



TOWARDS A PARADIGM FOR HEALTH

(Discussion paper)

Health for all remains the overall goal of WHO and countries. It was a visionary concept when it was adopted and remains so now. The concept was well understood and widely accepted. Since Alma-Ata dramatic changes have taken place that alter some of the assumptions upon which the strategy for health for all was based. New efforts are needed to identify what the problems in the primary health care approach have been and to analyse approaches that have been successful, with a view to finding realistic and practical ways to address prevailing health and health-related problems in the light of present realities and continuing changes in political, economic, social and technological conditions. A paradigm for health can provide the framework for the development of operational approaches suited to current realities at country and local levels in order to achieve health for all.

This paper raises some questions for discussion for the purpose of reaching a common understanding of the means to achieve the goal of health for all.

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I. INTRODUCTION

1. The value system advocated by WHO and its Member States as embodied in its Constitution, namely that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being", is clear. In 1977 the World Health Assembly decided that the main social targets of governments and WHO in the years ahead should be "the attainment by all the peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life". That principle remains the overall goal.
2. The model developed at Alma-Ata 13 years ago was based on the primary health care approach and reflected certain ideals that remain valid. However some of the assumptions made at that time no longer hold true. Dramatic changes have occurred in the health supportive environment: the political scene has changed rapidly; many developing countries are facing economic recession and debt crises which have affected government and individual expenditures for health; rapid environmental degradation has given rise to new health concerns; population growth has put an additional strain on resources, especially in the health and social sectors; demographic and epidemiological shifts have contributed to changing patterns of morbidity and mortality and thus to the types of services needed; scientific and technical developments have contributed to improvements in health status and created increased expectations; at the same time, rising costs have jeopardized the affordability and therefore the sustainability of health services and health care systems.
3. In the light of these realities, new thinking is needed about what the problems in implementing PHC have been, and about the best way to solve these while also building upon methods that have been successful in order to find the most effective approaches for continuing to work toward the goal of health for all. The collection of ideas, values, knowledge and methods needed to provide the common framework for understanding, and for dealing with prevailing problems and finding realistic and practical ways to solve them, may be called a paradigm.¹
4. The second evaluation of the strategy for health for all (Eighth report on the world health situation) is currently under way. Findings will be reported to the Executive Board and the Health Assembly in 1992. While not all the information from countries or on regional and global developments and trends has been analysed, certain preliminary impressions emerge. Globally, health status has improved, with particularly notable developments in many developing countries. Nonetheless, in many parts of the world, evaluation reveals deterioration in the sense that the gap between rich and poor within and between countries is not decreasing enough. There is persistent inequity in terms of accessibility to health care, which falls far short of the full social justice intended by the concept of health for all. National data, including those from developed countries, also show that even with the overall improvements in health status the gap between social groups within many countries has grown. In some instances, these marked differences in health status can be directly attributed to inequities in access to health services.

¹ Kuhn, T. The structure of scientific revolutions. University of Chicago Press, Chicago, 2nd edition, 1970. (For a historical overview of paradigms in health see Noack, H. "Concepts of health and health promotion", in Measurement in health promotion, WHO Regional Office for Europe, Copenhagen, 1987).

5. World economic output: World per capita output grew by about 1% a year in the 1980s, compared with 2% per year during the previous decade. However, there have been wide divergences according to regions. For example, in Latin America, per capita Gross Domestic Product (GDP) in 1990 was almost 10% lower than in 1980, while in Africa it was almost 20% lower. By contrast, in South and South-East Asia, including China, it grew by over 7% a year in the 1980s. The least developed countries in any region, however, showed least progress and in many, GDP per capita fell.
6. During the period 1980 to 1985, developing countries have, in most cases, maintained government health expenditure per capita at the same levels, although there has been a slight increase in the percentage of GDP spent on health. There were, however, disparities among different groups of countries with increases in per capita expenditure in Asia, but declines in countries of sub-Saharan Africa, as well as in Latin America and the Caribbean.
7. For the developed countries total health expenditure per capita in 1984 varied from about US\$ 275 to about US\$ 1600. During the period 1970-1984 per capita expenditure on health grew faster than per capita GDP. Significant differences in health expenditure also exist between different social groups within countries.
8. Basic health indicators: Global average life expectancy at birth reached 65 years in 1990 as compared to 61 years in 1980, while the infant mortality rates in 1990 fell to 65 to 70 per 1000 live births from 83 per 1000 live births in 1980. The range of these values between developed and developing countries also decreased during the 1980s. By 1988, 87 Member States, with a total population of 3100 million had a life expectancy at birth of more than 60 years; in 68 Member States, with a total population of 2700 million, infant mortality rates were less than 50 per 1000 live births.
9. Population growth: With the majority of the world's population expected to live in urban areas by the end of the century, rapid urbanization, accompanied by urban concentration, will have major implications for provision of adequate services. By the year 2000 it is projected that 7% of the world's population, or more than 400 million people, will be aged 65 and over. Services for the care of the elderly, taking into account the high incidence of disability at these ages, will become increasingly necessary.
10. Progress against major communicable diseases of childhood has been offset by increases in chronic diseases in many developing countries. This epidemiological transition will create the need for more appropriate health promotion campaigns, particularly in developing countries. At the same time, however, malaria, diarrhoeal diseases, acute respiratory infections and the vaccine-preventable diseases continue to kill many young children.
11. By 1990, safe water supplies had been extended to 80% of urban dwellers and about 60% of rural inhabitants, and adequate sanitation to about 70% and 50%, respectively. Nonetheless, in developing countries, nearly 1200 million people remain without safe water supply and about 1800 million without adequate sanitation.
12. While access to local health services has increased, millions of people, particularly in the least developed countries, have no access to medical care or to the support and education needed for preventive care. Immunization coverage had increased globally to about 70% for DPT, measles and polio vaccines and BCG by 1988, but for the least developed countries immunization coverage was only about half that. About 13 million children still die each year before the age of five years, almost all in developing countries. Immunization of pregnant women against tetanus has increased, but about half a million women die each year from conditions related to pregnancy and childbirth, 99% of them in developing countries.

II. PRACTICAL QUESTIONS FOR HEALTH DEVELOPMENT

13. It may be useful to consider some of the major practical questions that will need to be answered by countries and WHO as they face the challenge of implementing and applying the concepts and principles embodied in the HFA strategy. The relation between four such questions, namely, health and population, human rights, technology and economics, is outlined in the diagram in Annex 1.

Public policy, ethics and social values

14. Health is a fundamental human right. Governments are committed to implement health-for-all policies to provide equitable access to health care. Yet in some social and economic development models health care is seen more in terms of expenditure than as an essential investment in human and social development. Measures to ensure equity in health must involve many sectors and many different government ministries, with encouragement from the highest authority.

Health science and technology

15. There have been many developments in health technology in the recent past, but they have not been matched by the ability to apply it. Technology creates opportunities and new treatment possibilities, and adds to life expectancy. Developments in technology can pose new problems and questions about resource allocation, quality assurance and ethics. Technology permits better projections and facilitates broader dissemination of information. But the developments may lead to increased expectations and increased demands on the health sector. If availability of, and access to, services do not also increase, there may be dissatisfaction with the health sector or frustration with government.

Population and health

16. Population structure dictates the type of demands on the health and social sectors, and trend assessment shows that population structure is rapidly changing. Tomorrow's needs will not be the same as those of today.

17. Rates of population growth remain high in many of the world's poorest countries, particularly in urban areas. Population growth can outstrip the benefits of economic growth and this in turn may further jeopardize resources for the health sector. Although population pressure may call for greater emphasis on family planning, it may be countered that when populations are well fed, healthy, educated and employed they constitute a major national resource for socioeconomic development.

18. A range of opportunities for health promotion and disease prevention, diagnosis and therapy is available in all countries. Vulnerable groups and those with special needs may require more health resources than the average - although they should not be provided at the expense of quality of care. Individuals, families and communities, and - for example - women's groups, need to be given more authority and responsibility in action for health. Governments may need to find a new balance between traditional approaches providing for centralized authority and decision-making and those that ensure a rapid, efficient and pragmatic response to real needs.

Changing patterns of health and disease

19. Health status and disease patterns have been changing in response to social, demographic, economic and technological developments. Quality of life, however, has not always increased with increasing longevity. Environmental degradation detracts from the quality of life. Health status in the first years of life, or exposure to certain diseases or risk factors, such as tobacco use, further influence the development and/or expression of disease. Communicable diseases prevail in many developing countries, where the burden of chronic diseases is now also increasing. Many chronic diseases are associated with lifestyles (i.e. eating and drinking habits and tobacco use, exercise)

and environmental factors (i.e. exposure to pollutants and toxic agents, noise, stress, unsafe surroundings). Unfortunately, individuals and communities cannot always avoid such risk factors, make healthy choices or prevent conditions causing health problems later in life.

20. While individual action is necessary, it is not sufficient. Changes may be needed in public policy to protect and improve the social, economic and physical environments and positively to encourage healthy choices by individuals and communities. Information from projections and trend analyses, combined with the increasing knowledge of natural history of diseases and human life cycles, must be the basis for future planning, policy-setting and action.

Information and communication

21. Information and communication are prerequisites for responsible planning and decision-making. Information and the ways in which it is communicated can have either a positive or a negative impact. Information for the public should be reliable, understandable and available when and where it is needed to help protect and promote health and to help responsible decision-making. More effective ways need to be found for providing the health sector with the information required for policy-setting and management.

Organization and management of health systems infrastructure

22. A fundamental weakness of the health sector in many countries is the underdevelopment and lack of sustainability of health system infrastructure. This has negative consequences for public and private institutional care (hospitals, etc.) as well as for non-institutional care. At peripheral level, however, much preventive action and care for the sick are assured by individuals, families and communities - and more could be done; the community level is where practical solutions appropriate to local needs can most readily be found and applied. Nongovernmental organizations also make significant contributions at this level. In order to maximize the impact of such action, however, it is essential that the expertise, knowledge and resources of the health system be made available at the peripheral level and that integrated services appropriate to local needs are ensured (see Annex 2).

23. Although emphasis has been placed on decentralization of authority and decision-making in the health sector, particularly to the peripheral level, in reality little attention is paid to the practical ways of implementing this. Health systems remain concentrated on institutions and government-provided services and action. Health systems management as presently practised is too often a hierarchical process or a set of bureaucratic procedures. For decentralization to be more than a trendy word, central government must give lower political and administrative levels greater responsibility and autonomy, appropriate resources and power, and the educational and training opportunities to develop health and management skills. For example, more financial resources could be reallocated from central level to community level. While communities can - and increasingly do - raise resources, the needs of those with fewer resources must continue to be met.

24. The benefits of community action include the possibility for greater responsibility at peripheral level. Furthermore, community initiatives can build up a critical mass of action and ideas to serve as examples for other parts of the country.

Economics and financing

25. Two very different economic paradigms have been dominant influences on government approaches to policy-making, financing and management in this century, namely centrally-planned and free-market economies. Each has had implications for health and for the provision of health care, and each has faced serious problems of affordability and sustainability of health services. Both perspectives are now under challenge in the face of significant changes worldwide in the political, social and economic spheres. Yet no new economic paradigm has yet emerged.

26. The 1980s saw a stagnation of the economies of many countries due to high interest rates, low commodity prices and large debts. The predominant role of governments in the management of the national economy has been reduced in many countries. Ministries of health may be severely constrained by resource shortages due to decisions taken by the ministry of finance. In many of the countries where planning was formerly central, the sudden promotion of market-oriented economies may temporarily lead to an inequitable distribution of wealth and/or an increase in poverty. Countries faced with the need for "structural readjustment" may decide to allocate fewer resources to the health sector in order to give more to the so-called productive sectors. Where this choice is made, it is because health is seen only as an object of expenditure. However, to maintain current improvement in health status and to ensure continued progress in health and social development it is essential that individuals, communities and government continue to invest in health.

27. Shortage of resources is not the only problem. Even developed countries suffer the consequences of inefficient use or waste of resources, duplication of effort, and the use of expensive technology where equally effective and less costly methods are available.

28. In order to ensure sustainable development, governments will have to answer many questions. For example, how can ministries of health influence other ministries and other sectors to take policy decisions and measures with positive implications for health and ensure adequate resources for health? What decisions must be taken by the health sector itself in allocating resources? What models are being used in different countries for ensuring an appropriate balance between the role of government, public and private sectors, between institutions, communities and individuals, in raising and in allocating resources for health? Other questions are how to divide funds between hospital and institutional care and the peripheral level; how to allocate additional resources to vulnerable groups and groups with specific needs without depriving the rest of the health sector; how to meet recurrent costs; what strategies to follow for controlling health care costs.

29. Another issue in sustainability of health development is the importance of health infrastructure. Vertical programmes often have great immediate impact, and this attracts donors. But if improvements in health are to be sustained, a strong health infrastructure is also required; the priorities of donors should not deflect national authorities from this purpose. In their negotiations with donors, countries must insist on a proper balance between national priorities and those of donors - recognizing that the expertise, skills and capacities that result from the focus of energy and resources on specific issues can profit the health system as a whole.

III. MAJOR ISSUES EMERGING

30. From the above overview of the global health situation, the different factors contributing to health, and the analysis of practical questions, it is possible to identify a number of major concerns that countries and the international community will have to face well into the twenty-first century. Many of these issues are familiar and are being dealt with through action in the health sector and in other sectors. Some are new, others may deserve a different emphasis, and yet others may not have been posed or recognized.

(a) respect for human rights, especially for the underprivileged, in health and social development;

(b) the need to consider human health in a changing environment, taking into account the new realities resulting from changes in the political, economic, social and physical environments;

(c) equity of access to care through sustainable health infrastructures, integrated health services, and measures to "empower" individuals and communities to ensure their own health through information, knowledge, skills and resources, so that each individual has the opportunity to meet his or her basic health needs;

(d) continued development and communication of scientific knowledge and improvement of technical interventions for health; attention to scientific, technological and economic trends, and to their implications for health, for health system management and for health care;

(e) promotion of healthy behaviour and lifestyles, including nutritional habits, using public policy to influence and shape the social, economic and physical environments and to enable individuals and communities to make healthy choices;

(f) mobilization of sufficient resources for health, and measures to ensure optimal use and sustainability of those resources, particularly for countries in greatest need;

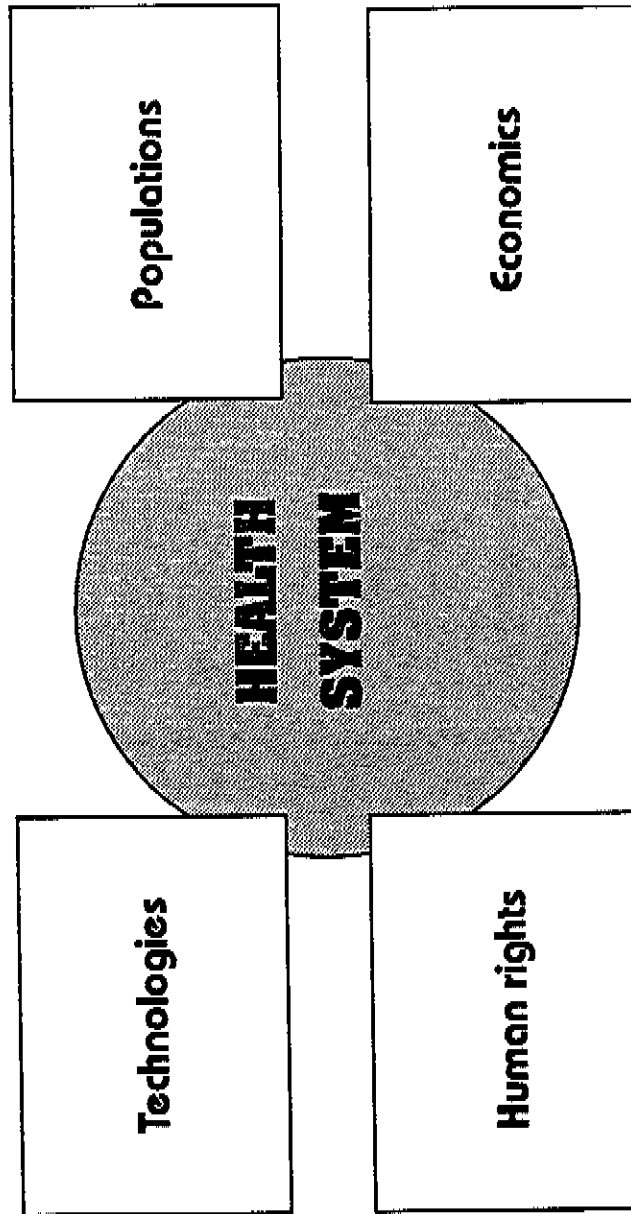
(g) the role of the ministry of health in influencing public policy and government decision-making, including resource allocation for the health sector;

(h) global interdependence where health is concerned, including international action to mitigate the effects of epidemics and natural and man-made disasters;

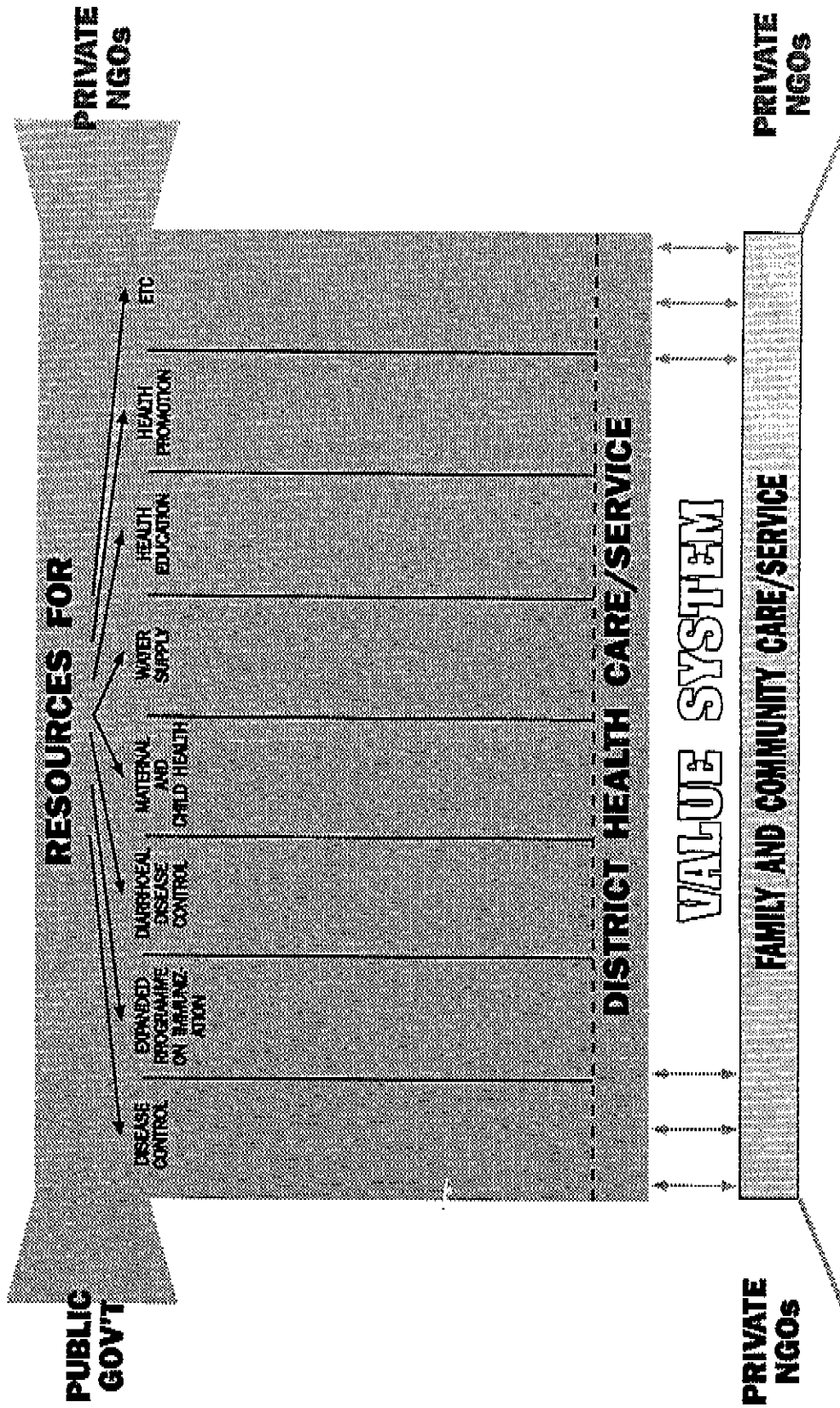
31. Questions for WHO include: the need to relate directly to the ministry of finance and to other ministries, as well as to the ministry of health; how to better mobilize and influence the allocation of international funds for sustainable health development; and how to stimulate more concerted action for health within the United Nations system.

IV. CONCLUSION

32. In the light of the lessons learnt from the evaluation of the strategies for health for all and in order to respond more effectively to changes that have occurred in the world, inter alia by building upon successful approaches and methods already being used, it would be useful to have a health paradigm. For WHO this would provide the framework for its international health work and would contribute to the development of the Ninth General Programme of Work. Countries could adopt such a paradigm for their own needs and in the light of their own social, economic and political contexts and cultures. Economic realities have to be a fundamental element of any workable paradigm.



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