring the international health community when, in 1986 the Ottawa Charter on health promotion introduced the concept of “healthy public policies” underlining the unavoidable influence of policies outside the health sector and the need to put health on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health, an approach that, as we will see below, WHO re-proposes today.

But things rather went the other way round; health sector policies would soon have to follow the macro-economic policies that the World Bank was de facto imposing on developing countries.

The World Bank had been progressively occupying the ground since 1979 when it created its own Population, Health and Nutrition Department increasing its involvement in the health sector.

The World Bank, Structural Adjustment programmes and the Health Sector Reform

Based on its 1987 Financing Health Services in Developing Countries: An Agenda for Reform and as an integral part of “structural adjustment” programmes (social spending cuts, privatisation, abolition of protectionist barriers), the World Bank pushed developing countries to adopt a single recipe Health Sector Reform enforcing fee payment for health services, encouraging privatisation of health services, promoting the introduction of private insurance schemes, and fostering the decentralisation of health care management. Structural adjustment policies imposed on poor countries had been among the main determinants in the worsening of people's living conditions and in the collapse of those health systems, which countries were now asked to reorient.

The increasing influence of the World Bank also coincided with the loss of leadership of WHO. Mahler's tenure was followed in fact by a “dark period” for both WHO and global health.

WHO became over-centralised at headquarters and regions, top heavy, poorly managed, bureaucratic and its image reached a very low level also because of corruption suspects on its staff. WHO director general Hiroshi Nakajima failed to come up with convincing responses to the challenges posed to world health and to WHO during this period, he alienated WHO staff and partners through his management style, high-profile disagreements and communication failures.

In the 1990s the World Bank started to directly orient the global debate on health. Its World Development Report 1993 entirely devoted to international health, has been described as a “watershed in international health” (Ruger, J.P) giving legitimacy to the Bank in the health sector. The Bank put renewed emphasis on a “selective” approach by means of a "minimum essential package" for the control of a limited number of diseases, and went on advocating the privatisation of health services, policies that had severe consequences in terms of poorest countries' population reduced access to health services.

The World Bank soon became the largest international donor in the health sector in middle and low-income countries, significantly altering the panorama of international health co-operation. With the size of its operations, the conditions imposed to countries in order to access to credit and the strategies it adopted, the World Bank changed the sectoral priorities and the relationship between donors and beneficiaries both at global and national level.

The international health scene was progressively changing. The weak WHO leadership had to deal with an increasing number of players. In addition to the World Bank and other UN organisations, regional development Banks and Funds, the private corporate sector of the great multinational pharmaceutical companies, along with the non-profit-making sector of a growing number of non-governmental organisations, were all claiming a role in the health sector. In the meantime, instead of growing, Official Development Aid decreased by 20% during that decade.

Philanthropists, GPPP and the corporate sector: Public Health goes private

Among the new actors appearing in that period on the global health scene is the billionaire Bill Gates. In 1994, after years of contributing to charitable causes, Bill and Melinda Gates consolidated their giving to address also Global Health and the new William H. Gates Foundation, was formed with an initial stock gift of about $94 million. In year 2000, through further consolidation the Bill & Melinda Gates Foundation was established, maintaining Global Health among its top priorities. The Bill & Melinda Gates Foundation would soon become the single most important non institutional player on the global field, acting both directly and as a partner of the most important global initiatives.

In the changing scenario, also global public-private partnerships emerged as a new approach to improve the delivery of health services for a number of health problems. Many public–private partnerships were created during the late 1990s focussing on specific diseases such as HIV/AIDS, tuberculosis, and malaria. Notwithstanding the enthusiasm for public–private partnerships, their success in this context appears to be mixed, and few data are available to evaluate their effectiveness. Pretending lack of public resources – where the reality was one of reduced public commitment and of progressive privatisation of international aid – the Global Public Private Partnership (GPPP) model was repeatedly proposed at every summit as the answer to the most varied and dramatic world problems. Their number increased rapidly

surpassing 90 different health-related GPPP, duplicating interventions and further fragmenting global action for health, with heavy consequences also in terms of health governance, both at national and global level, and provision of health-care in beneficiary countries.

With the election of Dr. Brundtland, the experienced former Prime Minister of Norway, as the Director General of WHO in 1998 it seemed that once again the organisation could put itself forward as the leading advocate of public health and the most competent organisation to provide expertise, set standards and assist Governments in strengthening their health systems.

From the moment of her appointment, Brundtland defined four strategic directions for WHO: reducing the burden of disease, reducing risks to health, creating sustainable health systems, and developing an enabling policy in the health sector. With a wider look, taking up her position, she declared that the organisation's objectives were to combat poverty, underdevelopment and social inequalities. In that sense it seemed that WHO would take a new lead in fostering “Healthy Public Policies” (i.e. orienting public policies in other sectors, toward health objectives), a concept established since the Ottawa Charter in 1986.

In the year 2000, by courageously opening a new phase in the debate, the WHO centred its annual report on health systems. By defining the health system as “comprising all the organisations, institutions and resources that are devoted to producing health actions” and a health action as “any effort, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health”. WHO measured the performance of different countries' health systems in achieving this objective, evaluating aspects like the equal opportunities in accessing the health service, the pooling of risk and the responsiveness to expectations but, above all, by placing the accent on the level of intersectoral cooperation in achieving good health.

Notwithstanding that wider outlook, in practice Brundtland openly supported “vertical” initiatives to face a variety of specific diseases and health issues and their implementation through GPPPs. The promotion within WHO of partnerships and other interactions with the corporate sector also represented an important shift in organisational policy. Considering the difference between the objectives of WHO and those of corporate partners, and the increased dependance of WHO from private funds, Ford and Piedagnél anticipated that those interactions could potentially further reduce WHO independence. Among GPPPs she strongly supported the establishment of the Global Alliance on Vaccines and Immunizations (GAVI), which was later regarded as a reference for the GPPP model, and of the Global Fund to fight HV/AIDS, Malaria and Tuberculosis (GFATM).

In the year 2000 Brundtland also established the “Commission on Macroeconomics and Health” (CMH), led by Jeffrey Sachs, which added evidence to the direct relation between economy and health and how investment in the latter may induce economic development. However the Commission accurately avoided to explicitly questioning dominant macroeconomic policies, structures and mechanisms that contribute to the increase of worldwide health iniquities. In addition, when it came to identify solutions, the Commission's

report lacked originality and proposed interventions, already identified by others externally to WHO; without substantiating the recommendation, it gave its own blessing to the Global Fund to fight AIDS, tuberculosis and malaria sponsored by UN Secretary General Kofi Annan and G8 governments. In fact, the CMH Report stressed the role that public-private partnerships could play and cautioned the governing bodies of WHO not to constrain WHO's work by raising concerns about conflicts of interest.

One could imagine that WHO was looking for alternative, pragmatic ways to regain position and get needed resources. Brundtland's head of cabinet, David Nabarro, reportedly declared: "We certainly need private financing. For the past decade governments' financial contributions have dwindled. The main sources of funding are the private sector and the financial markets. And since the American economy is the world's richest, we must make the WHO attractive to the United States and the financial markets" (Le Monde diplomatique, July 2002). But that policy of submitting WHO to the dictates of Washington and global liberalisation turned out to be ideological, not practical: WHO did not establish interactions it would coordinate, it rather offered unconditional support to partnerships that would reduce WHO's role to one of a purely technical adviser of those new international entities.

Attentive analysis show that strengthening of interactions with the private sector since the 1990s within the United Nations and its agencies did not just happen by itself, come out of nowhere or go uncontested. It was strongly debated and largely was a result of constraints in the UN's funding, pressures from some member states and a strong commitment by the Secretary-General, Kofi Annan to take the UN in that direction.

Framework convention on Tobacco control

However one of the undoubted achievements of Brundtland's tenure went in the opposite direction. The launch of the WHO Framework Convention on Tobacco Control (FCTC) in 2003, which entered into effect as international law in 2005, established a milestone in the history of corporate accountability and public health. This initiative openly challenged the tobacco industry.

Already before the adoption of the initiative for FCTC by the World Health Assembly in 1999, international tobacco corporations Philip Morris/Altria, British American Tobacco and Japan Tobacco International sought to weaken and bury the treaty. This was pursued staging events to divert attention from the public health issues raised by tobacco use, attempting to reduce budgets for the scientific and policy activities carried out by WHO, putting other UN agencies against WHO, seeking to convince developing countries that WHO's tobacco control program was a "First World" agenda carried out at the expense of the developing world, distorting the results of important scientific studies on tobacco, and discrediting WHO as an institution.

Evidence was gathered by an Expert Committee established by WHO. The Committee found that the tobacco industry regarded the WHO as one of their leading enemies, and that the industry had a planned strategy to "contain, neutralise, reorient" WHO's tobacco control initiatives (WHO Committee of Experts, Tobacco Industry Strategies to Undermine Tobacco Control Activities at the World Health Organization, July 2000). Tobacco Industry considered the treaty to be an unprecedented challenge to the industry's freedom to continue doing business. Among others WHO was accused of ''creating an additional layer of bureaucracy and regulation in a policy area where national governments are competent to act.'' Although the transnationals had developed a common industry-wide approach to resisting government legislation and regulation, they were opposed to WHO formulating an international response to an international problem.

On the other side, the global tobacco treaty process showed the potential of an alliance with civil society and public health advocates. NGOs provided technical assistance to government delegates, monitored and exposed tobacco industry abuses such as interference in public health policy, generated direct pressure on tobacco transnationals including through boycott tactics targeting tobacco relates industries.

Among the member states, the United States worked to derail the treaty, trying to water down much of the document. Yet the developing world, led by a block of 46 African nations and supported by NGOs, such as Corporate Accountability International and NATT, united to push for positions that would prevent the spread of tobacco addiction, disease and death.

Putting health on the agenda of the Millennium Summit is another achievement that should be recognised to Gro Harlem Brundtland's leadership and more authors would agree that at the end of Brundtland's mandate, WHO's international credibility had been restored, the image and relevance of the organisation at the global level had been successfully improved.

G8 and the Global Health Agenda

Some external factors undoubtedly favoured the entry of health related issues, or better said a few diseases, in the global agenda. The diffusion of the HIV/AIDS epidemic – which unlike other diseases of the South also affected industrialised countries – has been one of those decisive factors. In fact, besides HIV/AIDS, attention remained selectively focussed on malaria, tuberculosis and a few other infectious diseases. Other conditions like malnutrition, diarrhoea and acute respiratory illnesses, which attracted attention in the past and whose mortality rate was and still is very high, seemed forgotten. For the first time in its history, in the year 2000, the UN Security Council became interested in disease and included the theme of AIDS in the agenda. That same year, at Okinawa summit, the G8 nations (G7 + Russia) included in their undertakings the fight against main infectious diseases and particular attention was paid to HIV/AIDS, malaria and tuberculosis.

Without considering wider possible “side-effects” (i.e. on global governance and the role of UN) and without any evidence about the comparative advantage of the GAVI model, notwithstanding emerging critical analysis, the GPPP approach – and specifically the described GAVI experience – was adopted as a model for the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM), the joint UN-G8 initiative, launched at the Genova summit in 2001.

At that time the need for an additional global initiative was still controversial, including among the group of G8 Health experts, who a few months before GFATM was launched still agreed on the inopportuneness of such a targeted initiative: “The Group didn't see any need to establish new formal structures or institutions; existing ones should rather be strengthened. Mechanisms may be further explored in order to bring health initiatives under a common framework, with a view to increase efficiency and reduce transaction costs, as well as attract additional resources without detracting from pre-existing commitments” (G8, Health Experts Group meeting, Summary, Rome, 12-13 March 2001). But the agenda had been already predetermined at the political level. It was also reported that at a higher political level there was no agreement on the sense of the new initiative and its structure. It has been argued that Italy and others were aligned against the U.S. and those who didn't want the GFATM to be run by either the U.N. or World Bank. Some authors have argued that one aim of some proponents of this GPPP has been precisely that: “to undermine the role of the UN system in policy-making” (Deacon, B, Ollila, E., Koivusalo, M., Stubbs, P).

The initiative, in any case, was again a cheap way to deal with a complex situation, without seriously addressing political, social and economical aspects, and inequities, underlying emerging health problems. Governance, representation, accountability and competence, were critical issues simply dismissed pretending lack of public resources.

Lauch of the Global Fund

We are not yet in the condition to definitively confirm the absence of “goodwill and commitment” that some authors bestowed to the G8-Annan initiative at its birth; however the situation is not as positive as expected. Kofi Annan solicited extra resources for $ 7 billions per year to face HIV/AIDS alone. After repeatedly renewed G8 commitment to the initiative, $ 9.5 billion had been paid in over the period 2001-2007 for the three target diseases. On the other hand, one of the fundamental objectives at the origins of the Global Fund, was the attraction of additional resources from public and private sources, and especially from the corporate sector, but the private sector remained quite cool about contributing. The UN Secretary General’s idea that a Global Fund "governed by an independent board", and external to the UN would "attract others to join the fight" (Source: Highlights from the noon briefing, by Manoel de Almeida e Silva, deputy spokesman for the Secretary-General of the United Nations UN Headquarters, May 17, 2001) didn’t prove effective: only 4.7% of the funding came from non governmental sources and of that percentage 77% in fact from the Gates Foundation. The corporate sector contribution was limited to $ 53 millions deriving from the RED – a brand created to raise awareness and money for the Global Fund by teaming up with the world’s

most iconic brands to produce (PRODUCT)RED™-branded products. A portion of the profits from each (PRODUCT)RED product sold goes directly to the Global Fund marketing campaign. Notwithstanding, the corporate sector maintains a seat in the GFATM's board.

With the launch of the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria the G8's influence on the global health agenda as a collective body, received an important push, while the WHO "was no longer setting the international public health agenda" (Lerer, L., Matzopoulos, R).

Summit after summit the G8 assumed new commitments related to polio eradication, to improved access to health care, including to drugs at affordable prices; addressing research on diseases mostly affecting developing countries; international co-operation against new epidemics such as SARS; the establishment of a Global HIV Vaccine Enterprise to accelerate HIV vaccine development; the strengthening of health systems (including supply chain management and reporting, and training and retaining health workers); research, development and production of vaccines, microbicides and drugs for HIV, TB, malaria and other diseases; launching innovative clinical research programs, private-public partnerships and other innovative mechanisms. Among these the so called Advanced Market Commitment (AMC), according to a personal communication to the author by B&MGF officers pushed forward by the Gates Foundation but promoted by Italy, based on the commitment of donors to subsidize the purchase of future vaccines that the pharmaceutical sector commits to produce according to agreed criteria, the first project being for the development of a new anti-pneumococcal vaccine.

A similar initiative, known as International Financing Facility for Immunisation (IFFIm), was launched in 2006 by at that time British Treasury Minister Gordon Brown. IFFIm is based on the issue of bonds to collect funds for the purchase of drugs and vaccines by GAVI. Clearly, market based solutions, influence of private foundations (e.g. Bill & Melinda Gates) and public-private partnerships (e.g. GFATM, GAVI) has been growing over the years, undoubtedly representing the most significant trend in the global health scene. If in some cases GPPPs seem having facilitated access to drugs and services for the treatment of specific diseases, the fragmentation produced by the increasing number of "vertical" initiatives in the wider context of development aid, their arguable sustainability, the waste of resources due to duplication and lack of alignment to national health plans, gave rise to increasing doubts about effectiveness and appropriateness of that approach, among very diverse observers. In addition, the raise of GPPPs' relevance in the global health arena also put new questions about global health governance, where WHO, the World Bank and other UN agencies such as UNAIDS, UNICEF and UNFPA are now often grouped with the Gates Foundation, the GAVI Alliance and the Global Fund, to form the "H8".

Back to Health for All?

In this emerging configuration WHO's Director General Dr Lee Jong-Wook, who in 2003 succeeded to Brundtland, but whose term of office was prematurely interrupted by his dramatic passing away in 2006, came back to "Health for All" indicating the MDGs as "strategic focal points within a broad health agenda that build on the Alma Ata legacy" (Minelli 2003). Introducing World Health Report 2003 "Shaping the future", the first published under his term as Director General, Dr Lee courageously stated: "Today's global health situation raises urgent questions about justice". The report reaffirmed the need for strengthening health systems, and urged to do so building on the values and practices of primary health care; it drew on notions of responsiveness to population needs and stewardship toward pro-equity health systems. That report, was considered "refreshing in its attempt to offer an integrated approach to improving health". The report also reminded to Lee's flagship initiative to treat three million people with AIDS with antiviral therapy by the year 2005 (known as "3 by 5"), however also when focussing on particular diseases, emphasis was on how health systems would play a part in meeting overall health goals. The most remarkable initiative of Dr Lee was probably the launch, in March 2005, of the Commission on Social Determinants of Health. Chaired by Michael Marmot, the Commission brought together leading scientists and practitioners to provide evidence on policies that improve health by addressing the social conditions which people live and work and to collaborate with countries to support policy change and monitor results.

After the sudden passing away of late Director General Lee Jong-wook the international health community looked with hope to the commitment of the new Director General, Dr Margaret Chan of working tirelessly "to make this world a healthier place" and called for a "noble system of ethical values" (M. Chan, Speech to the WHA, 9/11/06). Addressing the World Health Assembly after one and a half year in her position, Margaret Chan underlined that "investment in technology and interventions alone will not automatically 'buy' better health outcomes". For the Director General more investment should go into institutional capacity and in systems for delivery; to that effect she insisted on a "return to primary health care", its values, principles and approaches. In the 60th anniversary of the establishment of WHO, she recalled the organisation's mandate to direct and coordinate international health work. Recognising that "WHO is not alone in the drive to improve health", nevertheless unprecedented global interest and investment in health, as well as unprecedented challenges that can only be addressed through well-directed and coordinated global collaboration "gives WHO a clear role" (M. Chan, Address to the Sixty-first WHA, 21/09/08).

Without recognising the role of WHO, nor helping to re-establish clear responsibility and leadership for global health governance, but implicitly recognising the failure of an approach based on the promotion of individual initiatives that led to the current hyper-fragmented context, in 2007 UK's Prime Minister, Gordon Brown, led the launch of a new "International Health Partnership" (IHP). Signed by the representatives of other seven governments (Canada, France, Germany, Italy, Norway, Portugal, The Netherlands) and eleven multilateral and non governmental partners (African Development Bank, Bill & Melinda Gates Foundation, European Commission, GAVI, GFATM, UNAIDS, UNICEF, UNFPA WHO, World Bank, UN Development

Group), the IHP aims to make health aid work better for poor countries and accelerate progress by doing three things: providing better coordination among donors; focusing on improving health systems as a whole and not just on individual diseases or issues; and developing and supporting countries' own health plans. In fact the IHP is a call for the implementation of the 2005 Paris Declaration and its principles of alignment, harmonisation, country ownership, managing for results and mutual accountability.

Health - a Fundamental Human Right

The need for a holistic approach to health and health systems was finally marked by the almost coincident publication of WHO's 2008 annual report, which re-focussed o Primary Health Care in the 30th anniversary of the declaration of Alma Ata and the Report of the Commission on Social Determinants of Health.

The World Health Report 2008 critically assesses the way that health care is organized, financed, and delivered in rich and poor countries around the world. Powerful forces have often driven Health systems away from their intended directions: hospital-centrism, fragmentation deriving from multiplication of programmes and projects, and the pervasive commercialisation of health care. The proposed way forward, puts the accent on equity and universal coverage, primary care and people centered health systems, public policies for health and leadership reforms, reaffirming main governmental responsibility.

The Commission on Social Determinants of Health concluded redefining the overarching significance of health as possibly the most comprehensive indicator for development: "The development of society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health". It challenged the longstanding paradigmatic equation development = growth, by stating that: "Growth by itself, without appropriate social policies to ensure reasonable fairness in the way its benefits are distributed, brings little benefit to health equity."

A new trend is clearly emerging: health, is a fundamental human right, and as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", it cannot be pursued through health care alone, nor focussing on the control of single diseases. Logic and evidence indicate that it can only be attained trough a much wider and inter-sectoral outlook. This, together with equity and community participation, prioritising prevention and appropriate technology, was the basis of Primary Health Care: the strategy toward "Health for All by the year 2000" adopted in 1978 at Alma-Ata, and soon betrayed. 30 years later old challenges remain and new priorities have emerged. Missed targets have been postponed to 2015, but again, Millennium Development Goals risk not be met. Today, as thirty years ago, the major obstacle lays in lack of vision and political will, not of resources. In the spirit of Alma Ata, a systemic approach to health is needed, one promoting human rights and social justice, rather that, once again, one selectively focused on improbable quick-fix solutions for single diseases.

While there are many health institutions global in scope, WHO is the only multilateral institution with the political legitimacy and dedicated mandate to promote and protect health. While there is a “need to recognize how certain aspects of democracy, such as transparency, accountability, and provisions to limit the role of direct coercion, could be incorporated into multilateral institutions, making them more robust against charges of illegitimacy” (Keohane 2006), in the interest of “health for all” leadership for global health governance should be fully returned to WHO, eventually promoting the review of internal mechanisms to allow wider debate and inclusiveness.

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References

- Brown, T.M., Cueto, M. and Fee, E., The World Health Organization and the Transition From International to Global Public Health, American Journal of Public Health, 2006, 96 (1) pp 62-72
- Global Health Watch, Global Health Watch 2005-2006. An alternative world health report, Zed Books Ltd., London 2005
- Missoni, E., Health & sustainable development in the framework of international cooperation. Doctors for the environment an international bulletin. Special Edition, 10th Congress and Assembly. 2001, 1 pp 63-66
  WHO, Financial Report and Audited Financial Statements for the period 1 January 2006 – 31 December 2007, A61/20, 28 March 2008
- WHO, The Ottawa Charter for Health Promotion. First International Conference on Health Promotion, Ottawa, 21 November 1986
- Ruger, J.P., The changing role of the World Bank in Global Health, American Journal of Public Health, 2005, 95 : 60-70
- The World Bank, Financing Health Services in Developing Countries.Washington DC, 1987
- Italian Global Health Watch, From Alma Ata to the Global Fund: The History of International Health Policy, Social Medicine, 2008, 3 : 36-48
- Missoni, E., Critical analysis of WHO's role in promoting health, Presented at the International Conference "The Ottawa and Bangkok Charters: from principles to action", SIASS, Firenze, 21-23.11.2006
- Smith, R., The WHO: change or die. BMJ 1995, 310 : 543-544

- The World bank, World development Report 1993, Investing in Health, Washington DC,1993
- Whitehead M., Dahlgren G. and Evans T., Equity and health sector reforms: Can low-income countries escape the medical poverty trap? , Lancet, 2001, 358 : 333-336
- Buse, K., Gwin, C., The World Bank and global cooperation in health: the case of Bangladesh, Lancet, 1998, 351 : 665-669
- Walt, G., Globalization of international health, Lancet, 1998, (351) 434-437
- Barr, D.A., Ethics in Public Health Research: A Research Protocol to Evaluate the Effectiveness of Public–Private Partnerships as a Means to Improve Health and Welfare Systems Worldwide, American Journal of Public Health, 2007, 97 : 19-25
- Missoni, E., Le partnership globali pubblico-privato, in: "Osservatorio Italiano sulla Salute Globale, Rapporto 2004 salute e globalizzazione", Feltrinelli, Milano, 2004, pp. 210-216
- World Health Report 2000. WHO, Geneva
- Deacon, B, Ollila, E., Koivusalo, M., Stubbs, P., Global Social Governance. Themes and Prospects, Ministry of Foreign Affairs of Finland, Hakapaino Oy, Helsinki, 2003, p. 45
- Ford, N. and Piedagnél, J., WHO must continue its work on access to medicines in developing countries. Lancet, 2003, 361: 3
- Missoni, E., La Global Alliance for Vaccines and Immunization come prototipo, in: "Osservatorio Italiano sulla Salute Globale, Rapporto 2004 salute e globalizzazione", Feltrinelli, Milano, 2004, pp. 217-220
- Sanders, D., Chopra, M., Two key issues for the new WHO leadership, Lancet, 2003, 361: 172-173
- Missoni, E., Pacileo, G., Il ruolo dell'OMS, in: "Osservatorio Italiano sulla Salute Globale, Rapporto 2004 salute e globalizzazione", Feltrinelli, Milano, 2004, pp. 233-244
- Saloojee, Y.; Dagli, E., Tobacco industry tactics for resisting public policy on health, Bulletin of the World Health Organization, 2000, 78 (7) 902-910
- Minelli, E., World Health Organization. The mandate of a specialized agency of the United Nations, Dissertation for the Political Science Degree specializing in International Relations at the Catholic University of Milan, 2003 (http://www.gfmer.ch/TMCAM/WHO_Minelli/Index.htm)
- Brugha, R., Starling, M., Walt, G., GAVI, the first steps: lessons for Global Fund, The Lancet 2002; 359; 435-438.
- Yamey, G., Global vaccine initiative creates inequity, analysis concludes. News roundup. BMJ 2001; 322; 754.
  Godal, T., GAVI, the first steps: lessons for the Global Fund, The Lancet 2002; 360; 175-176
- Phillips, M., Infectious-disease fund stalls amid U.S. rules for disbursal, Wall Street Journal, 5 august 2002
- Missoni E, The Global Health Fund: a global bluff, www.bmj.com/cgi/eletters/323/7305/152#16179 , 22 Aug 2001
- Brugha R, Walt G. A global health fund: a leap of faith? BMJ 2001; 323; 152-154
- Lerer, L., Matzopoulos, R., The worst of the both worlds: the management reform of the World Health Organization, International Journal of Health Services, 2001, 31, (2) 421

- Kirton, J. and Mannell, J., The G8 and Global Health Governance, Paper prepared for a conference on "Global Health Governance: Past Practice: Future Innovation,"Ottawa and Waterloo, November 10-12, 2005
- Tremonti G. Minister of the Economy and Finance, Italy. Background papers to Advanced Market Commitments for vaccines. A new tool in the fight against disease and poverty. Report to the G8 Finance Ministers, London, 2/12/2005
- Buse, K., Harmer, A.M., Seven habits of highly effective global public-private health partnerships: Practice and potential, Social Science & Medicine, 2007, 64 : 259-271
- IDA, Aid Architecture: an overview of the main trends in official development assistance flows, IDA, 2007
- Hsiao, W., Heller, P.S., What should Macroeconomists Know about Healt Care Policy?, IMF, Working Paper, WP/07/13, January 2007
- Conway, M.D., Gupta, S., Prakash, S., Building better partnerships for global health, The McKinsey Quarterly, December 2006
- Garrett, L., The Challenge of Global Health, Foreign Affairs, January-February, 2007, 14-38
- Bartsch, S., Accountability of Global Public-Private Partnerships in Health, Sixth Pan-European Conference on International Relations, University of Turin, Italy, September 14, 2007
- Nishtar, S., Public-private 'partnerships' in health – a global call to action, Health Research Policy and Systems, 2004, 2 (5): 1-7
- Walt, G., WHO's World Health Report 2003. Shaping the future depends on strengthening health systems. BMJ , 2004, 328 : 6
- WHO, The World Health Report 2008, Primary Health Care, Now More Than Ever, WHO, Geneva, 2008
- WHO, Commission on Social Determinants of Health, Final Report, Closing the gap in a generation, Health equity through action on the social determinants of health, WHO, Geneva, 2008
- Keohane, R.O., The Contingent Legitimacy of Multilateralism, GARNET Working Paper: No: 09/06, 2006, p. 23

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