

Report on

**FUTURE HEALTH AND MEDICAL CARE -
CONSULTATION WITH LEADING MEDICAL
PRACTITIONERS**

WORLD HEALTH ORGANIZATION, GENEVA
23-24 August 1989

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**FUTURE HEALTH AND MEDICAL CARE -
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**Opening Address by Dr Hiroshi Nakajima,
Director-General**

Distinguished colleagues,

First of all may I welcome you all to Geneva and to WHO, and thank you for responding to my invitation to this consultation which will explore issues relating to the future of health and medical care. We are going to devote the next two days to free and informal discussion in search of new ideas; in other words to "brainstorming", which by its very nature is an informal activity. I believe this is an apt forum in which to consider a wide range of issues. Therefore, I shall not make a formal speech.

In 1977, WHO and its Member States committed themselves to the goal of health for all by the year 2000. In 1978, the Declaration of Alma-Ata recognized primary health care as the key to achieving this goal. More than a decade has passed since these key events took place. Many countries, developing and developed, have started to introduce changes to bring about the goal.

Developing and industrialized countries alike are confronted with events that place constraints on these changes. Some of the constraints are already referred to in the background paper you

have before you. In the developing countries, the problem is what to do in the face of economic stringencies and diminishing health budgets. In the industrialized countries, the problem is the inflationary cost of health care.

All countries face increased life expectancy and greater numbers of the elderly. But developing countries also have to consider how to provide for even the basic necessities of daily life for their people. Many of them have to deal with armed political struggle, or rehabilitation and reconstruction after recently concluded peace.

On the other hand, the industrialized countries worry about the incessant clamour for increasingly sophisticated health care technology and about the dehumanization of care. The medical profession faces the growing dissatisfaction and disenchantment of the community, and even alienation. The modality of delivering health care itself is changing and sociologists speak of deprofessionalization and proletarianization. But we do want individuals in a community to contribute more to their own health, and we speak of giving them the means to do so.

Increasingly, every country in the world is facing the problems of a deteriorating environment, in large part due to uncontrolled development and exploitation. What is the resulting health impact of such changes in our ecology?

In the face of such challenges, the question must be asked, what can the medical profession do? And, in turn, we in WHO must also ask, what can we do? And what can we and the medical profession do together? I do not think it is possible for the medical profession to confine itself to making a patient well. It must also address issues that relate to the origins of the illness, many of which spring from socioeconomic imbalances.

So, to me, the fundamental question for us to consider during this consultation is how to determine and draw upon new resources, and how to make optimum use of those resources, for resolving problems relating both to socioeconomic imbalances and

to health. One thing is clear. The solutions must be bold and imaginative. Our current way of doing things has not permitted us to overcome even present-day constraints. Not only must physicians be committed to resolving the problems of their own countries, they must also consider what they can do across national boundaries.

Because this meeting will last for only two days, we shall have to focus on the major problems and how to solve them, but always in terms of how the solutions can be facilitated by the medical profession, at personal, national and international levels. It may take us the entire two days simply to determine the major problems, which could be discussed in depth later. Even that will be useful. I have been doing my own share of brainstorming, and have posed some questions that I feel are important, or at least interesting enough for us to review.

Since this is to be a free and informal discussion, I am sure you will agree that it would not be appropriate for you to designate a chairman. I propose instead that Dr Goon, Director, WHO Division of Health Manpower Development,¹ should serve as moderator.

I hope you will allow me to suggest that Mrs Hutar, Director of International Medicine, American Medical Association, should serve as your rapporteur. Members of the Secretariat will, of course, provide her with any support she may require.

Seated around us are a number of colleagues who are responsible for programmes germane to our discussions, and who will be able to intervene if clarification on certain issues is needed.

Thank you very much. I know you cannot fail to have a fruitful and successful meeting.

¹ Renamed Division of Development of Human Resources for Health as from 1 January 1990.

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BACKGROUND PAPER

Some current problems

1. The goal of health for all by the year 2000 is universally acknowledged as an important aspiration for mankind. It is not only a legitimate goal in its own right, but also contributes to another highly valued goal - peace.
2. But as we prepare to enter the 1990s and the twenty-first century, several challenges to further progress in health and medical care to achieve the goal have emerged. For many countries the gains of the 1960s and 1970s cannot be maintained owing to the economic crisis, while in the least-developed countries there is a real likelihood that indicators such as infant mortality rate, maternal mortality rate, and the mortality rate of children under five years of age will remain unacceptably high well into the next century.
3. In addition to the economic problems, developing countries have been confronted with increasing demands as a result of population growth and the higher expectations of communities and, for some, an increase in their elderly population, resulting in falling per capita expenditure on health services. Stagnation and abandonment of development plans are now common. Quality of health care is being eroded by shortage of drugs and other supplies, poor maintenance of equipment and insufficiency of incentives to attract, motivate and retain staff in active service. Deteriorating nutritional status, particularly of children, has been

reported from several countries. Recrudescence of yellow fever and yaws and resurgence of malaria have also been reported.

4. While most deaths and much ill-health result from the vicious circle of poverty and communicable diseases in the developing countries, they are also increasingly affected by diseases caused by socioeconomic pressure and changing life-styles which predominate in the industrial countries. These usually take the form of slowly increasing ill-health and disability. The cost of the technology to treat many of these diseases is exorbitant. The spiralling health care costs seen in the industrialized countries during the past decade have been due to this in large measure. The corresponding increases in fees and costs have left more and more people without access to proper and timely care. Also, quality of life and behavioural and environmental issues are becoming of utmost concern for individuals, communities and health providers.

What is to be done?

5. There are two interrelated solutions. On the one hand, additional resources can be made available for health care and, on the other, existing resources can be used more effectively.

6. Emphasis on the use of cost-effective interventions and on better management is important for improving the performance of health services, and this in turn would strengthen the health sector's case for additional resources. Many of today's diseases can be prevented by education of communities in healthy life-styles and personal behaviour. Our capacity for early detection of disease also needs to be improved. For this to be successful, epidemiology and clinical practice must join forces with health promotion and education.

7. Another important action involves the education of health professionals for new challenges. The needs and demands of patients are constantly changing, calling for new skills. Earlier assumptions that increasing the number of doctors would lead to

more of them working in remote communities were unrealistic. Excessive focus on high technology and pathology has led to less attention being paid to the patient as a human being. Is it any wonder that there is increasing alienation of medical professionals from communities? Similarly, is it surprising that other professional groups are taking on community health care? Is it the practice environment which has led practitioners to this state of affairs? Were there shortfalls in the educational system which did not inspire interest to work in communities? What are the long-term implications?

8. Despite this trend, the medical professional retains the prerogative of defining and providing its constituents with what they need. The vast changes that have occurred in information technology have increased consumers' interest in knowing more and being involved in health programmes. Is the profession responding adequately to this challenge?

9. Inequities in health and health care remain a challenge in all countries. Such inequities can be seen in particular geographical areas, social groups, occupations, the unemployed and migrants. The cornerstone of health for all is the identification of those who are not yet included in the "ALL" and the direction of special efforts to reach them. Is this problem recognized and taken seriously? Does the profession not have a role, indeed an obligation, to contribute its share?

10. A further issue is the apparent dichotomy between individual interventions and collective interventions. Individual interventions include medical treatment and health promotion. Collective interventions include public health services, the establishment of standards and the identification of individuals and population groups at risk, followed by the institution of appropriate measures. How can collaboration and synergism between the two types of interventions be maximized? This will be essential if the goal of health for all is to be achieved.

11. It is absolutely essential to ascertain the best responses to current challenges, some of which have been mentioned above.

This requires appropriate action, which includes research in a broader sense: not only technological, clinical, epidemiological or operational, but also in the fields of economics and health systems. Research, in this context, should have a unifying role, not only bringing together relevant disciplines and skills, but also involving key partners (consumers, providers, decision-makers, parliamentarians and tax payers/donors). Is adequate effort being made in this area? How can practitioners contribute to such a broad research effort?

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REPORT

On the initiative of Dr Hiroshi Nakajima, Director-General of the World Health Organization, a consultation was organized to explore the future of health and medical care and, more especially, the health issues embodied in the goal of health for all by the year 2000. "Health for all" is a many-faceted goal, and requires a committed and broad-based constituency, embracing all the actors in the health field, as well as the general public, if it is to be reached.

With this in mind, the Director-General brought together a group of leading medical practitioners and experts in world economy and invited them to "brainstorm" with WHO senior staff on ways of meeting the many challenges ahead.

Health care choices are becoming more difficult throughout the world. In countries at all levels of development, the economic context is one of continually increasing demands for health care fuelled by new technologies, demographic change and the emergence of new diseases. In developing countries these issues are especially acute because increasing demand has been accompanied by diminishing supply capacity. Poor economic performance and indebtedness have obliged many such countries to reduce government expenditure, and the cuts have often fallen disproportionately on the health sector. In these circumstances it is of overriding importance to mobilize all sources of funding for health - government, nongovernmental and community - and to focus relentlessly on reducing waste and inefficiency.

The difficulty of conquering poverty and communicable diseases in developing countries has been compounded by the emergence of diseases similar to those faced in developed countries and caused by socioeconomic pressures and changing life-styles.

Industrialized countries face growing demands by health consumers for sophisticated health care based on the latest technology, which adds further to rising health costs.

While the term "global interdependency" is generally used in the context of trade and economics, the term aptly expresses international concern over the devastating effects of environmental pollution. Both man-made and natural disasters wreak havoc regionally and globally. Moreover, many nations are struggling with demographic and ecological problems resulting from population growth that outstrips the carrying capacity of the ecosystem and the economy.

In light of the health problems that are still outstanding despite the notable progress made, the Director-General called upon medical practitioners to explore how the medical profession and WHO could work together to forge new partnerships and approaches for achieving "health for all". Opening the discussion, he said:

"the fundamental question for us to consider during this consultation is how to determine and draw upon new resources, and how to make optimum use of those resources, for resolving problems relating both to socioeconomic imbalances and to health. One thing is clear. The solutions must be bold and imaginative. Our current way of doing things has not permitted us to overcome even present-day constraints. Not only must physicians be committed to resolving the problems of their own countries, they must also consider what they can do across national boundaries."

SUMMARY OF DISCUSSION

Recognizing the magnitude of global health problems, the participants agreed that all resources in the public and private health sectors must be marshalled if the goal of health for all is to be reached. Early in the meeting the participants discussed the apparent dichotomy between the concept and practice of public health, with its focus on the community and on preventive and promotive approaches, and medical practitioners' concentration on individual, clinical, curative and rehabilitative medicine. There was unanimous agreement that no such gap should exist.

The theme of communication dominated the consultation. It examined communications:

- between WHO and the medical profession at local, national and global levels,
- within the medical profession itself,
- between the medical profession and other sectors,
- between medical practitioners in industrialized countries and their colleagues in developing countries.

Target audiences for communications from WHO were identified as: ministries of health; local, national, regional and international medical associations and other health organizations; and the public at large. Selective approaches, tailored to each, are needed to reach these audiences most effectively. Constructive criticism revealed the need for publications that are free from jargon and convey clear, factual information. Participants pointed out that the Organization's publications should be translated into languages other than the six WHO official languages, to be certain of reaching those countries and health workers most in need of health

information. Selected publications are already being translated in several countries on the initiative of national institutions or individual publishers. This approach is encouraged by WHO.

Observing that people who need access to WHO materials may not even know of their existence, the group underscored the importance of strong WHO public relations and public information campaigns. Professional journals can play a key role by publishing information from and about WHO.

A newsletter for medical practitioners was suggested by some participants. Others opted for less print and more media coverage, which was considered to have greater impact. In view of concerns over cost, the group suggested that informal partnerships be developed between WHO, medical practitioners and national medical associations in the translation, distribution and production of print and media material.

Continuing medical education (CME) received considerable attention. However, it was accepted that problems in medical education commenced even before graduation; help was therefore needed in the reorientation of medical education at all levels.

Problems encountered in continuing education include: the difficulty of assessing accurately the learner's CME needs; the inadequacy of existing tools for assessing the quality of medical performance; and the need to establish scientifically and statistically sound methods of evaluating the contribution of CME to improved competency.

In some countries, the medical profession is responsible for the accreditation and evaluation of CME, formalized through established accreditation councils or committees which establish standards for the evaluation of proposals for CME programmes. The accrediting body is empowered to award CME credit hours for physicians completing the training; these credits can be

aggregated toward "Physician Recognition Awards" attesting that the physicians concerned are continuing to update their knowledge and skills in the practice of medicine.

This is an area in which medical associations in developed countries might perhaps be of assistance to developing countries with a need for upgrading of medical education. Participants encouraged WHO to develop CME guidelines, in collaboration with medical education experts, and to disseminate them widely.

The Director-General had stated his conviction that the goal of "health for all by the year 2000" could not be attained through government health services alone but required an input from private medical practitioners. Examples were given of projects developed through cooperation between national medical associations and selected developed and developing countries. The national medical associations concerned had approached governments to learn how they might best complement and extend preventive maternal and child health (MCH) care, and had been invited to work in areas where the government was unable to provide services. The resulting projects represented a public-private partnership in delivering preventive care to previously unserved high-risk groups of mothers, infants and children. Activities included the establishment of community health posts with the help of formal and informal village leaders and community volunteers who encouraged the community to participate and, later, served as volunteer staff.

Such projects were beginning to show significant increases in coverage by the Expanded Programme on Immunization, the utilization of oral rehydration therapy, and the use of family planning services, with no additional costs to the public sector other than provision of family planning drugs and devices, and minimal time for liaison and coordination.

The projects had stimulated a spirit of community health activism on the part of private physicians, as well as villagers, and were achieving high visibility in underserved areas. Thanks to community support, it appeared likely that the activities could be sustained even after the cessation of outside funding.

Replicable and sustainable pilot projects, of potential usefulness throughout the developing world, demonstrate that medical practitioners are key actors in health for all and in preventive as well as curative care.

Participants were conscious of the need to develop incentives for health workers, including a clear career path, especially for health workers at the primary care level. They also considered it important that cooperative activities should not be conducted in a fragmented manner but as part of a coordinated whole, and felt that WHO might be able to assist medical associations in this respect.

International cooperation requires continued dialogue and selected cooperative endeavours between WHO and medical practitioners, both in their individual capacity, and through their national medical associations. A host of needs can thus be addressed in areas as diverse as: access to and quality of care; health economics for cost-effective health activities; primary health care programmes; continuing medical education; management training in planning, organizing, implementing and budgeting health programmes; and numerous other technical fields.

Participants pointed out that medical practitioners, through their national medical organizations, exert control and influence at many levels of their governments. These relationships can be helpful in communicating and interpreting WHO's policies and programmes, particularly those directed at meeting health needs in the developing world. In turn, WHO can offer information and practical

experience on global issues that can benefit medical practitioners and national medical associations in both developed and developing countries and help them meet the health needs of their populations. Much of value can be learned from the existing cooperative relationship between WHO and national, regional and international medical associations.

Expression could be given to this spirit of cooperation by inviting representatives of WHO to attend medical associations' meetings, at all levels, as speakers and resource persons on various health issues. WHO could in turn invite members of medical associations to participate as experts in various technical and policy development conferences.

THE WAY FORWARD

All present agreed that the consultation had enabled participants to single out a number of issues and activities that could benefit from a cooperative effort between WHO and national medical associations.

The range of health needs still to be met had emerged from the discussions, as had the need to forge a partnership between WHO and medical practitioners. It had become clear that all trained human resources must be marshalled to continue the struggle against disease and to work for social and economic development for all peoples.

New partnerships between public and private forces can enhance and reinforce the efforts of each of these sectors. Through dialogue and exchange of information, they can then identify the priority areas in which their mutual support can make a real difference.

Consideration of this broad range of issues quite naturally led the participants to discuss a process or framework for a continued working relationship with WHO. Some participants suggested a formal relationship involving continued consultation at the international level, and voluntary consultation groups at the national level to be composed of representatives from WHO, national medical associations, ministers of health and other key private or public health organizations. However, most participants felt that this was premature, although it was a possible option for the future.

The Director-General considered that a formal structure was not necessary at present and suggested that the consultations should continue, possibly on an annual basis. Additional consultations could be devoted to specific technical topics. While continuity was important, consideration could be given to widening the participation beyond the initial core group.

The Director-General's proposal was accepted by consensus. Participants expressed their appreciation for his leadership in bringing together such important groups, with their shared responsibility for the achievement of health for all.

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List of Participants

Professor Ope Adekunle
Secretary General of the Confederation of African Medical
Associations & Societies
Department of Surgery
University College Hospital
Ibadan
Nigeria

Dr H.P. Brauer
Secretary-General
Bundesärztekammer
Herbert-Lewin Str. 1
5000 Köln 41 (Lindenthal)
Federal Republic of Germany

Dr C. Cricelli
International Relations Commission
Federazione Nazionale degli
Ordini dei Medici
Via Venezia No. 7
Campi Bisenzio
50013 Firenze
Italy

Professor J.D. Hamilton
Dean, Faculty of Medicine
University of Newcastle
Newcastle
New South Wales 2308
Australia

Dr H. Haneda
President
The Japan Medical Association
5, 2-chome Kanda Surugadai
Chiyoda-ku
Tokyo 101
Japan

Professor Pertti Kekki
Department of General Practice and Primary Health Care
University of Helsinki
Mannerheimintie, 172
SF - 00280 Helsinki
Finland

Dr A.R. Nelson
President
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
USA

Dr Saburo Okita
Former Minister of Foreign Affairs
Chairman
Institute for Domestic & International Policy Studies
Fukokuseimei Building
2-3 Uchisaiwaicha 2-chome
Chiyoda-ku
Tokyo
Japan

Professor Keizo Takemi
Associate Professor
Faculty of Politics and Economics
Tokai University
Tokai, Tokyo
Japan

Dr S. Thier
President
Institute of Medicine
National Academy of Sciences
2100 Constitution Avenue
Washington, DC 20418
USA

Dr H. Lindsay Thompson
Immediate Past President
Confederation of Medical Associations in Asia and Oceania, and
Past President Australian Medical
Association
53 Railway Parade
Lakemba, NSW 2195
Australia

Professor A. Wojtczak
Vice Minister of Health
Ministerstwo Zdrowia
Miodowa 15
00-923 Warsaw
Poland

Observer

Mr Matsuoka (Assistant to Dr Okita)
Institute for Domestic & International Policy Studies
Tokyo
Japan

WHO Secretariat

Dr H. Nakajima, Director-General, World Health Organization
Dr M. Abdelmoumène, Deputy Director-General

Dr T. Bektimirov, Assistant Director-General
Dr J.-P. Jardel, Assistant Director-General
Mr W.W. Furth, Assistant Director-General

Dr J.-C. Alary, Chief, Development of Epidemiological and Health
Statistical Services

Mr A. Creese, Health Economist, National Health Systems and Policies

Dr R. Cumming, Senior Consultant, Office of International Cooperation

Dr E. Goon, Director, Division of Development of Human
Resources for Health

Dr H.R. Hapsara, Director, Division of Epidemiological Surveillance and
Health Situation and Trend Assessment

Ms F. Herzog, External Relations Officer, Office of Director, Planning,
Coordination and Cooperation

Mrs Patricia Hutar, Director, Office of International Medicine, American
Medical Association. **Temporary Adviser**

Dr Y. Kawaguchi, Director, Planning, Coordination and Cooperation

Dr J. Martin, Responsible Officer, District Health Systems

Dr H. Nakatani, Chief, Human Resources Policy Analysis

Dr F. Siem Tjam, Medical Officer, District Health Systems

Dr J. Szczerban, Chief, Office of Research Promotion and Development

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