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Health for All in the 21st Century - Issues, Priorities, Implementation

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It is, for me, a great pleasure to be with you today and address this important event on behalf of the Director-General of the World Health Organization, Dr Gro Harlem-Brundtland, who asked me to give you her greetings and best wishes in the opportunity of the 25th Jubilee of Medicus Mundi Switzerland. As you know, WHO is also celebrating this year its 50th anniversary, therefore, it is not a coincidence that Medicus Mundi and WHO share their major concerns about the universal access to health and health care in the world.

Over half a century ago, the founders of the World Health Organization defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The Constitution of WHO proclaimed, "the health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States ". This was the vision in the post war world of the late 1940s. Our challenge for the next two decades is to build on the achievements of the past to achieve a healthy and secure world.

The WHO Constitution declares, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..". The right of all people to a standard of living adequate for health and well-being includes the right to adequate food, water, clothing, housing, health care, education, reproductive health and social services; and the right to security in the event of unemployment, sickness, disability, old age, or lack of livelihood in circumstances beyond an individual's control. Respect for human rights and the achievement of public health goals are complementary.

As we all know, the concept and vision of Health for All (HFA) were defined in 1977, when the Thirtieth World Health Assembly decided that the main social target of governments and WHO in the coming decades should be "the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life". The Declaration of Alma-Ata, adopted in 1978 by the International

Conference on Primary Health Care, which was jointly sponsored and organized by WHO and UNICEF, stated that primary health care was the key to attaining Health for All as part of overall development. This call for HFA was, and remains fundamentally, a call for social justice.

Health for All was conceived as a process leading to progressive improvement in the health of people and not as a single finite target. It can be interpreted differently according to the social, economic and health characteristics of each country. However, there is a baseline below which no individual's health in any country should fall. All people in all countries should have a level of health that will permit them to work productively, and to participate actively in the social life of the community in which they live. Health for All acknowledges the uniqueness of each person and the need to respond to each individual's spiritual quest for meaning, purpose and belonging. At the same time, HFA is a societal response that acknowledges unity in diversity and the need for social solidarity. Our common humanity, and responsibility for current and future generations, demand that we embrace HFA.

Health for All in the 21st Century is a continuation of the HFA process. It builds on past achievements, guides action and policy for health at all levels (international, regional, national and local), and identifies global priorities and targets for the first two decades of the 21st century. Most of all, it takes account of the dramatic global changes of the past 20 years. It is the result of an extensive and inclusive process of consultation with and within countries - a process essential to creating ownership of the policy, and thereby helping ensure its implementation by all partners.

Over the past two decades, governments and nongovernmental organizations have increasingly accepted HFA as their goal in their efforts to improve health, and most countries have adopted primary health care. Access to the elements of primary health care, as defined at Alma-Ata, has steadily increased, albeit with wide variations both with populations and between countries. Primary health care, together with economic, educational and technological advances, has contributed significantly to the worldwide decline in infant and child mortality and morbidity and to the substantial increases in life expectancy at birth. Millions of children have survived to adulthood as a result of early health interventions.

However, despite these health gains, progress has been hampered by a number of factors- The pace of improvement and the achievement of targets have not been uniform. Disparities between countries, and among certain population groups within countries, in health status and access to health care (including primary health care) are greater now than they were two decades ago. Millions of people still do not have access to certain elements of primary health care and, in many places, effective primary health care services do not exist.

In the poorest countries, a lack of funding for health and social services, and an inability of governments to raise domestic and international funds for health, seriously hamper progress towards HFA. In other countries, failure to establish or maintain essential health system functions has led to stagnation or deterioration in the health status of populations. Emerging and re-emerging diseases constitute a significant threat to health. Rapid growth of private

health care in many middle-income countries has had mixed impact on public-sector services. In some cases, it has contributed to rising costs, inefficient care, and unequal access to health care. In advanced industrialized countries, the basis of health care reforms consists of cost control, expanding choices for individuals, and ensuring quality care in the face of population ageing and rapid increases in the price of and demand for new technologies. In most countries, private and public-sector health care providers have not established effective partnerships, further hampering health development.

At the same time, the world has seen considerable gains in health over the past 50 years. These gains have been due not only to advances in science, technology, public health and medicine, but also to expanded infrastructures, increased literacy, rising incomes, and improved nutrition, sanitation, education and opportunities, particularly for women. The incidence of infectious diseases has declined in many countries and smallpox has been eradicated. Control and prevention of diseases, such as measles, poliomyelitis, and diphtheria, have greatly reduced childhood mortality and morbidity. People are living longer: the average life expectancy at birth has increased from 46 years in the 1950s to 65 years in 1995. The gap in life expectancy between rich and poor countries has narrowed, from 25 years in 1955 to 13.3 years in 1995.

However, despite some gains, certain health gaps between and within countries have widened. There are alarming trends in the incidence of a number of diseases, and projections suggest that some achievements will not be able to be maintained in the future. The debt crisis of the 1980s resulted in many countries reducing their support for health and social services. Dramatic political changes in the 1990s in several countries, often accompanied by civil unrest, seriously impaired and retarded health and economic development. Health has suffered most where economies have been unable to secure adequate income for all, where social systems have collapsed, and where natural resources have been poorly managed. A host of global and local environmental and social problems continue to add to the burden of disease and ill-health.

The number of people living in absolute poverty and despair is growing steadily despite unprecedented wealth creation worldwide in the past two decades. Today, nearly 1300 million people live in absolute poverty. Poverty is a major cause of undernutrition and ill-health; it contributes to the spread of disease, undermines the effectiveness of health services and slows population control. Morbidity and disability among the poor and disadvantaged groups lead to a vicious spiral of marginalization, to their remaining in poverty, and in turn, to increased ill-health.

Improvements in health status throughout the world, associated with achievements in public health and economic growth, have led to a number of demographic and epidemiological changes. Increased life expectancy, lower birth rates and a rise in noncommunicable diseases, combined with exposure to new threats, define the challenges for the future. Sheer population numbers in some countries, and high resource consumption in others, compromise the chances of meeting the future needs of the world's people.

Noncommunicable diseases are a heterogenous group that includes major causes of death, such as ischaemic heart disease, diabetes and cancer, and disability, such as mental disorders. Today, they contribute significantly to the global burden of disease. If current trends in tobacco use, a high-fat diet and obesity, and other health risks continue, such diseases will become the dominant causes of death, disease and disability worldwide by the 2020s. Tobacco use is a risk factor for some 25 diseases and, while its effects on health are well known, the sheer scale of its impact on disease, now and in the future, is still not fully appreciated.

Violence occurs in different forms in different societies, including tribal or ethnic conflict, gang warfare, and family violence. In some countries, exposure to violence in the entertainment media, combined with easy access to weapons, and use of alcohol and illicit drugs, has contributed to an increase in violence. It is one of the most glaring features of social disintegration. In many societies, there is concern about social disintegration stemming from the weakening of human relationships based on sharing and caring, of the bonds sustaining and nurturing intergenerational relations, and of the family as a social unit. Unemployment, alcohol dependence and mental disorders are on the rise. Injuries are also likely to increase, partly as a result of increased use of motor vehicles, urbanization and industrialization.

National and local decisions are affected as never before by the global forces and policies. The dramatic grown in trade, travel and migration, together with developments in technology, communications, and marketing, particularly since the end of the Cold War, has resulted in substantial gains for some groups and severe marginalization for others. The spread of information technologies and advances in biotechnology worldwide will increasingly help in detecting, preventing and mitigating the impact of disease outbreaks, famine and environmental health threats, and in bringing health services and education to many more people. However, there is concern that increased trade in products harmful to health and the environment threatens the health of populations, particularly in low-income countries. Increased transnational trade in food and the mass movement of people constitute additional global threats to health.

Evolving opportunities and the reality of an uncertain future require that HFA be seen, not as a blueprint, but as a commitment to working together in pursuit of a shared vision. HFA strategies in our changing world need to:

- incorporate an explicit gender perspective;
- emphasize health as central to sustainable human development;
- make use of available new technologies for health;
- recognize the expanded role of civil society in health; and
- promote global action to protect national and local health.

HFA seeks to create the conditions whereby people everywhere, throughout their lives, have the opportunity to reach and maintain the highest attainable level of health. It is a vision that recognizes the oneness of humanity and, therefore, the need to promote health and to alleviate ill-health and suffering universally and in a spirit of solidarity. The HFA vision is based on the following key values:

- recognition that the enjoyment of the highest attainable standard of health is a fundamental human right;
- ethics: continued and strengthened application of ethics to health policy, research and service provision;
- equity: implementation of equity-oriented policies and strategies that emphasize solidarity; and
- gender sensitivity: incorporation of a gender perspective into health policies and strategies.

These values should underpin and be incorporated into all aspects of health policy, influencing policy choices, the way those choices are made, and the interests they serve. They are closely interlinked, serving as supports for the execution of appropriate strategies. At the global level, WHO has the leading responsibility for the advocacy of these values, although all members of society have a shared responsibility for their propagation and sustainability.

The goals of HFA will be realized through the implementation of two policy objectives:

- making health central to human development; and
- developing sustainable health systems to meet the needs of people.

These policy objectives are interrelated and are intended for application at all levels - local, national, regional and global. Their adoption and further elaboration into specific strategies, that are adequately financed, fully implemented and carefully evaluated, should lead to improved health and to a narrowing of the gaps in health status across social and economic groups. The process of adoption should harness political, social and economic forces and engage potential partners through expanded systems of governance for health. Investments in health will contribute to improvements in health outcomes and will foster achievement of sustainable human development goals.

It is important to recognize that health cannot be considered in isolation from human and social development. It is a function of the social, physical, mental, economic, spiritual and cultural environment of the communities in which people live. The purpose of human development is to permit people to lead economically productive and socially satisfying lives. This requires progressive improvements in the living conditions and quality of life enjoyed by all members of a society. Good health is both a resource for, and an aim of, sustainable human development.

Health systems must be able to respond to the health and social needs of people over their life span. National and local systems need to reach out to citizens, and engage them in improving their own health by emphasising promotion of health and prevention of disease. Efforts should be directed towards clearly identifying health needs and organizing comprehensive services within a well-defined population base. Health systems of the future must be flexible and responsive to pressures, such as:

- demographic and economic change;
- a change in the epidemiological patterns of disease;
- expectations of health service users for quality and participation in decision-making; and
- advances in science and technology.

Progress from policy to action requires dynamic leadership, public participation and support, a clear sense of purpose and resources. Translation of the HFA policies into action must be considered in the context of the overall economic and social situation of a country or locality; the decisions needed are not easy, given the multiple pressures and uncertainties of a complex policy environment. Each country will select the best mix of policies to achieve Health for All. The mix will vary according to national needs, capacities and priorities.

Governments need to have a strong policy-making capacity to address the major challenges confronting them. They will have to overcome several obstacles to the implementation of their policies. In many countries, health personnel are able to conceptualize policy, but cannot translate it into action. Governments need to develop strategic management expertise, minimize outmoded bureaucratic procedures and rules, and establish a legislative and regulatory framework that provides a sound basis for reform.

For policy to be based on scientific evidence, a solid research base in health and epidemiology is needed, together with related information on public preferences as well as on the availability of resources. This requires the strengthening of the scientific and technological infrastructure (particularly in developing countries), the promotion of health policy and systems research, and methodological innovation in measurement, analytical techniques and resource allocation models. Ethical considerations must guide the use of scientific evidence.

National governments have an obligation to ensure that health is explicitly considered in the development of public policy. Decentralized decision-making for health, within a broad development framework in which partnerships in the provision of services are encouraged, will help to ensure that local needs are considered. Local participatory planning, full use of local capacity and resources, and more effective collaboration in bringing environmental, social and economic services closer to people will strengthen community ownership of those services and increase their utilization. Good local governance of health systems, supported by national, regional and global action, will promote healthy living and working conditions, as well as access to health care throughout the life span.

There are a wide range of strategies available to improve health, but resources are limited. This means that governments must set boundaries for action and select priorities within those boundaries. The process of setting priorities will differ according to whether the choices relate to national, local or individual levels. Five possible levels of financial decision-making for health systems are:

- macro-level of funding for health-systems and services;
- distribution of the budget between different geographical areas and services;
- allocation of resources to particular forms of treatment;
- choices concerning which patients should receive treatment;
- decisions on how much to spend on individual patients.

The growing pluralism affecting the governance of the health sector is evident. Partnerships are needed between the multiple levels and sectors concerned with health, and will be a primary component of HFA implementation. Productive partnerships will enable different ideologies, cultures and talents to come together in a way that creates energy and stimulates the imagination in working towards improved health. Working in partnership involves defining roles, demonstrating accountability, critically assessing the impact of joint actions, and above all, developing trust.

Community partnerships and the development of skills, with the aim of increasing both the options available to individuals and countries, and the control they exercise over those options, constitute the essence of HFA. Partnerships between people and institutions at all levels allow for the sharing of the experience, expertise and resources necessary for the attainment of Health for All. The need for community participation was stressed at Alma-Ata. People's direct and indirect participation in the promotion and maintenance of their health, and that of their families and communities, lies at the core of people-centred approaches to development. Such approaches require the implementation of sustainable development programmes, based on self-reliance, that are managed and owned by the community. Increased commitment by all is urgently needed to ensure full implementation.

Governments should aim to create an environment that stimulates and facilitates partnerships for health. Both formal partnerships and community-based informal networks at different levels are needed. WHO and governments should consider developing guidelines with the private sector, aimed at ensuring that new partnerships are mutually beneficial and always benefit health. Partnerships can draw upon the energy and vitality of civil society, particularly nongovernmental organizations, to develop environments that support health. Informal networks are important, but are often absent in areas undergoing rapid urbanization or migration, in refugee communities and in post-conflict situations. Establishments (or re-establishment) of cultural, sports, religious and women's groups through a system of local governance can enhance social cohesion and a social environment conducive to health.

In closing my intervention, I wish to reiterate the importance that WHO is giving to NGOs working in health, particularly to Medicus Mundi for its dedicated and efficient work for the benefit of the less favoured population. I hope we can continue a very fruitful cooperation between WHO and Medicus Mundi in the 21st century. Thank you.

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