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Annex 2

RENEWING THE HEALTH-FOR-ALL STRATEGY

GUIDING PRINCIPLES
AND ESSENTIAL ISSUES
FOR THE ELABORATION
OF A POLICY FOR
EQUITY, SOLIDARITY
AND HEALTH

CONSULTATION
DOCUMENT



WORLD HEALTH ORGANIZATION
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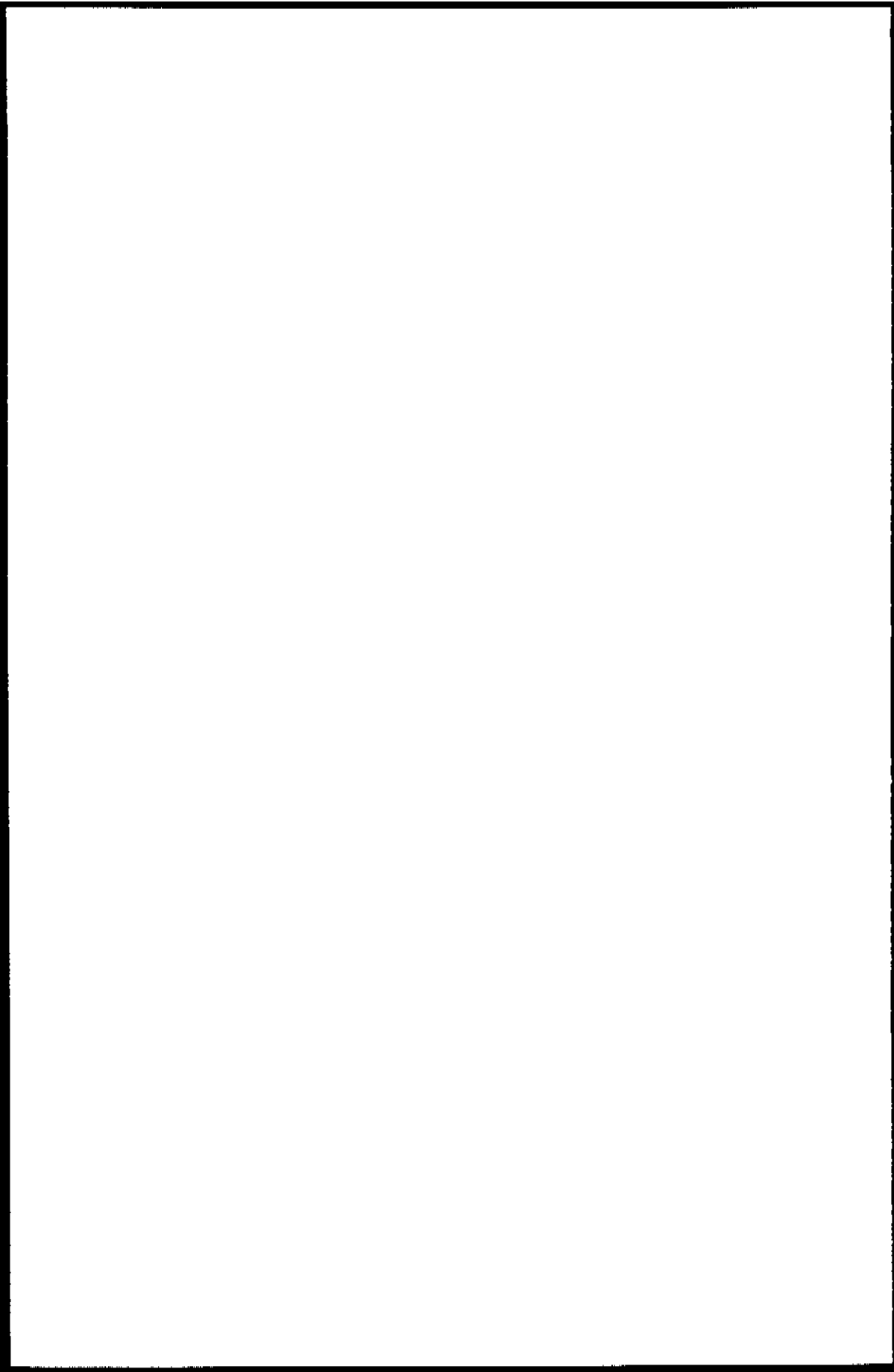
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TABLE OF CONTENTS

INTRODUCTION	1
I BACKGROUND	5
I-1 The new realities	5
I-2 Health for all for the year 2000: progress and lessons	7
I-3 Preparing for the twenty-first century	10
II MAJOR INFLUENCES ON HEALTH: TRENDS BEYOND THE YEAR 2000	11
II-1 Political, economic, environmental, social and cultural influences on health and health systems	11
II-2 Epidemiological transition, health situation and trends	12
II-3 Countries' capacity to respond to the health needs of their populations	17
II-4 International capacity to respond to country needs	17
III POLICY FRAMEWORK	19
III-1 Strategic priorities	19
III-2 Policy principles	19
III-3 Main policy orientations	21
III-4 Aspirational policy goals	26
IV FROM POLICY TO ACTION	27
IV-1 Country policy formulation	27
IV-2 International partnership	29
V CONCLUSION	33
PROPOSED TIMETABLE FOR FORMULATING THE NEW GLOBAL HEALTH POLICY	34



INTRODUCTION

SINCE the International Conference on Primary Health Care, held at Alma-Ata in 1978, the call of health for all by the Year 2000 through primary health care, has provided a motivational and unifying concept in international health development and made an important contribution to the achievements of better health which have occurred around the world: increased life expectancy, declining infant mortality and improved access to basic health services.

Through the association with the year 2000, "health for all" served as an aspirational goal for all countries. However, as the target date approaches, it can now be seen as limiting, may be misunderstood and, above all, proposes a time frame which is not universally attainable. To cite just a few examples of the remaining challenges: in 53 countries, representing 13% of the world's population, average life expectancy at birth is less than 60 years; there are wide variations in infant mortality between countries; and maternal mortality in sub-Saharan Africa is three times greater than in less developed countries as a whole.

There will not be health for all until these gaps are filled, and the efforts of all WHO Member States to achieve the highest possible level of health for their entire populations should not be abated. As new political, economic, social, cultural and environmental equilibriums are appearing in the world, it is time to reinvigorate the health-for-all strategy and to update plans of action in individual countries. Simultaneously, all agencies concerned, and WHO first among them, should renew their commitment to support country efforts.

A new policy based on equity and solidarity, and buttressed by appropriate technical, political and economic strategies, should be universally adopted to serve as the objective and guidance for the updating of global, regional and national health-for-all strategies and for the development of means and mechanisms to enable all contributing partners to fulfil their role.

The policy must be based on a consensus for concepts and action. To this effect WHO is consulting all those concerned in its Member States and, at the international level, all those who are expected to support, at one time or another, the implementation of national policies. A framework for the policy has been developed to cover general and individual health situations in the world; to cover a wide variety of political, economic, social and cultural situations; to serve as the repository of new concepts and ideas in health development; and to serve as a basis for the development of new national policies.

As the principal purpose of the new global policy is to stimulate individual countries to address the serious health challenges of the coming decades, extensive and intensive consultation is essential to ensure ownership of the new policy by all concerned. Simultaneously, consensus will be sought to support national efforts among the bodies dedicated to health and social development such as the United Nations system, other international and nongovernmental organizations, to ensure that the foundation is laid for implementation in countries, with no overlap.

In countries, national decision-makers, technical experts and representatives, politicians, nongovernmental organizations, religious leaders, business and trade-union leaders, other opinion leaders and the general public will be invited to collaborate in a consultation process to take stock of their health situation and expected trends in the next 25 years to identify the main health issues for the country. Opinions will be sought on health challenges and major policy orientations, identifying the roles of specific sectors and country institutions in developing and implementing the new strategy. This country statement, replying to and enlarging on the issues raised in the present document, will form the major element of feedback to WHO and will include opinions on the role of WHO and others in supporting the policy.

This document, which provides the framework for the consultation process, can be used as to indicate the response, and other information can be provided which reflects the particular circumstances of the participants in the consultation about the desired content of the new global health policy and action to implement it. A timetable for the consultation is included in annex 1, which also provides an indication of future action following adoption of the new policy.

Achieving better health is a realistic and desirable goal. The resources, the knowledge and the skills exist. What is needed is the will and commitment of governments, civil society and the international community to apply them in partnership. It is with this challenge in mind that the Forty-eighth World Health Assembly adopted resolution WHA48.16, which reads as follows:

FORTY-EIGHTH WORLD HEALTH ASSEMBLY
AGENDA ITEM 22.2

WHO48.16(*)
12 MAY 1995

WHO RESPONSE TO GLOBAL CHANGE: RENEWING THE HEALTH-FOR-ALL STRATEGY

The Forty-eighth World Health Assembly,
Stressing the continued validity of "health for all" as a timeless aspirational goal, while recognizing that it may not be universally attainable by the year 2000;

Recognizing that political, economic, social, cultural and environmental situations are changing throughout the world;

Concerned by the negative trends in some of the major health determinants shown by the third monitoring of progress in implementation of strategies for health for all by the year 2000;¹

Recognizing the need to give priority attention to those most seriously deprived in terms of health or health care, whether owing to poverty, marginalization or exclusion; and recognizing also in this regard, the need for intensified support of the international community;

Stressing the importance of a broad national and international consultation among those dedicated to health and social development in order to create a renewed commitment to health under WHO leadership;

Having considered the report of the Director-General² outlining the steps taken to implement the recommendations of the Executive Board Working Group on the WHO Response to Global Change³ on the updating of the health-for-all strategy, objectives and targets in response to global change;

Having noted with appreciation the contribution of the task force on health in development created by resolution WHA45.24;

Agreeing that a new global health policy should be elaborated,

1. ENDORSES the steps already taken by the Director-General to implement the recommendations on updating the health-for-all targets in response to global change;
2. URGES Member States:
 - (1) to take appropriate steps for consultations to raise the awareness of the general public, political leaders, ministries and other partners concerned with social and economic development policy to the need to place health high on the political agenda, in order to address the serious health challenges of the coming decades and to ensure that the foundation is laid for implementation of the global health policy in countries;
 - (2) to forward to WHO the consensus views on health challenges and major policy orientations resulting from the national consultation to serve as a basis for the elaboration of the global health policy;
 - (3) to adapt the global health policy, after its adoption, into national or subnational context for implementation, selecting approaches specific to their social and economic situation and culture;
3. CALLS ON other organizations of the United Nations system as well as intergovernmental and nongovernmental organizations active in the field

1 Monitoring of progress in implementation of strategies for health for all by the year 2000, third report (documents EB95/5 and EB95/INE/DOC/15).

2 Document EB95/1995/REC/1, Annex 5.

3 Document EB92/1993/REC/1, Annex 1.

of health to participate in the elaboration of the global health policy, to define their role in carrying it out and to join forces with WHO for its implementation;

4. REQUESTS the Director-General:

- (1) to take the necessary steps for renewing the health-for-all strategy together with its indicators, by developing a new holistic global health policy based on the concepts of equity and solidarity, emphasizing the individual's, the family's and the community's responsibility for health and placing health within the overall development framework;
 - (2) to ensure the convergence of all relevant work carried out on the subject at all levels of the Organization;
 - (3) to consult widely with all Member States and other partners of WHO in health development to this effect;
 - (4) to support Member States in the elaboration of their contribution to the global health policy, *inter alia*, by preparing user-friendly material to that effect, accessible to all sectors;
 - (5) to solicit the contribution of other institutions dedicated to health and social development, such as those of the United Nations system and other international and nongovernmental organizations, to the formulation and implementation of the global health policy;
 - (6) to elaborate the new global health policy, based on the outcome of the consultation process, to serve as objective and guidance for the updating of global, regional and national health-for-all strategies and for the development of mechanisms to enable all concerned to fulfil their role, taking into account that essential aspects of primary health care have not yet been achieved by a number of countries, especially the least developed countries;
 - (7) to redefine WHO's mission and the meaning of technical cooperation for WHO in pursuance of that global health policy;
 - (8) to take the necessary measures for WHO to secure, at a special event connected to the World Health Assembly of 1998, in conjunction with the fiftieth anniversary of WHO, high level political endorsement of a health charter based on the new global health policy, in order to obtain political ownership of the policy and commitment to its implementation;
 - (9) to report on the plans for securing this endorsement to the Forty-ninth World Health Assembly.
-

FRAMEWORK FOR A POLICY FOR EQUITY, SOLIDARITY AND HEALTH

I BACKGROUND

NOTES TO PARTICIPANTS IN THE CONSULTATION¹

The purpose of this section is to underline the most crucial changes in the world situation – political and economic transition, social and cultural evolution, and environmental and demographic changes with emphasis on population and poverty – that have led to the need to renew the health-for-all strategy and health policies at all levels.

Participants in the consultation process are asked to use the following text, proposing modifications or specifications in conformity with situations they have experienced at the country or international level.

I-1 THE NEW REALITIES

The final decade of the twentieth century is characterized by the consequences of dramatic political changes which followed the end of the Cold War. These will continue to have repercussions well into the twenty-first century. Calls for democracy and good governance, social justice and respect for human rights, a clearly defined role for the State, increased community involvement in decision-making and economic globalization, adjustment and transition to market economies are the ingredients of change affecting the daily lives of the world's population. While the benefits of these shifts remain incontestable in principle, it is evident that the intermediate outcome remains uncertain in many countries, and the transition process may be costly, prolonged and harsh.

Governments are under pressure to meet human rights demands, extend democratic processes and safeguard social progress. Political concern and popular pressure, often amplified by the media, dictate the adoption of short-term measures to the detriment of longer-term reforms. Social programmes are operating under ever-tighter resource constraints as greater economic efficiency is sought. The price is often greater inequity within and between countries as a result of cuts in government expenditure

¹ At the beginning of each section, a box outlines the purpose of the following text and poses a few questions to foster constructive thinking, stimulate reflection and encourage comments. Participants in the consultation are invited to be as creative as possible in their contributions, as the new policy should be the result of a genuinely dynamic process.

prompted by deterioration in the balance of trade and perverse – though unintended – effects of structural adjustment policies and economic reforms.

In many parts of the world, per capita income has been increasing during the last 20 years, but quality of life for many people has not improved. For too many, the path to change is accompanied by conflicts and bloodshed; displacement from their homes and a hopeless existence as refugees; weakening of the rule of law and oppression of ordinary people; and uncontrolled profiteering which is indifferent to the common good.

The situation is compounded by the increase in the total population of the world and related demands for health services. Furthermore, the number of extremely poor people in the world more than doubled between 1975 and 1990. The gap between rich and poor, educated and uneducated, and between men and women, in developed and less developed countries, and particularly in the former compared with the latter, is increasing. In 1960, the income of the richest 20% of the world's population was 30 times greater than that of the poorest 20%; by the early 1990s it was more than 60 times greater. Furthermore, people in the developed world consume natural resources at a rate, on average, 10–20 times that in the developing world. The basic line of division in the world today is the growing gap between the economic worlds of the rich and of the poor, who can benefit neither from democracy nor from technology for development.

A large-scale flow of capital from industrialized to lower-income economies is taking place. However, this is due essentially to private investment, and the destinations are those countries with the potential rapidly to become industrial exporters or mass markets, or both. While the role of external aid and technical cooperation is increasingly important, the percentages of bilateral assistance for health have been decreasing recently; economic adjustment and governance reforms are poor substitutes for health development. There is a need for the donor community to devote more resources and attention to sustainable development and poverty reduction, which often remain secondary concerns in spite of the United Nations Conference on Environment and Development and Agenda 21 (which advocates a global movement for sustainable development). In addition, adequate resources are required so that the increased need for relief, peace-keeping and resolution of conflicts is not met at the expense of measures to alleviate chronic poverty.

There are, however, some encouraging developments for health. In particular, there is a move towards greater health consciousness among populations. Some health and medical technology, preventive and curative, is becoming more available and affordable. The increasing role

and "visibility" of the United Nations system and the Bretton Woods and other international financial institutions in health matters throughout the world as advisers, brokers or indirect participants, through the influence they have over international development policy and economic affairs, has brought health to a higher position on the international agenda. Also, in the last 20 years the influence and fiscal strength of a variety of nongovernmental organizations have grown, making them willing and indispensable partners in health development. Health has also featured prominently in the consensus achieved about the need for sustainable development at the important international conferences which have been held to shape the twenty-first century. Finally, most encouraging is the recognition that health can be a bridge to peace. There is an urgent and continuing need to fashion health policies which, when implemented, make significant contributions to global and regional stability and security and which are sensitive to the spiritual dimension of societies.

I-2 HEALTH FOR ALL BY THE YEAR 2000: PROGRESS AND LESSONS

NOTES TO PARTICIPANTS IN THE CONSULTATION

This section takes stock of the progress made through 20 years of implementing health-for-all strategies at the national, regional and international levels.

The information is selected from the 1994 monitoring of the health-for-all strategies¹. Participants in the consultation process are asked whether the information selected is in fact the most crucial and relevant for the development of the new policy.

"Health for all" has created a revolution in **long-term thinking about health** and the place of health in development. Primary health care has been an inspiration for all health systems in the world, and the momentum should be maintained as the goal of health for all is more relevant today than ever before. The way to achieve it, however, must be in keeping with the current economic, social and political environments in countries. While commitment to the aims of health for all has remained firm and Member States have adopted the primary health care approach as described in the Declaration of Alma-Ata for the development of their

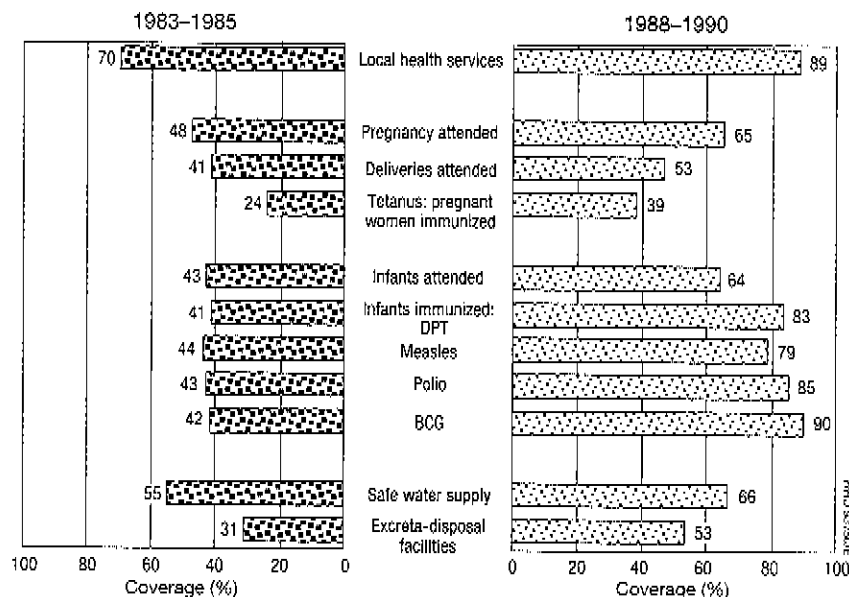
¹ See documents EB95/15 - Monitoring of progress in the implementation of strategies for health for all by the year 2000 - Third report and EB95/INEDOC/13 - Monitoring the progress in implementation of strategies for health for all by the year 2000 - Summary of findings on indicators.

health care systems, the implementation of strategies to achieve those aims has in many cases slowed down. This has been the result not only of economic factors but also of the rigidity of health systems, weak infrastructure, the constraints on achieving real participation by all related sectors and the inadequacy of efforts to promote health and prevent specific health problems.

Health for all was launched at a time when some parts of the world were entering a period of economic recession. The potential for significant and sustainable improvement in health was thus impaired. In addition, there were a number of challenges which were underestimated in the initial enthusiasm. For example, health was often not a major ministerial portfolio and remained only one among many national and international priorities for resource allocation. There is also a considerable body of experience which demonstrates that putting primary health care into operation has turned out to be much more complex, difficult and exacting than had been foreseen – particularly at a time when sophisticated health technology was receiving much attention internationally. The importance of community participation and local determination of priorities and programmes has been underestimated. The immense diversity of problems with a bearing on health, and the ways in which solutions must vary from community to community across the full range of developed and developing countries, make decentralization and local determination essential.

In general, indicators of access to primary health care, e.g., immunization coverage, trained attendance at childbirth, water supply and sanitation, besides basic curative care, have also improved. In certain areas, gaps between the developing and developed countries have been significantly reduced, although improvements in some of the least developed countries have been less satisfactory, and poverty remains a major challenge for health for all. The victims should not be blamed, and countries experiencing difficulties should receive additional support. Trends in closely monitored immunization programmes reveal disquieting evidence of stagnation and even a reversal of progress in a number of countries in the African Region. Following achievement of the 80% coverage target in 1990, significant decline has been documented in some countries, while the steady improvements noted in previous years have stopped. Empirical evidence suggests that this may be the result of the effect of economic and political instability on already fragile, peripheral health systems. In environments of instability and poverty such evidence constitutes compelling grounds together with lower life expectancy for an urgent assessment by countries of the most recent health trends as part of a renewal of their health-for-all policies and strategies. **Coverage levels for various elements of primary health care** in developing countries are illustrated in Fig. 1.

FIG. 1. PRIMARY HEALTH CARE AVAILABLE - AT LEAST THE ESSENTIAL ELEMENTS, DEVELOPING COUNTRIES, 1983-1985 AND 1988-1990



Improvements have also been made in **health status**: life expectancy at birth has increased from about 40 years for developing countries in 1950 to more than 62 years in 1990; and from more than 66 years in the more developed countries to 74 years over the same period; the infant mortality rate dropped from 179 per thousand for developing countries in 1950 to 70 per thousand in 1990; and from 59 per thousand in the more developed countries to 10 per thousand over the same period. Nevertheless, there are still 53 countries, representing 13% of global population, where the average life expectancy at birth is less than 60 years. Moreover, in some countries a relative deterioration in life expectancy has taken place, linked to the economic crisis which has accompanied the rapid political changes of recent years. World infant mortality has continued to diminish. However, the global average of 64 deaths per 1000 live births conceals widely differing rates (from 10 per 1000 in developed countries to 110 in the least developed countries). Some national reports indicate, against present trends, that infant mortality is increasing. It is estimated that at the end of the 1980s, maternal mortality in sub-Saharan Africa was three times greater than in the less developed regions as a whole; and nearly 150 times greater than in more developed regions.

I-3 PREPARING FOR THE TWENTY-FIRST CENTURY

NOTES TO PARTICIPANTS IN THE CONSULTATION

The purpose of this section, to be completed after, and on the basis of, consultation, is to underline the new priority given to health in the world; the rights of people to health; the importance of equity of access; the balance in promoting and protecting health; the responsibilities of government; and individual, community and government participation.

It is thus essential that participants in the consultation process consider options for this section after the above analysis of the situation and before sections III and IV below, and state succinctly the main challenges they will have to face to reach health for all in the next 20 to 25 years. This section will be completed after consultation, in order not to preempt results or unduly influence participants in the process.

II MAJOR INFLUENCES ON HEALTH; TRENDS BEYOND THE YEAR 2000

II-1 POLITICAL, ECONOMIC, ENVIRONMENTAL, SOCIAL AND CULTURAL INFLUENCES ON HEALTH AND HEALTH SYSTEMS

NOTES TO PARTICIPANTS IN THE CONSULTATION

Each country or group of countries will undergo particular political, economic and sociocultural influences; they are important determinants of the health situation. The text below outlines some of these determinants and their expected evolution in the next two decades. Participants in the consultation process are asked to analyse the validity of the statements, and to complete them where necessary.

Political freedom leads to increasing calls for more equitably distributed, better-quality services and for a greater say in decisions about priorities for access to health services. Availability of **information** will continue to expand around the world, bringing innovative images more rapidly to more people, together with certain forms of education if not literacy. As information technology serves to improve public health, it may raise people's expectations far beyond what can really be achieved for all in the near future. Recent changes in **economic policy** in many countries have frequently been made with the intent to enhance commercial markets. The risks of aggressive commercial marketing of health technology are well documented, in that increased consumption is stimulated at the expense of other services which may be more cost-effective. **Economic growth** should improve health through better shelter, nutrition and services, but its benefits should be equitably distributed, and the adverse consequences on health associated with the destruction of environmental resources must be prevented through sustainable economic policies. The past decade has, however, witnessed **economic decline in 47 countries**. Structural adjustment policies in many developing countries may continue to impose tight control over public expenditure on health and social services, often to the detriment of poor populations who depend upon access to subsidized or free services.

The average annual **population growth** rate, running at 1.57% in 1990–1995, is expected to decline slowly to 1.0% by 2020–2025. This decline should not be used to disguise the real threat posed by the real increase in the world's population, which is expected to reach between 7600 million and over 9000 million by 2025. This will be accompanied by continued rapid urbanization in developing countries; the **urban population** is ex-

pected to rise to 61% of the world total by the year 2025. Population growth often erases the gains made in health service coverage; while the percentage of coverage increases, the actual numbers of people without cover continue to rise.

Migration of all kinds, including that due to environmental and economic causes, is a continuing concern. The worldwide population of **refugees** has grown from 2.5 million in 1970 to over 18 million today. At least 24 million people are displaced within their countries of origin and residence. Tourism and short-term economic migration also have health impacts. More attention needs to be given to disaster preparedness planning, pre-positioning of disaster supplies and other preparatory measures which will reduce the damage to health and property caused by disasters either man-made or due to natural causes.

The increase in primary school enrolment should lead to dramatic rises in **literacy** rates in the developing world, which will result in improved public health. Yet, according to projections the number of illiterate people in the world by the end of the century is expected to be 1000 million. At present there are about 600 million illiterate women, with illiteracy rates higher in rural areas than in urban areas. Such women have little chance of improving their education.

While improvements have been made throughout the world in access to **safe water and adequate sanitation**, differences of availability are a good illustration of the gaps between regions in living conditions that influence health status. For example, 54% of sub-Saharan Africa's population still lack safe water and 64% are without proper sanitation.

II-2 EPIDEMIOLOGICAL TRANSITION, HEALTH SITUATION AND TRENDS

NOTES TO PARTICIPANTS IN THE CONSULTATION

This section will describe selected elements of the current health situation derived from the second evaluation of the implementation of the global health-for-all strategy. It addresses epidemiological transition and expected situations on the basis of projections. It underlines the bio-medical and technological changes and reviews new concepts influencing public health. Countries are encouraged to introduce positive health indicators whenever possible.

This is a key section which can only be completed with analytical information provided by participants in the consultation process, in the light of their experience of health and strategic health trends and the scientific data available to them. They may wish to respond according to the outline below or provide additional information.

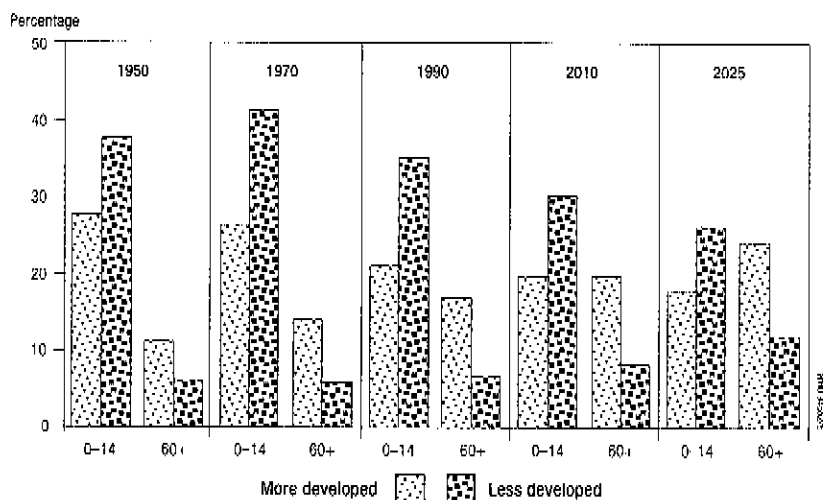
The world health situation is a complex picture with marked variations in both the pattern and severity of disease burdens between regions. It shows the often limited possibilities for people to lead socially and economically productive lives.

HEALTH STATUS: TRENDS

Despite improved life expectancy in all developing regions, the pace of health gains has been more favourable in some countries than others, with a number of the least developed countries remaining dependent on external support for their health "take-off". Whereas least developed countries were only five years behind less developed as a whole in **life expectancy** in 1950 (36 compared with 41 years), by the early 1990s the difference had doubled to over 10 years (51 compared with 62 years).

Infant mortality in the least developed regions was only 8% higher than in less developed regions as a whole in 1950 (194 compared with 179 per 1000), but nearly 60% higher by 1990 (110 compared with 70 per 1000). Reductions in **infant and child mortality** are expected to be more modest in sub-Saharan Africa than in eastern Asia and Latin America, partly due to the AIDS pandemic. The projected decline in infant (including perinatal) and child mortality is based on the assumptions of sustained, if low, improvement in socioeconomic conditions and expansion of coverage by health technology such as family planning, immunization, oral rehydration, and appropriate treatment for acute respiratory infections. Meanwhile the proportion of the population aged 60 years and over is projected to increase, giving the typical profile shown in Fig. 2.

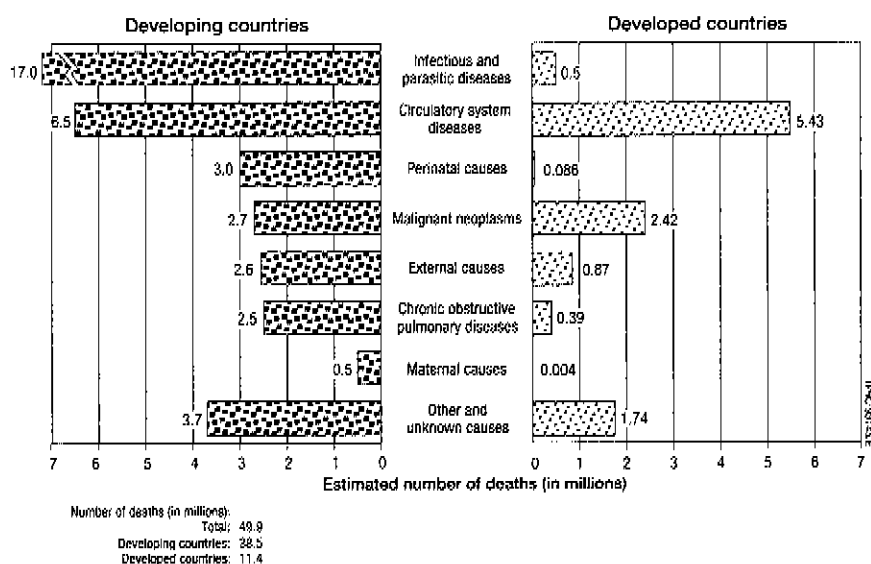
FIG. 2 PERCENTAGES OF THE POPULATION AGED 0-14 YEARS, AND 60 YEARS AND ABOVE



Source: United Nations World Prospect (the 1992 revision).

In recent years there have been not only demographic, socioeconomic, cultural and educational transitions but an **epidemiological transition**. This is the term which describes the process by which developing countries begin to exhibit patterns of disease traditionally associated with more developed status. Fig. 3 summarizes causes of death in developed and developing countries. Many if not most countries demonstrate features of both: high infant mortality rates and morbidity and mortality due to both communicable as well as noncommunicable diseases.

FIG. 3 ESTIMATED ANNUAL NUMBER OF DEATHS BY CAUSE IN DEVELOPING AND DEVELOPED COUNTRIES, 1990



Health trends vary from country to country and from region to region, but the most significant expected causes of mortality and morbidity¹, particularly in the developing world, are:

- ◆ **Respiratory disease:** as childhood deaths from the vaccine-preventable diseases fall, the proportion of total deaths caused by acute respiratory infections, including pneumonia, has been increasing. **Pulmonary tuberculosis** will continue to rise because of reactivation of the disease in individuals infected with human immuno-deficiency virus (HIV). **Diarrhoeal diseases:** although there are treatments for

1 Further details and analysis are provided in the World Health Report 1995 *Bridging the Gaps*, World Health Organization, Geneva, 1995.

these diseases, little progress can be made as long as the patients return to an insanitary environment. The **malaria** situation is stationary in many areas and deteriorating in others, particularly in new settlements. Nearly 90% of the projected **HIV infections and AIDS** cases in this decade will occur in the developing countries. **Leprosy, dracunculiasis** and **poliomyelitis** should have been eliminated before the year 2000.

- ◆ **Malnutrition:** only long-term changes in food quality and safety, backed by good nutrition education programmes, will make a permanent difference. **Cardiovascular diseases** will remain the leading cause of death during the next decade. **Cancer** will be an increasingly important cause of death among adults, in developing as well as developed countries. **Mental illness** will continue to be a major public health problem; in addition, as populations age the prevalence of disorders such as dementia will rise.
- ◆ **Accidents at work** will increase, and so will major **technological disasters** like those which have already occurred in the nuclear, chemical and petrochemical industries. Mortality and disability due to **traffic accidents** will increase further in many developing countries.

HEALTH SYSTEMS AND RESOURCES

Improved access to services will remain the main objective, especially in less developed regions and countries, and carefully planned **decentralization** can promote this objective. The desire to **improve performance** and quality will lead to other improvements, including greater intersectoral cooperation, review and revision of procedures, and problem-solving. The constraint most often cited by countries in the implementation of the health-for-all strategy is shortage of qualified and competent **health personnel**, despite the fact that all categories of personnel have been growing faster than operating budgets; the problem is that they are wrongly combined and distributed. Reform in the public sector will continue to shape human resources for health.

The increasing interest in experimenting with, and developing various health **financing schemes**, such as health insurance, social security, and fee-for-service financing of health care combined with community-support mechanisms, will continue. **Cost-conscious management** will become increasingly important in the health sector.

COMMUNITY ACTION, HEALTHY LIFESTYLES AND ENVIRONMENTAL HEALTH

Community involvement will be encouraged; people should be increasingly involved as full partners in the health process, from the identification of needs, selection of priorities, planning and implementation to

the evaluation of activities to improve their own health. Governments, the health sector and interest groups do not make optimal use of such involvement. Particular efforts need to be made to involve women in decisions affecting their health.

It is expected that many countries will pay more attention to various elements of **quality of life**, especially healthy nutrition, the benefits of physical activity, well-being as an indicator of adequate quality of life, reduction of tobacco and alcohol consumption, reproductive health, protection against sexually transmitted diseases, family planning, and prevention of teenage pregnancy.

The world's growing population demands ever more water, yet **water resources** for human, agricultural and industrial use are diminishing. Toxic wastes **pollute** land and seep into the water supply. Water polluted by human wastes causes disease, as does air polluted by sulfur and nitrous oxides, for example. The measures now being taken to limit emissions will have little noticeable effect in the next decade. In the twenty-first century countries will still be coping with the environmental health consequences of industrialization, energy production, food and agricultural practices, and urbanization as major determinants of human health.

BIOMEDICAL AND TECHNOLOGICAL CHANGES

Research on vaccines, pharmaceuticals and medical equipment is becoming more expensive, with the result that the prices of end-products are beyond the reach of developing countries. The trend towards more expensive treatment for diseases affecting fewer people will have to be reversed. Only 5% of global expenditure on health research is concerned with the needs of developing countries, which suffer 93% of the world's premature mortality. The gap between knowledge and its application is wider than ever before. **The rational application of existing knowledge** is essential for the improvement of any renewed national or international strategy. Similarly, technologies appropriate for various socioeconomic situations may need further exploration.

Rapid advances in areas such as biotechnology and biomedical engineering now pose serious ethical, social, legal and economic challenges. It has become more important than ever to put in place **ethical safeguards** and methods of protecting rights of individuals and communities to health-related technology. Given an international consensus, ethical standards must be developed on a country-by-country basis for research involving human subjects, fetal tissue transplantation, genetic counselling and genetic engineering, organ transplantation, *in vitro* fertilization and embryo transplantation, *inter alia*. Ethical considerations will also prompt

the systematic establishment of national mechanisms for monitoring and regulating the application of technology and withdrawal of inappropriate technology.

II-3 COUNTRIES' CAPACITY TO RESPOND TO THE HEALTH NEEDS OF THEIR POPULATIONS

NOTES TO PARTICIPANTS IN THE CONSULTATION

Countries require the capacity to respond to changing health situations and needs of various populations if they are to keep up with the trends outlined above. Capacity is an expression not only of basic economics, infrastructure and human resource availability, but also of the will to take effective action. Achieving self-reliance and assuming responsibility for socioeconomic development are important goals for each country to ensure stability, and security in health.

This section will be completed after consultation. The purpose is to demonstrate the diversity in countries' responses to growing health needs. The health-for-all strategy evaluations have shown the crucial need to increase countries' capacity. Participants in the consultation process should give their views of changing health situations in different countries and strategies in response to the health needs of populations during the next two decades.

II-4 INTERNATIONAL CAPACITY TO RESPOND TO COUNTRY NEEDS

NOTES TO PARTICIPANTS IN THE CONSULTATION

While major influences on health and their trends are very specific the international capacity to respond to country needs will have to continue to be flexible. First and foremost, WHO has not only changed its priorities internally but also its managerial approaches to meet country requests and priorities. Simultaneously, other agencies of the United Nations system have been giving more prominence to health and a large number of nongovernmental organizations and regional geopolitical and economic organizations are becoming valuable partners of countries in health development.

Participants in the consultation process should report how they view international support, in particular that of WHO, for their own capacity-building.

During the coming decades a growing number of countries will continue to need international support and the support of other countries experiencing similar situations. The effectiveness of, and motivation for, traditional multi- and bilateral technical cooperation during the last three decades has been questioned. Nevertheless, international health work has in recent years seen a welcome growth in support for national capacity-building from an increasing number of organizations. The amount of resources transferred is not the only indicator of success; even with small amounts of resources "quantum leaps" can often be achieved in countries, as was the case with the Model List of Essential Drugs and the partograph. The possibility for countries to adapt the experience of others to their own situations also indicates an effective, low-cost approach.

III POLICY FRAMEWORK

III-1 STRATEGIC PRIORITIES

NOTES TO PARTICIPANTS IN THE CONSULTATION

The purpose of this section is to outline the foundations of the new policy and the ultimate purpose of consultation. The findings of this process should not be preempted, and participants are therefore asked if the strategic priorities listed below can bridge the gaps in health development which remain after 20 years of implementation of health for all.

The overall purpose of the policy for equity, solidarity and health is to assist countries to determine their priorities, to make a selection from a large number of policy options, and to ensure that health has its place in development. To this effect, the policy proposes a focus on five strategic priorities:

- ◆ to **reduce poverty and its health consequences**;
- ◆ to ensure **equity of access to, utilization of and outcome of the health system**, with special measures for those most affected by inequalities, such as women;
- ◆ to secure the **place of health within the overall development framework**, including securing adequate, equitable and sustained **financing for health systems** based on primary health care;
- ◆ to ensure the availability of **newly acquired knowledge** whenever necessary and the **rational application of existing knowledge and technology** to the health development process; and
- ◆ to mobilize the **various actors in international health work** according to their mandates and capacities, within the framework of a coordinated country plan managed by the country and supported by WHO.

III-2 POLICY PRINCIPLES

NOTES TO PARTICIPANTS IN THE CONSULTATION

The purpose of this section is to determine the principles that will ensure changes over the next two decades on which the new policy of equity, solidarity and health can be based.

Participants in the consultation process are asked to review the following policy principles and reflect on their validity for international policy which will lead to the renewing of national policies.

The principles that have led countries towards health for all during the past two decades, creating opportunities that have stimulated a series of new public health concepts and paradigms, remain valid. The need to eliminate inequities, to ensure intersectoral, national and international solidarity for health action and foster the willingness to form new partnerships has led to the emergence of values and principles upon which the new policy should be based. In endorsing these principles the international community should direct financial and technical assistance to those countries in greatest need.

Health-for-all policies and implementation strategies should continue to be **country-specific** in view of the variety of health needs and problems, as well as the financial resources and human capacities available for meeting them. The achievement of health for all depends on political will and leadership not only in the health sector but also affecting government in the broader sense, as well as nongovernmental organizations, the private sector and society as a whole. Support from the international community must take these realities into account, much more than before; in particular, multi- and bilateral development assistance must reflect the needs and priorities of the recipient countries rather than the specific interests of the donors.

To translate health for all from concept to realizable goal, countries should redefine national and local approaches in terms of **reducing inequities** in health status, increasing access to primary health care and avoiding major health risks. Providing for demographic, political, economic, environmental and social influences on health in an effective manner requires an **intersectoral approach** in the context of human development. While intersectorality has always been a basic component of health for all and the primary health care approach, progress has been slow.

Countries should define and quantify the factors that determine the **sustainability** of progress towards health for all, particularly the **financial affordability** of their policies and their requirements in **human resources**. This implies devoting resources to local priorities and selecting the most effective measures for long-term development rather than short-term results; it also implies **accountability** of all those involved, measured by regular evaluation. A major investment must be made in public capability to regulate a plurality of providers and financing agencies. Recognizing that achieving health for all is a task for society as a whole, country policies and implementation strategies should provide for maximum **community participation**, beginning with national political, social and financial commitment. Clear policy and administrative guidelines must provide for the involvement of all concerned, including those at the periphery.

Health for all means "health by all" in a strong spirit of **solidarity of support and partnership** for policy development and implementation. Those responsible in the health sector will have a leading role in promoting the process and in providing technical information and guidance; health personnel must learn to work with colleagues from other sectors, and vice versa; **national political leaders** at the highest levels must attend not only to the needs of their own populations but also, in a spirit of international solidarity, to the challenges to health for all which transcend national boundaries. Health for all must also involve high-level **national policy- and decision-makers** from all economic and social sectors whose action impinges on health; leaders and representatives of **public opinion** at all levels, including religious leaders; professionals and academics in all spheres related to health; representatives of **local and national nongovernmental organizations** for social and economic development, with emphasis on activities for the poorest and most in need; and the **international community** of multilateral, bilateral and nongovernmental agencies whose goals include both the economic and social dimensions of human development.

Policy action is needed further to enhance **women's status**, providing them with basic knowledge and skills and access to services, and bringing them into the mainstream of development as equal partners.

III-3 MAIN POLICY ORIENTATIONS

NOTES TO PARTICIPANTS IN THE CONSULTATION

The new policy for equity, solidarity and health will follow fundamental orientations reaffirming health for all and emphasizing that health is a fundamental human right and a worldwide social goal. Yet the new policy approach, based on the results of 20 years of implementation of the strategy, should concentrate on furthering health for all, taking into account new problems and weaknesses that have been identified. To this effect, four main areas for action have been selected and summarized in this section.

Participants in the consultation process should analyse these areas with a view to furthering the goal of health for all, and determine what specific content may be incorporated to ensure that the global policy for equity, solidarity and health can be adapted to country or regional situations.

The eight essential elements of primary health care (education concerning prevailing health problems and the methods of preventing and

controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs) have served well as a guide during the last 20 years. Experience shows, however, that while new emphases have emerged, some elements are lagging behind, causing an imbalance in primary health care implementation. Furthermore, the successful achievement of some of the elements should enable governments to shift attention to other issues, such as the worldwide increase in the elderly population. Health policies must be extended beyond the health sector while continuing to be based on primary health care. The new policy should be strengthened through the four main areas for action outlined below: political action and advocacy for health; health protection and promotion; health system development, reform and management; and combating ill-health.

(A) POLITICAL ACTION FOR HEALTH

Owing to the concept of health for all, a better understanding has been gained of the crucial contribution health measures make to economic activity, to improving the human environment and to development as a whole. However, this recognition is not sufficiently clearly translated into adequate **political commitment** in most countries. Primary health care has to be translated into policies which not only define the role of the health sector and identify feasible resource commitments, but which accept **accountability for health** at the highest level of government. This commitment should encompass the reduction or elimination of health risks, particularly with respect to the most vulnerable population groups, and should specify the health-related goals of all sectors. Political commitment is dependent on technical leadership and the taking of initiatives by the health sector to define the health-related responsibilities of other sectors and promote health policy. It should also include an overall **financial strategy** for health development in countries, with the involvement of the ministries concerned, such as ministries of finance, planning, economic development, agriculture, trade and education.

The first challenge for WHO and Member States will be to achieve international consensus on the importance of **health in development** and to gain the support of the international community in terms of technical guidance and solidarity in pursuing it. This consensus will be translated into political action in countries through regulatory mechanisms for maintaining and protecting health; coordinated financial and technical cooperation for developing it; and the inclusion of health for all on the agendas of international summits.

The second challenge will be for those responsible in the health sector to assume a more assertive and confident leadership role in measuring and drawing attention to health effects and opportunities in the environment in which people live and work, and improving the capability to analyse the health effects of development activities, influence public policies relating to development, and affect decisions on resources.

(B) HEALTH PROTECTION AND PROMOTION

The risk that macroeconomic, agricultural, industrial, energy and trade policies conflict with the need to **protect the public by legislative, regulatory and, whenever necessary, fiscal measures** from the unhealthy side-effects of these policies continues to challenge policy-makers. Growing awareness of the contribution that lifestyles play in good health results in efforts to tackle the determinants of healthy lifestyles and good health. While healthy behaviour is not always a matter of personal choice and opportunity, reasonable influence can be exercised on individual ways of coping with and solving conflicts and fostering responsibility without blaming those affected. **Health education and promotion** widely publicizing the rapid positive effect on health of appropriate measures affecting lifestyle, such as abstention from tobacco use, improved oral hygiene, and safer sexual behaviour, will continue to be essential. In addition to immunization and other efforts to protect the health of children, including promotion of breast-feeding and safe weaning, the health sector must focus more on **primary prevention**. As better methodology becomes available, countries should reorient resource allocations towards strategies and programmes which meet the need to prevent ill-health, not only as an economical measure, but also as a way of limiting human suffering. Higher priority should be given to early action in schools and communities.

The health sector must develop better links with other sectors such as **environment, education and housing** through the expanded use of health impact assessment and monitoring, as well as participation in the formulation of specific health-related policies for each development sector, in order to prevent adverse health consequences of development activities and foster an environment "supportive" of health. The role of policy-makers and health specialists is to protect the health of populations, in particular the most vulnerable who may have little influence on their own surroundings. For example, **uncontrolled industrialization and trade** can create physical, chemical, biological and psychosocial conditions that cause short- or long-term health problems. **Disability** may result from a number of such disorders and from visual, hearing, locomotor or mental injuries. The implications of disability and injury for the health and related sectors should be more fully addressed

in many countries, especially those which are rapidly becoming industrialized, where disabled people are often condemned to poverty.

(C) HEALTH SYSTEM DEVELOPMENT, REFORM AND MANAGEMENT

The major challenge in strengthening health systems which eliminate inequities and which are sustainable, cost-effective and culturally relevant remains that of ensuring **access** to health for those groups most in need. While efforts for reform are under way in many countries, a number of key issues must still be addressed. In most countries, moves towards decentralization of health services are being made. A major obstacle is that encountered in reorienting resources from centralized, specialist curative centres to other levels of the system. Questions of **access, equity and ethics** loom large in relation to the development of **high technology** and **pharmaceuticals**.

Community involvement in health system development is a crucial principle of the health-for-all strategy. Programmes which redirect attention and resources to particular groups, such as the rural and urban poor, must be coordinated with communities in order to identify problems, develop solutions and enrol local support for implementation. Ownership principles dictate that programmes should emanate from within communities. Activities traditionally of the health sector should be redirected to others if the solution to health problems lies there, and vice versa, relying on the close human relations at the community level.

Better management in the health sector is fundamental to greater equity; more efficient administration, more accountability to the people and improved quality and performance of services are called for. A public health management information system is also needed. Major challenges exist in the area of **training, employment conditions and distribution of health personnel**; education and training in other sectors should take health into account, and the converse is also true. Reforms in the use of resources have been undertaken, but greater attention must be given to alternative mechanisms for financing delivery of health services which promote equity and take into account rational household expenditure for health care.

The **integration of specific programmes**, such as immunization, communicable and noncommunicable diseases control, nutrition and essential drugs, into health systems at the appropriate level should be ensured in accordance with epidemiological evidence and trends. Too often, especially in the least developed countries, a collection of vertical programmes financed entirely from external assistance provides fragmented and patchy coverage of local populations. One of the purposes of the present policy is to renew the interest of donors in tailoring bilateral programmes as closely as possible to the needs and circumstances of countries, with the

ultimate purpose of long-term strengthening of health systems; the identification of complementary needs in all components of the policy will create subjects for **research** and ensure that expenditure is relevant to the orientation of the new policy.

(D) COMBATING ILL-HEALTH

Improving **perinatal health** is the key to a number of developments. Childbirth is too often associated with maternal mortality, especially in the least developed countries. The improvement of antenatal, intrapartum and postpartum services is necessary to reduce mortality rates and ensure safe motherhood. Teaching parents to recognize symptoms, when to seek treatment and how to ensure hygiene, including that of food, will prevent many infant deaths, as will access to prompt clinical care and local advice. The provision of accessible **family planning** services will make a significant contribution to the health of populations as a whole. The increasing **elderly population** will require expensive services and drugs; new approaches will have to be found to maintain very old people's health and to provide them with social support enabling them to live full and independent lives.

Malaria will remain one of the major health problems. Early diagnosis and effective treatment, together with sustainable, cost-effective prevention methods are essential because of the development and spread of insecticide and drug resistance and difficulties in maintaining mosquito control. Approaches such as these and reduction in the cost of drugs will also assist in the control of other parasitic diseases wherever they are prevalent.

Communicable diseases must be continuously monitored for the resurgence of diseases, the emergence of new strains and resistance; for example, if tuberculosis control is not dramatically improved using prevention methods and the cost-effective standardized short-course chemotherapy strategies, and if compliance with treatment prescriptions is not ensured, incidence is expected to increase.

HIV infection and AIDS will continue to be a major health threat during the first decades of the twenty-first century, with the majority of cases in developing countries. A sustained integrated approach to the prevention of HIV and other sexually transmitted diseases will be needed, together with models of cost-effective clinical and community care, and related research.

For a number of locally prevalent diseases, systematic cost-effective measures may permit control at the local level. For example, those with communicable parasitic **eye diseases** will benefit significantly from low-cost cataract surgery, trachoma control and onchocerciasis control. Similar low-cost approaches, such as those for **oral health**, will improve other specific health conditions.

While measures to improve lifestyles and diet will contribute significantly to reducing **cardiovascular diseases**, it is likely that they will remain a major cause of death in the next decade. Other noncommunicable diseases may cause increasing problems if the difficulties experienced in modifying lifestyles are not overcome. Public health approaches to prevention, early detection and treatment, together with pain relief and palliative care, will become increasingly important for **cancers**. **Other chronic diseases** such as diabetes, chronic nonspecific lung diseases and chronic rheumatic diseases, are increasing throughout the world and require costly diagnostic and treatment measures. Cost-effective interventions and medication will be needed, as these diseases and disorders often require life-long treatment.

Mental health and neurological disorders will create increasing demands for clinical and community care, and are compounded by the problems caused by civil strife, social marginalization, the aging of the population and HIV infection, for example.

III-4 ASPIRATIONAL POLICY GOALS

NOTES TO PARTICIPANTS IN THE CONSULTATION

While detailed targets for the solution of health problems in countries or for realizing health programmes should be set at several levels (see section IV below), a number of aspirational goals may be adopted with the policy at the global level. Some of these goals are the result of international conferences whose conclusions are relevant to the new policy, or of international decisions to reduce or eliminate a number of health problems. Others may indicate the importance to be given to concerted effort in certain directions.

No goals are enumerated; participants in the consultation process are requested to give their opinion on the types of goals to set for the new policy, according to area¹.

¹ A few goals may be proposed by the Executive Board in January 1995 for adoption by the Health Assembly; in the meantime, ideas may be derived from targets and goals enumerated in the Ninth General Programme of Work, such as the following:

- at least 85% of the world's population will have access (within an hour's walk or travel) to the treatment of common diseases and to essential drugs and vaccines, biological products and blood products of good quality;
- all pregnant women will have access to prenatal care, trained attendants during childbirth and referral facilities for high-risk pregnancies and obstetrical emergencies; and
- the percentage of the population with access to sanitary excreta disposal facilities or services will be at least 75%.

IV FROM POLICY TO ACTION

IV-1 COUNTRY POLICY FORMULATION

NOTES TO PARTICIPANTS IN THE CONSULTATION

Once the policy for equity, solidarity and health is approved at the international level, and its main recommendations translated into national situations, individual Member States will select approaches specific to their social and economic situation and culture, and de-emphasize those which have been shown to be deficient during the past decade of implementing the health-for-all strategy.

Having selected their approaches Member States will follow a number of steps in policy formulation, thus ensuring that the main provisions of the policy are translated into their national or subnational contexts and implemented through the best combination of approaches.

This final component of the policy for equity, solidarity and health may appear merely managerial, yet lack of management has often been the major obstacle to the implementation of some of the best health policies in the world.

Participants in the consultation process will thus need to consider the following approaches and assess their feasibility in different country contexts, to ensure that they are implementable in their own situations.

(A) POLICY FORMULATION

In the light of the global policy framework each country will formulate its policy for equity, solidarity, and health, as follows:

- ◆ identification of demographic, political, economic, environmental and social factors which affect health, and related **trend analysis**, permitting assessment of health problems and needs and identification of the most vulnerable population groups, with emphasis on those without access to health care or whose access is seriously limited; policy orientations can then be determined;
- ◆ assessment of the prospect for change, including assessment of the available financial, human, physical and intellectual **resources**, with the contribution that representatives of the public sector and others can make in the formulation and implementation process, to give them a stake in the process and engender wide commitment to the policy;
- ◆ subsequent elaboration of targets for different levels according to policy orientation and specific to each situation, and serving to evaluate progress

towards attaining "aspirational goals" of the policy (during this process the need for setting standards may arise);

- ◆ accordingly, selection of the most appropriate **actions** applying the principles of equity, sustainability, and affordability, with mechanisms to monitor implementation – this will include definition of technical responsibilities of each sector in contributing to prevention, health protection and provision of access to health care, as well as personal responsibilities in implementation; the actions will be costed and the programme readjusted as a result – an essential element of this exercise will be to define the responsibilities at different political and administrative levels with regard to accountability for the health of the population;
- ◆ inclusion of these actions in the **national and local budgets** as the condition *sine qua non* for the implementation of the policy for equity, solidarity and health.

(B) APPROACHES FOR POLICY IMPLEMENTATION

Reaching consensus at the international level on the recommendations in a health policy is not enough. Adaptation of the policy to country situations will require its endorsement by all those concerned: politicians, specialists in health and other sectors, communities, professional groups, nongovernmental organizations and individuals – all are expected to collaborate in the implementation of the policy through the application of a number of approaches. This may mean the elaboration of new national or subnational policies; the updating of existing health policies; the reorientation of these policies or the inclusion of a number of activities ensuring the main country emphasis.

Specific country approaches taking into account political, economic and sociocultural aspects, as well as managerial traditions, will have to be devised for:

- ◆ **policy issues** such as: health-for-all financing, including resource allocation policy, both within the health sector and as a proportion of the national budget for health for all; funding and commissioning of decision-oriented research; the responsibilities of the health sector with respect to technical collaboration with other sectors and the implementation of their policies; decentralization and support from national and regional levels; personal, household and community responsibilities and mechanisms for participation;
- ◆ **management issues** such as: optimizing the use of health-sector resources, including economic analysis and resource management; accountability; strengthening provincial and district health systems; management of all services and institutions, including the appropriate integration of disease prevention, control and curative services, with supervision and quality control and management information systems

that can, *inter alia*, indicate risk groups and permit reductions in inequities;

- ◆ **intersectoral issues** such as: advocacy and promotion of health as a condition for development, with appropriate policy-making and planning; analysis of the impact of development activities in all sectors on health status; monitoring of health status in relation to environmental conditions and specific measures such as those for urban health, and related indications.

IV-2 INTERNATIONAL PARTNERSHIP

NOTES TO PARTICIPANTS IN THE CONSULTATION

The growing involvement of the United Nations system, other inter-governmental and nongovernmental organizations in action for health development at the international and national levels makes them interested partners for countries. While the richest countries make sophisticated use of these organizations for international information exchange, as well as standard-setting, less developed countries are sometimes not as well prepared for coordinated action.

Part of the purpose of the policy for equity, solidarity and health is to foster international solidarity and partnership with the main thrusts identified here, and ensure their coordinated implementation in countries' development. The purpose of this section is to determine the capacity of different agencies for support, and to stress WHO's key role in coordinating support for health aspects of development in individual countries.

It is the responsibility of the international community to ensure that the importance of health in overall social, political, cultural and economic development is reflected in the policies of all sectors, both as an effect of progress and as a stimulus for change.

A growing number of countries will need external support before they are able to achieve autonomy in health development. However, international resources for development are scarce, and it is therefore essential to **optimize support** through the application of rational mechanisms. Creating common aspirations, goals, targets and approaches for all concerned in adopting a worldwide health policy is a step in this direction.

(A) ROLES OF INTERNATIONAL PARTNERS

Reaffirmation of WHO's mission and that of other agencies concerned with health, and redefinition of their cooperation in support to countries

for health development, are essential to the implementation of the policy. Strengthening management capacity at country level to absorb accelerated action entails renewed efforts to ensure that health priorities are matched by the international resources allocated, both financial and human. All members of the United Nations system, the Bretton Woods institutions, the regional development banks, international organizations, nongovernmental organizations, agencies in the private sector and others have recognized the importance of country-level management for health development, and should thus ensure that **their policies and programmes are implemented in accordance with the priorities of the country policy and in close collaboration with national programmes**. While the motivations of these different partners may vary, their **comparative advantages** and **various mandates** must be recognized and respected, so that social responsibility compels them to coordinate their action. If overlapping is to be avoided, the mandate of WHO in the coordination of international health work is to be respected. Regular policy consultation aimed at exchange, rather than formal mechanisms, should be a feature of such a cooperative endeavour. Throughout the past 20 years international conferences shaping consensus on health development issues have contributed to this preference; however, working mechanisms may still need to be strengthened.

Mandates and *modus operandi* vary considerably. **The United Nations system** has been created to promote global peace and reconstruction and human development. WHO, according to its constitutional functions, acts as the directing and coordinating authority on international health, and maintains effective collaboration with the special agencies and bodies like UNICEF. Some of the organizations, such as UNESCO and ILO, have mandates mostly outside the health sector, yet in recent years their activities and their involvement in health have been increasing, as has the role in health development of the Bretton Woods institutions. Other organizations of the United Nations system have functions in the health field, and a number of different programmes and funds also have large health components and contribute to country health development with technical cooperation, advice and information. Other international agencies are increasingly important sources of technical assistance and policy research, as well as development financing. A number of regional political and economic groupings and regional banks have been drawn into the health sector by its political significance and the amount it spends. The bilateral agencies are crucially important partners for many countries, as they provide financial resources, as well as information.

Nongovernmental organizations, whether national or international, are often unsurpassed in their ability to work closely with communities. They have become most important to the health development process and in-

deed unique in certain health sectors where their independence is an asset for national and local authorities. While they command a total of resources greater than those of the entire United Nations system, these will only be effectively used if activities are properly coordinated by countries.

The combined strength of all international organizations dedicated to health development is impressive. Their ability to advance the policy for equity, solidarity and health is also a complementary factor; countries should organize and maximize international support in implementing their policies.

(B) RESTATING WHO'S MISSION

At the international level, the advocacy role of WHO in fulfilment of its mandate, and its promotion of the principles of this policy and coordination of its implementation, are essential if consistent application at the country level is to be assured. The function of WHO as the authority for the direction and coordination of international health work, and its technical cooperation function, should accelerate progress in relation to the three principal gaps identified in the health-for-all evaluations: by combating **poverty and the barriers to access to health** which it creates; applying the **overall economic development** framework and related measures for **health system financing**; and remedying **the failure to apply already available knowledge** to health development. This will involve the more consistent application of its established mechanisms for a country-based, bottom-up approach and a renewed commitment to catalysing, supporting and coordinating health cooperation and collaboration among countries and with other partners for health-for-all policy renewal and implementation.

Within this framework WHO's mission will be to:

- ◆ support Member States in **renewing their health-for-all policies** to take account of the major health challenges which they must address in the coming 25 years;
- ◆ **ensure technical cooperation** with Member States in defining their strategies **for policy implementation**, with renewed emphasis on building and strengthening capacity to further develop and implement their specific activities (capacity-strengthening will focus on countries which cannot attain self-sufficiency in the health field);
- ◆ **undertake normative functions**, i.e., set standards, in support of the policy, to ensure global accountability for health, including the monitoring and evaluation of this policy; disseminate and exchange information, including the results of research and development for new tools and approaches to achieving health for all, which will be crucial to WHO's role in implementing the new global health policy;

- ◆ **promote and coordinate effective support** for health for all by **the international community**, including partnership-strengthening and resource mobilization, and undertake global monitoring, with international partners, of the progress made in implementing the policy.

WHO's mission will be kept regularly under review by its governing bodies, and implementation will be crystallized every six years in the General Programmes of Work. Shorter-term implementation through programme budgets, based on country needs, will ensure that the tasks are matched with country health realities.

A review of the performance of WHO programmes since the beginning of the health-for-all strategy's implementation shows that the Organization has demonstrated a capacity to adapt and respond to changing demands thanks to its own and countries' mechanisms to revise national policies and programmes and ensure that the activities under the WHO programme budget are relevant to country needs. The Organization will keep under review its managerial process to ensure that direct support to Member States is appropriate.

Special care will be taken during all discussions in WHO governing bodies to keep under permanent review the major issues identified in the policy, i.e., reduction of inequities in health, accountability of all national and international partners, participation and solidarity.

V CONCLUSION

The success of the implementation of the policy for equity, solidarity and health will depend on the extent to which Member States and others concerned recognize the urgency of tackling the formidable challenges of ill-health and inequity. The vision of the policy is ambitious and the difficulties are daunting, yet the hope to attain health for all is such that the elaboration of this new policy poses a moral imperative; ambitious as well is the commitment to bring all partners together in support of its implementation. In spite of the formidable nature of the task, WHO will pursue for all peoples the highest attainable standard of physical, mental and social well-being as one of the fundamental human rights.

PROPOSED TIMETABLE FOR FORMULATING THE NEW GLOBAL HEALTH POLICY

DATE	MEMBER STATES	WHO GOVERNING BODIES	WHO SECRETARIAT
Jan. 1995		Ninety-fifth Executive Board session: review of the proposed consultation document and report to Forty-eighth World Health Assembly	
May 1995		Forty-eighth World Health Assembly: review of the proposed consultation document and advice on process with Member States	
May to Sept. 1995	Set up/strengthen mechanisms in countries for the consultation process ¹		After Forty-eighth World Health Assembly, Director-General to initiate consultation process with Member States, United Nations agencies, intergovernmental and non-governmental organizations Briefing of WHO staff at all levels on content and methods for reviewing of health-for-all strategies
June 1995			Finalization of the consultation document, as amended by the Executive Board and the Health Assembly, as well as methods to be used; creation of special mechanisms as may be desirable and issue guidance

1. Examples by which this could be achieved include: a retreat by cabinet ministers to discuss the new policy; special sessions or discussions in national assemblies or parliaments; inter-ministerial/Intersectoral committees or structures for policy formulation and implementation; establishment of "think tanks" to consider various aspects of the new global health policy; etc.

DATE	MEMBER STATES	WHO GOVERNING BODIES	WHO SECRETARIAT
Autumn 1995		WHO regional committees: review of consultation document and ways of formulating regional policy	Regional Directors' reports to regional committees on approaches to policy formulation and WHO support
From Sept. 1995	Review of national policies, strategies and plans of action for health for all, review of analysis and projections, national groups to consider the new policy and WHO's mission in support of it		Meetings, seminars, workshops and similar activities with regional and subregional organizations; United Nations agencies, other international and nongovernmental organizations
Jan. 1996		Ninety-seventh Executive Board: review progress in formulating new global health policy and consultation process and report to forty-ninth World Health Assembly	
Throughout 1996	Consultation process in Member States, with other international and nongovernmental organizations		Provision of support to Member States during the consultation process
May 1996	Report on progress at World Health Assembly	Forty-ninth World Health Assembly: review progress in formulating new global health policy and consultation process in Member States	
Jan. 1997		Executive Board: review progress in the elaboration of proposed global policy and report to Fiftieth World Health Assembly	
Feb. 1997	Member States' contributions to the policy and views on WHO's mission forwarded to WHO Secretariat, as well as those of other international and nongovernmental organizations		

DATE	MEMBER STATES	WHO GOVERNING BODIES	WHO SECRETARIAT
Feb. to June 1997			Regional drafting groups and development teams: consolidation of replies from Member States and preparation of information relevant to the formulation of regional policies
May 1997		Fiftieth World Health Assembly: review progress	
June to Dec. 1997			Elaboration of the new global health policy
Autumn 1997		Regional committees (optional): review of draft regional policy	
Oct. 1997	Participation in regional preparatory conferences to review/adopt policy (can be linked to regional committees)		Presence at regional conferences
Oct. to Dec. 1997	Initiate action to obtain commitment at highest governmental and political levels for the policy		Policy development team: consolidation of new global policy
Jan. 1998		Executive Board: final review of the proposed new global policy and report to the Health Assembly	
May 1998	Country reports to Fifty-first World Health Assembly	Health Assembly: at a special event connected with the Assembly, adoption of resolution in support of policy and charter	
Continuing from June 1998 onwards	Development or reorientation of national plans of action, and implementation of the national, regional and global policies with WHO support	Periodic progress reviews and evaluation by regional committees, Executive Board and Health Assembly	Continued technical cooperation and support to national, regional and global action to implement the policy

DATE	MEMBER STATES	WHO GOVERNING BODIES	WHO SECRETARIAT
Summer 1998	Comments on Tenth General Programme of Work		<p>Director-General to consult with other executive heads on United Nations response to charter</p> <p>WHO to host meeting of international community to agree policy and strategy for support to health for all, particularly in countries in greatest need</p>
Sept. 1998		Regional committees: review of policy implementation; regional response to charter; review regional budget 2000-2001	
Jan. 1999		Executive Board: review Director-General's report on orientation of Secretariat to implement new policy, Tenth General Programme of Work, and budget 2000-2001 (transitional)	<p>Submission of report on reorientation of Secretariat, draft Tenth General Programme of Work and draft budget 2000-2001</p> <p>Director-General to request high-level political commitment starting with national health-for-all progress review on World Health Day 1999</p>
April 1999	World Health Day health-for-all reviews are initiated		ACC agrees United Nations response to charter and content of response to ECOSOC
May 1999		Fifty-second World Health Assembly: theme of transition to the new millennium; adoption of Tenth General Programme of Work; approval of budget 2000-2001	
July 1999			Director-General to report to ECOSOC
Sept. 1999		Regional committees: adjustments to regional plans and preparations for the year 2000	

