

**KEY ISSUES IN
HEALTH FOR ALL
RENEWAL:**

**Technical Seminars
1996-1997**

**Policy Action Coordination Team
(PAC)**

World Health Organization

Geneva



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PREFACE

This document is intended to give an overview of a series of technical seminars on the broad topic of Health for All presented at WHO in 1996 and 1997. The series of seminars was organized within the framework of the initiative for Renewal of Health for All, and as part of the consultations and debate leading to the development of the new global health policy for the twenty-first century.

The seminars, held mainly informally during the lunch hour at WHO, were given by a number of eminent speakers in specialist fields of public health from a wide range of national and international institutions throughout the world. They invariably attracted a large audience of WHO staff from the whole spectrum of technical programmes, as well as representatives of Geneva-based missions to the United Nations.

The topics chosen covered a wide public health field, including public health training and human resource development, public health legislation and health care financing. They also focused on priorities for health research, technologies for health and health policy and planning tools. Of more specialized interest were the seminars on burden of disease studies and new technologies for the control of communicable and non-communicable diseases.

It is hoped that this series of technical seminars will serve to stimulate active debate on the process of Health for All Renewal, and lead to more informed discussion and involvement in the development of the new global health policy, as well as commitment to its implementation.

EQUITY IMPLICATIONS OF INCREASING NON-COMMUNICABLE DISEASES FOR FUTURE HEALTH POLICY

20 September 1996

Moderator: Dr D. Yach, Chief, Policy Action Coordination Team, WHO

Presenter: Dr. D. R. Gwatkin, Director International Health Policy Program, Washington

- Diseases are not equally distributed among different populations. By comparing the burden of disease for the poorest billion people in the world, the richest billion people in developing countries, and the richest billion people in all countries, significant differences can be observed.
- 54% of the poorest billion die of communicable diseases. For the richest billion this percentage is 10 %. For communicable diseases these percentages are respectively 40% and 81 %.
- Consequently, health gains through reduction of communicable diseases, or health gains through the reduction of non-communicable diseases will have different impacts among (global) income groups.
- A reduction in the current burden of non-communicable diseases could be particularly beneficial for the richest populations of the world. A reduction in the current burden of communicable diseases would result in more health gains for the poor, and, from a global perspective, reduce inequity. The longterm implications require further study.
- The age distribution between the richest billion people and the poorest billion is different. About 40% of the poorest billion are children (under 15 years), while only 20 % of the richest billion are children. Since communicable diseases particularly affect children, a reduction in communicable diseases will have particular impact on this group.

NEW TECHNOLOGIES IN MALARIA CONTROL

10 October 1996

Moderator: Dr M. K. Behbehani, Director, Division of Control of Tropical Diseases, WHO

Presenter: Dr D. le Sueur, Principal Investigator, National Malaria Control Programme, Medical Research Council, South Africa

- Malaria is one of the major global health problems, with an estimated 2.1 million people dying annually as a direct result of malaria infections. In addition, it is an important contributor to anaemia and malnourishment. Malaria is not equally distributed. More than two thirds (1.5 million) of the deaths are children under the age of five years. Populations in sub-Saharan Africa are particularly at risk of contracting malaria.
- Scientific progress and new technologies such as, information and communication, offer new opportunities for future control. An innovative programme was recently launched: the MARA (Mapping Malaria Risk in Africa) initiative. In this programme data from a wide variety of sources and models will be utilised to plot malaria on the map of Africa by establishing a so-called geographical information system.
- Such a system will enable researchers and policy-makers to have access to relevant information in the control of malaria. It will enhance the quantification of malaria risks and the understanding of malaria epidemiology. It provides a base for the integration of data for further research and planning on all aspects of malaria, and will facilitate the implementation of large scale interventions.
- This geographical information system is set up in collaboration with regional and international partners and is an example of the application of "hi-tech" approaches to solve the problems of the rural poor. Information will be made available to national, regional and international organizations. Furthermore, it can be integrated with other health issues, and used to construct a disease or health atlas for targeted geographical areas.

GLOBAL HEALTH THREATS: THE ROLE OF INTERNATIONAL LEGISLATION AND OTHER INSTRUMENTS

29 October 1996

Moderator: Dr N. P. Napalkov, Assistant Director-General, WHO

Presenters: Dr D. Bettcher, PPE/PAC, Mr N. Collishaw, PSA
Mr S. Fluss, HPD

- The implications of globalization, in terms of increased transnational trade, travel and migration, can be both a threat and an opportunity for health. Globalization will influence the distribution of communicable diseases and the trade and consumption of tobacco and other harmful products. However, globalization can also facilitate the transfer of technologies, knowledge and ideas, and boost the introduction and implementation of concepts such as "health as a human right".
- To ensure that the opportunities of globalization are optimally used and the negative implications minimized, legislative and regulative mechanisms have to be developed. Good examples can be found in the past, both in the domain of public health (International Sanitary Regulations) and in the area of international trade (Codex Alimentarius). However, it is important in this context to assess how new mechanisms, such as international tobacco conventions, can be implemented and enforced, and what their real impact is. Furthermore, it is critical that early warning systems are in place, targeting not only emerging infectious diseases but also other health hazards.
- International instruments and legislation related to human rights, violence against women, and child labour have established these topics high on the international agenda. It is now crucial to review the experience of WHO programmes and other UN bodies in this field and to explore how these tools can support public health objectives in the future.

THE HFA TARGETS EVALUATED IN THE NETHERLANDS: LESSONS FOR THE FUTURE

31 October 1996

Moderator: Dr T. Mertens, Chief, Development of Programme Evaluation,
WHO

Presenters: Dr H. van de Water, TNO Prevention and Health, The
Netherlands.
Dr L. van Herten, TNO Prevention and Health,
The Netherlands

- The Health for All Strategy of WHO Europe has been an important stimulus for the development of new policies in the Netherlands, and, inter alia, resulted in new research programmes on equity, and a strengthened focus on prevention.
- The (EURO) targets set for the HFA policy are, however, too ambitious. This applies particularly to the ultimate targets, the targets that are directed towards the reduction in mortality and morbidity. One of the reasons is that the setting of targets has been influenced by political desirability, more than by scientific considerations.
- The Evaluation report in the Netherlands reveals that not one target will be achieved in the year 2000, and that only about a quarter of the targets will be partially achieved. For about one half of the targets no conclusions can be drawn, because they are not adequately operationalized.
- The setting of targets is still important, because it requires a sound analysis of the health of the population, and an explicit discussion of the policy and strategies. Furthermore, it supports priority setting and facilitates a more concrete evaluation
- It is however important for targets to be achievable, even when these are set for motivational purposes.

HEALTH IN SUSTAINABLE DEVELOPMENT: EXAMPLES FROM AGRICULTURE

19 November 1996

Moderator: Dr W. Kreisel, Executive Director, WHO

Presenter: Dr M. F. Gomes, Division of Control of Tropical Diseases, WHO

- Development projects, like many other capital investments may have an unintentional impact on health, and particularly on tropical disease incidence. However the links between these projects (agriculture, forestry) and disease morbidity and mortality are complex. There are still many gaps in our knowledge, and more quantitative data are required to fill these gaps, if appropriate policies are to be developed.
- A Task Force on Tropical Diseases & the Environment has been established to quantify the health risks from new agricultural and agro-forestry investments, and to develop methods to evaluate health outcomes, and internalize these costs in the appraisal phase of new projects and investments. This will also facilitate the assessment of the real rate of return, in which health costs should be included.
- There are many examples from all over the world, in which agriculture and forestry projects have had a significant adverse impact on health, e.g. where teak plantations increased the local incidence of malaria substantially. Knowledge of the habitat of disease vectors is essential to forecast the effect of these projects.
- Cooperation with the agriculture sector, presentation of quantifiable data and an assessment, including the health costs, are required in an early stage of the project appraisal process, at least before the capital investments are made. Furthermore a continuous dialogue with the investment banks, and consideration of the incentives of those who make the investments, are necessary to prevent much of the unintentional health damage done by some of the development projects.
- Ongoing discussion about how to ensure that health policies are more firmly linked to sustainable development is required at WHO.

MAJOR FINDINGS AND RECOMMENDATIONS OF THE AD HOC COMMITTEE ON HEALTH RESEARCH RELATING TO FUTURE INTERVENTION OPTIONS

10 January 1997

Moderator: Dr K. Janovsky, Division of Analysis, Research and Assessment,
WHO

Presenter: Dr T. Godal, Director, Special Programme for Research and Training
in Tropical Diseases, WHO

- The Ad Hoc Committee on Health Research Relating to Future Intervention Options has utilized a five step model to develop a relevant base for resource allocation for health research. Each step constitutes a question that needs to be answered:
 - Step 1. How big is the health problem?
 - Step 2. Why does the disease burden persist?
 - Step 3. Is enough known about the problem now to consider possible interventions?
 - Step 4. How cost-effective will these interventions be? Can they be developed soon and for a reasonable outlay?
 - Step 5. How much is already being done about the problem?
- ▶ Step 1. To estimate the magnitude of the health problem, the Burden of Disease Study gives useful information. The study forecast that, mainly as a result of changes in demographic and risk factors, a substantial shift in disease pattern can be expected in the coming decades (see annex 1). The rise of noncommunicable diseases, particularly in developing countries, is of concern.
- ▶ Steps 2 and 3. In order to facilitate the response to these questions the Ad Hoc Committee has developed a matrix for health research, identifying four broad content areas, requiring further research, and distinguishing which three types of research are most relevant to each area (see annex 2).
- ▶ Step 4. In order to get the best value for money, cost-effective analysis is an essential tool in the process of resource allocation. Studies reveal that the differences in the magnitude of cost-effective ratios are often so impressive, that more detailed studies are not needed for decision making.

- ▶ Step 5. Currently there is a significant mismatch between the percentage of funding for a specific disease and its contribution to the total burden of disease. Particularly diseases that are solely prevalent in developing countries are underfinanced. E.g. Pneumonia and Diarrhoeal Diseases constitute 15.4 % of the total global disease burden, but only 0.2% of the total global R&D spending (1990).
- Unfortunately, over the last decade, a negative trend emerges both in funding for health R&D investment for low income countries (compared to the total global Health R&D investment) and in financing the health sector in these countries through bilateral and multilateral support (although it should be noted that the funding for Water and Sanitation has increased during the same period).
- The Ad Hoc committee has recommended six initiatives to further the results of their report (see annex 3). The initiative for Health Policy Research and Training has already resulted in the funding and creation of a project for health sector reform initiatives. In this project, five areas of research are identified, covering different aspects of health sector reform (see annex 4)
- The report was regarded by many as an excellent effort to set a future agenda for health research. The emphasis has been very much on measurements relating to disease. It was suggested that in the future health in a broader context should be the starting point, and as a consequence, research and interventions in environmental health, social and behavioural (health promotion) areas, and so on, should be included as well. Particularly, the cost-effectiveness analysis of interventions to address risk factors and determinants would represent an important part of that agenda.

Annex 1 - Ranking of diseases according to their contribution to the global Burden of Diseases (in Daly's)

| 1990 | Rank | Rank | 2020 |
|------------------------------|------|------|------------------------------------|
| Lower respiratory infections | 1 | 1 | Ischaemic heart disease |
| Diarrhoeal Diseases | 2 | 2 | Unipolar major depression |
| Perinatal Conditions | 3 | 3 | Road traffic injuries |
| Unipolar major depression | 4 | 4 | Cerebrovascular disease |
| Ischaemic heart disease | 5 | 5 | Chr. obstr. pulm. disease |
| Cerebrovascular disease | 6 | 6 | Lower respiratory infections |
| Tuberculosis | 7 | 7 | Tuberculosis |
| Measles | 8 | 8 | War |
| Road traffic injuries | 9 | 9 | Diarrhoeal diseases |
| Congenital anomalies | 10 | 10 | HIV |
| Malaria | 11 | 11 | Perinatal conditions |
| Chr. Obstr. pulm. disease | 12 | 12 | Violence |
| Falls | 13 | 13 | Congenital anomalies |
| Iron-deficiency anaemia | 14 | 14 | Self-inflicted injuries |
| Protein-energy malnutrition | 15 | 15 | Trachea, bronchus and lung cancers |

Annex 2 - Matrix of broad areas of health research and the different types of research required

| | Strategic Research (inadequate knowledge base) | Intervention Development (Inadequate tools) | Policy Related Research (Inadequate use of existing tools) |
|---|--|---|---|
| Unfinished agenda of MCH | | ++ | +++ |
| Microbiological threats | +++ | ++++ | + |
| Noncommunicable diseases | ++ | | +++ |
| Inequities and inefficiencies in health systems | | ++ | +++ |

Annex 3 - Initiatives proposed by Ad Hoc Committee to further the report

1. Initiative for Health Policy Research and Training
2. Initiatives on Steps to Inform Resource Allocation in R&D for Health
3. Initiative against Injuries and Violence
4. Initiative on Noncommunicable Disease and Healthy Aging
5. Initiative for Collaboration between Public and Private Sectors
6. Global Forum on Health R&D

Annex 4 - Health sector reform initiatives

Topic 1: Hospital reform - autonomy, regulation, fee retention and exemption mechanisms

Topic 2: Decentralization - impact on cost sharing, equity, efficiency and the quality of care

Topic 3: Health insurance and managed care - impact on cost containment, quality and access

Topic 4: The behaviour of private providers and regulatory implications

Topic 5: The process of policy formulation and decision making

HEALTH FINANCING IN DEVELOPING COUNTRIES: ISSUES, EVIDENCE AND OPTIONS

28 January 1997

Moderator: Mr A. Creese, Division of Analysis, Research and Assessment, WHO

Presenter: Professor D. T. Jamison, Professor of Public Health and of Education, University of California, Los Angeles

- Professor Jamison presented work in progress by Dr. R. Feachem and himself. He emphasized that country data on health outcomes and lessons learned from OECD countries could be utilized to guide policy-makers in developing countries in choosing between options to finance the health care system. Analysis of the performance of health systems in different countries over a long timespan reveals important information. He mentioned the need for good data, particularly on financing, which is unfortunately often lacking in low income countries.
- Two trends were clearly visible in countries that are developing (increasing their income per capita):
 - ▶ When income (or Gross National Product) per capita increases, the percentage spent on health care tends to increase as well. In general, more public spending on health care also seems to take place.
 - ▶ When income rises, in most countries prepaid financed systems are favoured at the expense of "out of pocket" health spending. In OECD countries, for instance, 80-90% is currently spent through such prepaid schedules.
- Performance of health systems can be assessed by analysing how well countries do during a certain year, in terms of health outcomes (under 5 mortality rate, male adult mortality rate, female adult mortality rate and fertility rate), taking into consideration their GNP and educational level. By comparing the performance of a certain country to the standard (calculated through statistical regression), conclusions about the financial system could be made.

- Three policy dimensions can be distinguished, for which crucial decisions should be made, based on evidence. They have important consequences for the costs and performance of health care systems:
 1. As a result of the increase of prepayment preference in countries that are growing in economic terms, the basic question will be what kind of prepayment schedule will be developed; private or public. According to the presenter, publically financed systems have been significantly more successful in containing costs and achieving health gains.
 2. Prepaid schemes reduce the risk for the consumer (1st party). They transfer the risk to the government or to insurance companies (3rd party), resulting often in a rapid increase in costs. A better option might be to divert some of the risk to the providers (the second party), e.g. in the form of capitation payments. This could ensure that in the decision-making process of health service delivery, costs are still taken into consideration. However these 2nd party entities should be big enough to share such a risk.
 3. Health care markets are not really competitive markets. This would require complete information on both sides (provider and consumer). Nevertheless competition between providers should be stimulated, for instance in a capitated system, that gives, when required, the necessary information (e.g. on provider performance) to consumers. Such a system would welcome the private sector, but within a framework of strong government regulation and a publically financed system.

ARE SCHOOLS OF PUBLIC HEALTH READY FOR THE 21ST CENTURY?

7 February 1997

Moderator: Mr O. Adams, Division of Organization and Management of Health Systems, WHO

Presenter: Dr E. de Leeuw, Secretary General, Association of Schools of Public Health in the European Region

- Within the European Region there are enormous differences between schools of public health in size, staff and curricula . This is a result of the wide definition of public health (in some countries the training of community nurses is regarded as public health education) and the absence of a strict accreditation procedure. Several types of schools can be identified (see attached article). Some schools stand on their own, others are fully supported by and accountable to the ministry of health or education.
- Schools of public health should strive to become both centres of excellence (focus on academic integrity, independence, international standards and fundamental research) and relevance (focus on societal integrity, interdependency, local standards and applied research). Type 6, in which the Ministry of Health designates multi-schools programmes in a university as the national school of public health, and 8, the equivalent of the accredited school of public health in the US, meet these criteria best.
- Crucial for the schools is how they respond (through the courses that are offered) to the concept of new public health. A global study has revealed that there are significant regional differences, both in the emphasis of the educational programme and in the mission of the school, which was strongly associated with the profile of the dean.
- Although many schools are now developing broader curricula than the traditional focus on epidemiology and diseases, and preparing themselves for the new challenges ahead, the public health sector consists to a large extent of professionals that have no specific training in public health. Consequently the Schools may not be the driving force in public health. It may therefore be important to sensitize other educational institutions for training programmes in public health.
- There is an uneven distribution of Public Health schools over the world. Africa, in particular, is underserved, often resulting in local staff taking courses in Europe and the US. Priority must be given to strengthening local capacity in developing countries. This seems through the use of modern communication technologies more feasible than ever before.

ESSENTIAL PUBLIC HEALTH FUNCTIONS: A NEW INITIATIVE IN SUPPORT OF HEALTH FOR ALL IN THE 21ST CENTURY

13 February 1997

Moderator: Dr R. H. Henderson, Assistant Director-General, WHO

Presenter: Dr S. Sapirie, Chief, Strengthening Country Health Information, WHO

- The formulation of Essential Public Health Functions is a new initiative in support of the Renewal of Health-For-All. The aim is to incorporate this concept in the overall HFA policy for the 21st century, and to support the setting of performance standards for use in countries.
- A wide range of evidence is available indicating that when certain critical functions are not performed adequately, this may result in increased morbidity and mortality and considerable human suffering. Furthermore, rapid changing epidemiological, environmental, technical and organizational conditions, and the effects of health system reform (including privatization) make it necessary to define a set of functions that are so crucial for the overall performance of a health system that their performance needs to be ensured by the state.
- "Essential" refers to the importance and cost-effectiveness of the functions in maintaining and improving the health of populations. Consequently, the role of the government needs to focus on facilitating and ensuring that these functions are implemented at a certain performance level. The actual implementation may take place by, or in cooperation with NGO's, the private sector and the community.
- The current categorized list of functions extends across health system functions and includes some types of primary health care. There was agreement that overlap with PHC is inevitable, and that separate categories of functions may be needed to clarify the difference between health system maintenance, public health services and medical care.

TECHNOLOGY FOR HEALTH IN THE FUTURE

20 February 1997

Moderator: Dr A. E. Wasunna, Director Programme on Health Technology, WHO

Presenter: Dr D. Wyper, Department of Clinical Physics and Bioengineering, Southern General Hospital, Glasgow

- Technology itself, along with an adequate technology management policy has the potential to make a significant impact to reduction of the burden of disease in the coming decades. Importantly, technologies for health encompass not only devices, drugs and procedures but also the knowledge that is associated with them, as well as environmental and information technologies.

Although it is crucial to actively assess the potential of current and future technologies, the need for a certain technology should be the driving force.

- Two broad areas may be distinguished that require special attention:
 - ▶ First, many technologies are, though available, not utilized adequately. Several barriers were identified that hamper the implementation of current technologies. These need to be addressed. In this context, it may be beneficial to identify those technologies that are essential, in terms of cost-effectiveness and importance, and on the implementation of which health systems should focus.
 - ▶ Second, in order to facilitate the emergence of new technologies that decrease human suffering substantially, it is crucial to formulate a sound research and development policy. Priority setting, in order to direct funding for future technology development, should be based on clear criteria like cost-effectiveness and appropriateness.
- Broad partnerships should be established with academia, NGO's, the private sector and consumers, which would be mutual beneficial. Furthermore, it is vital for WHO to operate in a proactive manner, and systematically assess emerging technologies and their impact.

IS PRIMARY HEALTH CARE THE VEHICLE THAT WILL BRING US HEALTH FOR ALL IN THE 21ST CENTURY? DO WE SEE NEW DIRECTIONS?

12 March 1997

Moderator: Dr D. Mukarji, World Council of Churches, Geneva

Presenter: Dr E. Tarimo, Director, Division of Analysis, Research and Assessment, WHO

- Primary Health Care originally emerged from the analysis of what was happening in the health sector in the different regions in the 70s. The PHC movement has been responsible for a tremendous ideological shift: A shift from curative to preventive care, from hospital care to community care and public health, and from urban to rural health care. Furthermore, it linked health to its determinants, often outside the health sector, and it emphasized the responsibility of people for their own health, through the decentralization of health services and political power.
- The Primary Health Care strategy has resulted in significant health gains. Though it may have lost some of its appeal in international organizations, it is still effective and alive at the country and subnational levels. However, globalization, and the favouring of market economies and privatization, urbanization and changing disease patterns may make it difficult to sustain gains, which justifies a radical rethinking of Primary Health Care.
- There are three important directions, relating to both Primary Health Care and the Health-For-All policy, that need to be highlighted:
 - ▶ The Health-For-All goal should not be attached to a certain timeframe. Health-For-All is needed now, and the challenge is to assist those countries that fail to achieve this goal.
 - ▶ Unfortunately, a population-based approach has not been as successful as was expected. The concept of healthy villages or healthy communities could constitute a new stimulant to mobilize populations.
 - ▶ It is vital to define the roles of all stakeholders and partners. The successful implementation of PHC would require a social contract for partnership, enhancing a consolidation of efforts and global support.

DEVELOPING HUMAN RESOURCES AND LEADERSHIP FOR INTERNATIONAL HEALTH

13 March 1997

Moderator: Dr M. J. Hirschfeld, Health Systems Development Programme, WHO

Presenter: Dr U. Panisset, Associate Director, WHO-Collaborating Center for International Health, University of Texas Medical Branch

- Though transnational health phenomena (e.g. the cholera epidemic in Peru) influence the international relations of a country, most governments are not adequately prepared to participate in intricate negotiations over these health issues, and are often excessively dependent on international organizations for their resolution. However, the distribution of state and economic power at the international level affects the health situation of populations.
- In order to facilitate the analysis of these phenomena, an analytic framework is proposed in which the domestic manifestations (the cholera epidemic itself affecting the health of the Peruvians) and the international manifestations (consequences for trade, travel, and policy negotiations) can be identified and examined. The superposition of these two realms (called the "International Dimensions of Health" and "Health as an International Issue") are the subject of analysis and determine the International Health outcome. The use of the two realms helps to give a sense of space, direction, and timing of the phenomena.
- Five fundamental conclusions can be drawn from case studies such as the Peruvian cholera epidemic:
 - ▶ International health phenomena require a high level of decision-making, preferably through an organizational structure that addresses international health.
 - ▶ A broad range of organized sectors of civil society should participate in such an effort.
 - ▶ A health intelligence system should be developed.
 - ▶ Emphasis should be given to the development of human resources that can respond to these challenges.
 - ▶ Domestic and international legislation is required to regulate international health phenomena.

STRATEGIES FOR NONCOMMUNICABLE DISEASES IN THE 21ST CENTURY:

WHAT HAVE WE LEARNED FROM THE PAST?

25 March 1997

Moderator: Dr M. S. Tsechkowski, Director, Division of Noncommunicable Diseases, WHO

Presenter: Professor D. Maclean, Head, Community Health and Epidemiology, Dalhousie University, Halifax, Canada

- The increasing burden of Noncommunicable diseases, both in developed and developing countries, and the rapid globalization of trade and marketing, call for the development of a Global Strategy for these diseases. The approach of this strategy should be multidimensional, recognizing the complexity of risk factors and determinants, and incorporate health promotion, prevention and care. Noncommunicable diseases should be addressed within the framework of equity and cost-effectiveness, both important principles of the HFA in the 21st century policy, and driving forces in many health system reforms.
- The strategy should aim to integrate NCD into the current prevention and control activities of the health system. Strategies needed to address the coming pandemic include appropriate policy development, technical assistance, professional education, social marketing, establishment of partnerships, building information systems, and strengthening resource mechanisms.
- It is crucial to utilize the lessons that can be learned from the industrialized countries. These indicate that the business as usual scenario will not be adequate to address the future burden of Noncommunicable diseases. Strategies need to be developed that can assist developing countries to design innovative strategies and not to focus solely on curative services that are often expensive, non sustainable and ineffective.
- In order to be prepared, new models for prevention and control should be explored and operationalized. Furthermore, programmes for Noncommunicable diseases should be linked to the Agenda 21 movement, in order to ensure that health and sustainable development are closely linked.

BURDEN OF DISEASE STUDIES: HOW DO THEY CONTRIBUTE TO DECISION MAKING?

30 April 1997

Moderator: Dr T. Kjellstrom, Director, Office of Global and Integrated Environmental Health, WHO

Presenter: Mr C. J. L. Murray, Harvard University, Boston, USA

- In recent years several Burden of Disease Studies have been conducted at the national and subnational levels. Their purpose was to obtain a consistent estimate of the mortality and disability arising from diseases. Several crucial steps have to be taken in the research process, such as the collection, assessment and correction of data on basic demography, mortality and morbidity figures, and the valuation of disabilities. Moreover, models have been to be used to ensure internal consistency.
- The national BOD studies are, besides their use in resource allocation debates, vital for planning of health manpower training, and for priority setting for research and development. Furthermore, they may facilitate the monitoring of health sector performance. However some studies, particularly in developing countries, are challenged by insufficient capacity in epidemiology, demography and health economics and often by the lack of disease-specific estimation methods, particularly for poorly studied conditions.
- It is of vital importance to ensure broad country involvement and ownership of these studies. While the process itself often reveals the strengths and the weaknesses of the health information system, it is also an ideal entrée into the debate about cost-effectiveness, and it may create a common understanding of intervention efforts. Strong leadership has been found to be critical to bring these studies to a successful conclusion.
- Though Burden of Disease Studies are a valuable tool in the process of decision-making, it is yet too early to assess their full impact. Furthermore, there may be a need for further refinements of the methodology, and for expansion of the domain, for instance by including sectoral burdens. A role for WHO may be identified in the development and implementation of these national studies, ranging from technical assistance to quality control and the refinement of the methodology.

COST CONSTRAINTS AND GOOD HEALTH CARE: A DILEMMA OR A CHALLENGE?

10 June 1997

Moderator: Mr J. Kutzin, Division of Analysis, Research and Assessment,
WHO

Presenter: Mr A. Podger, Secretary of the Department of Health and
Family Services, Australia

- The Australian Health sector is characterized, as most industrial countries, by a relatively high national expenditure on health (about 8 % of the GNP), a strong focus on curative and hospital care, and a strong commitment to universal access. Consequently, the Australian government has launched several initiatives during the past decade that were intended to meet the criteria of cost containment, quality assurance and equity.
- During the seminar, several of these initiatives were presented and discussed:
 - ▶ For drugs to be accepted in the Australian Health Care System, and to be reimbursed by the government, it is required that, besides the traditional criteria of safety and efficacy, they also meet the criterion of cost-effectiveness. Furthermore, for those drugs that have acceptable generic alternatives, the additional amount of money has to be paid by the patient. Consequently, the increase in the costs for pharmaceuticals has been limited
 - ▶ Since the Australian health care system is based on a fee for service basis, and the number of doctors is still rising, there is a tremendous potential that the number of services, and the costs of health care, will increase. In 1989 a vocational registration system, which includes quality control and continuing medical education, has been introduced. The system has gradually received wide professional support, also because the rebates for patients that utilize registered GPs, are higher. A General Practice Strategy has been launched to improve access, to strengthen the linkages with hospitals, to ensure quality through accreditation arrangements, and to explore the possibilities of capitation payment schedules.
 - ▶ Recently Coordinated Care Trials (not to be confused with "managed care") have been designed, in which funds from different resources are pooled, in order to improve the health and well-being of clients. They will be targeted at special population groups, and are coordinated by local health professionals. Control groups will be used to evaluate the outcomes of these trials.

- Through a wide mixture of targeted strategies, the Australian government has been able to contain health care costs over the last decade within reasonable limits. Simultaneously, it has been successful in ensuring the quality of care. However, it has to operate within a political and professional environment, which makes a process of continuous negotiation and priority setting necessary. It is crucial that these initiatives are carefully monitored and assessed, since they may constitute important lessons for future policy development for both Australia and other countries.

STRATEGIC IMPLICATIONS FOR THE IMPLEMENTATION OF THE HEALTH FOR ALL POLICY: A LATIN AMERICAN PERSPECTIVE

22 June 1997

Moderator: Dr E. Villar, Division of Strategic Support to Countries in Greatest Need, WHO

Presenter: Professor M. R. Rovere, University of Buenos Aires, Argentina

- The process of Renewal of Health for All in Latin America will be crucial for the development of strategies at all levels. To ensure that the development and the implementation of these strategies are successful, an analysis of the main social actors in the HFA process is necessary. Such a strategic approach, through which a realistic assessment of the situation is carried out, acknowledges that policy making and policy implementation results from the interaction of a wide variety of social forces and stakeholders. Hence their position regarding the HFA goals, and regarding their interests, values and experiences need to be considered.
- A new methodological framework should be used for strategic planning. This framework should include consensus building and conflict management, but also forms of regulated competition and improved cooperation. In this sense it is important to capitalize on 20 years of Health for All experience.
- Though globalization may offer many opportunities, it can also lead to an increase in social and economic exclusion. In this context, and in the context of sustainable human development, internal markets and health sector reforms, the concept of governance has gained much attention, and should be included in the HFA process. Moreover a clear and comprehensive vision should be developed to create an alliance among the different actors to advance towards the same goals.
- Over the last decades, representative democracy is being transformed into a more participatory democracy. In this age of networks, breaking down hierarchies and establishing public/private entrepreneurship, a new basis for the development of strategies for HFA will emerge: one which is less hierarchical, less ethnocentric, and closer to democratic and multi-centric networks. This will underline even more the importance of strategic planning and rigorous rethinking of the positions and perspectives of all the stakeholders.

PRESENTATION OF THE NEW STRATEGY OF THE WORLD BANK ON HEALTH, NUTRITION AND POPULATION

9 July 1997

Moderator: Dr F. S. Antezana, Assistant Director-General, Deputy Director General a.i., WHO

Presenter: Dr R. Feachem, Director, Health, Nutrition and Population, World Bank,
Dr A. Preker, Principal Economist, World Bank

- Policy analysis/advice and lending schemes are the two instruments used by the World Bank to meet its mandate of sustainable economic growth and to alleviate poverty. Hence, its lending portfolio in the areas of health, nutrition and population control has grown substantially over the past decades and constitutes now 11% of total World Bank lending. The number of countries involved, where lending conditions depend on per capita income, has also increased substantially. The nature of the support is currently less programme specific and more sectorally based.
- The first sector strategy paper has been developed to give direction to World Bank policies and to create a common framework for good practice in health policy. This document, which will be renewed every three years, has a threefold focus: greater targeting of poverty groups, a redefinition of the role of government and enhanced partnerships with others. The document also emphasizes that the World Bank is enhancing its capacity in analysis and policy advice in relation to these foci.
- A distinction is made between the role of government in financing and service provision. Regulated systems, in which funding is generated through social health insurance and general revenues, achieve better control over expenditure than private health insurance and out of pocket financing. In the provision of services, a stronger collaboration between the private and public sector is required to enhance their mutual performance.
- The need for a strong collaboration between WHO and the World Bank was stressed. In many areas, particularly disease prevention and control, the World Bank indicated that WHO has the best international technical capacity, while in other areas, such as in the development of health system policies, an enhanced integration of the strategies of both organizations at the country level would be most effective.
- It was observed that in the current framework of assistance, a conflict could arise between lending and tied policy advice. Furthermore the lending instruments may currently favour short term lending with a bias towards quantity instead of quality. Developing improved monitoring and evaluation tools could assist to focus more on quality and performance.

**PERSPECTIVES FROM THE GLOBAL KNOWLEDGE
CONFERENCE:
WHAT IS THE RELEVANCE TO THE HEALTH SECTOR?
12 September 1997**

Moderator: Dr D. Yach, Chief, Policy Action Coordination Team, WHO

Presenter: Dr J. Tomaro, Director of Health Programmes,
Aga Kahn Foundation

- The recent International Conference on Global Knowledge, held in Toronto in June 1997, explored how global knowledge (or better "know how") and the information revolution were currently transforming the process of development. It strongly focused on how an enabling environment for information diffusion could be developed, particularly in terms of the required infrastructure and technologies.
- The conference was successful in posing several of the relevant questions, however, less successful in indicating approaches to answer them. Though a lot of enthusiasm about the Internet was shared, not many case studies were explored that indicated its contribution to improvements in economic or social well-being. A stronger focus on the real applications of these technologies and on the needs of populations might have been a more productive approach. Such an approach would indicate whether what is transmitted is also really used, since information alone, without the means to act, may be of limited value.
- Though most participants came from developed countries, a special focus was on empowering the poor with information and knowledge, and fostering science and technology in developing countries. Several factors, such as the difference in health problems between the rich and poor countries, the limited access to scientific information in developing countries, and lack of investment in health research, may limit the application of knowledge in these countries. Even though many high tech hardware is manufactured in developing countries, they don't have real control over their design or application. This may also hamper the diffusion of their unique social and cultural knowledge.
- New partnerships between the public and private sector, which aim to improve social and economic well-being are attracting great attention. However, how the state should both regulate and facilitate this process would need more in-depth discussion. Nevertheless, the conference was regarded by many as a first step, in giving these important questions a more prominent place on the international agenda.

HEALTH PROMOTION AFTER JAKARTA: WHAT ARE THE IMPLICATIONS FOR HEALTH FOR ALL IN THE 21ST CENTURY?

22 September 1997

Moderator: Dr H. R. Hapsara, Director of the Division of Health Situation and Trend Assessment, WHO

Presenter: Prof. D. Nutbeam, Director of the National Centre for Health Promotion, University of Sydney

- The 4th International Conference on Health Promotion was recently held in Jakarta. This conference, building further on the Ottawa Charter and the Health for All policy, aimed to identify new directions for health promotion in the 21st century. It was the first time that such a meeting was held in a developing country. Besides a strong delegation of nongovernmental organizations, the private sector was also represented.
- Several new challenges were identified such as environmental health, equity, respect for human rights, shelter, and, above all, poverty. It is clear that health promotion has to evolve continuously in the coming decades, also in order to meet demographic trends, social and behavioural changes and new (re-)emerging diseases.
- There is substantial evidence from research and case studies that health promotion can make the difference, by developing healthy life styles, and changing social, environmental and economic conditions. Health promotion may also offer a practical strategy to pursue equity in health. In this context, comprehensive approaches are most effective, while settings such as school, work-place, and city, offer practical opportunities and enable community participation and the establishment of new partnerships.
- At the global level it is important to create a global health promotion alliance, to raise awareness of changing determinants of health and support development networks. Such an alliance could also mobilize resources for health promotion, accumulate knowledge on best practice and enable shared learning.

- The Jakarta declaration highlights five priorities that were identified during the meeting and that will guide health promotion in the coming decades:
 - ▶ promote social responsibility for health;
 - ▶ increase investments in health;
 - ▶ consolidate and expand partnerships for health;
 - ▶ increase community capacity and empower the individual;
 - ▶ secure an infrastructure for health promotion.

The declaration stresses that by addressing the determinants of health, health promotion can create the greatest health gain for people, and can contribute to a reduction in inequities and ensure human rights.

MEASURING HEALTH INEQUALITIES: WHAT IS AVAILABLE?

1 October 1997

Moderator Dr D. Yach, Chief, Policy Action Coordination Team, WHO

Presenter: Dr A. Kunst, Erasmus University Rotterdam, The Netherlands

- One of the major challenges in the current discussion on equity is to make the concept operational. This is necessary for a comprehensive and consistent presentation of inequities to policy makers, for the analysis of the determinants of disparities and the assessment of the impact of policies that are developed to reduce inequalities. In this context it is particularly important to assess whether inequalities in health outcomes are increasing or decreasing over time and to make comparisons between countries.
- A framework of measures was discussed of how differences in socio-economic status (SES) are associated with health outcomes. Three dimensions were identified for these different measures:
 - ▶ impact vs. effect measures. The effect measures (relative and attributable risks for example) only incorporate the differences (ratios or absolute measures) between the highest and lowest SES-groups, while the impact measures also include the actual distribution of the population among the different groups (expressed for instance in population attributable risk). Hence it may be possible that, though the effect of socio-economic differences on health outcomes may increase, its total impact may decrease over the years, as a result of a decreasing number in low SES-groups.
 - ▶ relative vs. absolute measures. The relative measures are expressed in ratios (outcome of highest SES group/outcome of lowest SES group), while the absolute measures indicate the difference in the unit of health outcome.
 - ▶ simple vs. sophisticated measures. Sophisticated measures make use of more complex statistical methods, based on regression analysis. Hence information on all different socio-economic groups is included. However, the examples indicated that the outcomes of sophisticated and simple methods were often similar.
- Two examples from Finland and the Netherlands illustrated that it is crucial to understand the characteristics of the different measures since they have different perspectives. As such, they give valuable additional information, and need to be utilized in combination. While relative and effect measures will give information in particular on the causal links, the absolute and impact measures may be more relevant for the overall picture of health and for health care service provision.

HEALTH FOR ALL: A CASE STUDY FROM BANGLADESH

20 October 1997

Moderator: Dr G. Goldstein, Division of Operational Support in
Environmental Health, WHO

Presenter: Dr K. Rahman, Counselor, Bangladesh Mission, Geneva

- Like many developing countries, Bangladesh, has over the past decades made several efforts to develop and implement health policies based on the principles of "Health for All". However the complex interlinked web of poverty, illiteracy, environmental degradation, rapid population growth and health has often hampered the success of these policies. In addition, lack of resources has had a negative impact on the accessibility and quality of health services for most of the poor.
- Another major constraint in Bangladesh is the substantial barrier for patients to visit doctors, because of doctors' attitude and commercial mentality. Consultation fees are relatively high and no adequate regulation for private practice exists. Physicians who work in public hospitals for instance also practise privately, where their profits are much higher.
- As in many of the least developed countries, more emphasis needs to be given to improving management capacity, both in terms of quantity and quality. Priority should be given to using existing facilities more effectively by improving their quality and responsiveness to the needs of the population. In the context of Bangladesh, the contribution of nongovernmental organizations is particularly important. However, an overall framework for operation, and better guidelines that are transparent and emphasize accountability need to be developed.
- In countries such as Bangladesh the WHO-country-representative (WR) has an important role to fulfill, particularly in facilitating the development of national health policies. In this context, an enhanced national capacity for planning and priority setting is crucial. It is also important that WRs advocate for the integration of health policies into overall development policies and for a stronger cooperation between the national governmental health authorities and nongovernmental organizations.

THE "OSLO REPORT": WHAT ARE THE IMPLICATIONS FOR WHO- HEADQUARTERS?

25 November 1997

Moderator: Dr C. Abou-Zahr, Division of Reproductive Health, WHO

Presenter: Dr S. Mogedal, Director, Centre for Partnership in Development, Oslo

- Recently researchers finalized a study "Cooperation for Health Development - The World Health Organization's support to programmes at country level", also known as the Oslo report. The report includes recommendations on how WHO's contribution to building national capacity can be strengthened. The recommendations in the report are based on crucial findings that emerged from an assessment of a series of countries:
 - ▶ WHO's support, in terms of human resources and funding, is often based on historical reasons and often does not correspond to the needs and capacities of countries. A policy framework for managing the use of regular and extrabudgetary funds in relation to country needs and priorities is lacking.
 - ▶ There is substantial and increasing diversity among countries, though some kind of WHO presence is essential in all countries.
 - ▶ There is an increasing need for common global action, and at the same time a need for country specific functions to build capacity for acting nationally and globally.
- The report recommends dividing WHO's functions into two categories; common global functions and country specific functions. WHO's common global functions are of long-term relevance to all countries at all levels of development. WHO's country specific functions are relevant to individual countries requiring assistance with their health services, adapted to the needs of each specific country.
- The study's major proposal is the concept of essential presence. The essential WHO presence is determined by the different needs of countries to fulfil the common global and country specific functions. Consequently, WHO's funding for countries should be based on the level of essential presence required in order to achieve a more equitable distribution of funds and to direct more funds to countries in greatest need. Essential presence should be realized in the form of a contract, which is negotiable, adaptable and time limited.

- The report also emphasizes that WHO needs to develop a sharper profile for its identity, its product and relationships, based on strategic alliances, and ensure that the expertise of other partners is optimally utilized. WHO headquarters should distinguish between processes to serve common global needs and country specific needs. WHO particularly needs to strengthen its analytical capability in order to regularly reassess its level of essential presence, adjusting to changes in national capacity.

THE HELSINKI MEETING: NEW DIRECTIONS FOR HEALTH SYSTEMS

26 November 1997

Moderator: Mr O. Adams, Division of Organization and Management of Health Systems, WHO

Presenter: Dr G. Biscoe, Chief Executive Officer, Australian Management Health Network

- A recent meeting held in Helsinki on "Building Sustainable Health Systems - From Policy to Action", was attended by a wide variety of experts in health system development. The meeting discussed how new pressures, such as globalization and marketization, have an impact on future health systems. It also considered what the contents and financial strategies for sustainable health systems should be, and the functions and capacities required.
- Globalization will have a profound impact on health systems, posing both opportunities and threats. Not only will it influence health systems directly, e.g. through a possible decrease in public funding and the introduction of new technologies, but also through its impact on the determinants of health such as the increased trade in harmful products, and on both absolute poverty and equity. The challenge will be to establish health on the globalization agenda, and to minimize the negative implications for health, while making full use of its potential.
- More than ever, health systems should target the determinants of health and facilitate collective action for health, particularly in the areas of prevention and health promotion. Horizontal and vertical approaches should be merged and strategic and sustained alliances should be established. Governments will have to ensure that legislative, monitoring and regulative mechanisms are in place. While they may row less, they have to steer more.
- Sustainability refers not only to human resources, institutional and political factors, but also to good governance, the involvement of civil society, the voluntary and private sector, and moral leadership based on a clear vision and explicit values. In the context of building sustainable health systems, financial strategies and approaches such as privatization and (de)centralization should not become ends in themselves, but the means to advance the health of all populations.
- WHO's action in support of sustainable health systems needs to be focused and founded in a long term vision, with explicit values. It has to build strategic partnerships and foster the integration of different approaches. Messages should be clear, based on a common understanding of what sustainable health systems are.

DECENTRALIZATION AND HEALTH SYSTEMS: AN OVERVIEW OF INTERNATIONAL EXPERIENCE

28 November 1997

Moderator: Dr J. Kasonde, Special Programme of Research, Development and Research Training in Human Reproduction, WHO

Presenter: Dr K. Janovsky, Division of Analysis, Research and Assessment, WHO

- Decentralization has been at the core of many recent health reforms, serving a wide variety of objectives, such as improving the performance of health systems, introducing competition and fostering solidarity. The actual meaning and implementation of decentralization has been very context-specific. A study was presented which assessed how countries understand and implement decentralization strategies and what the effects in different circumstances are. Twenty seven countries participated in the study, representing both developed and developing nations.
- There are different streams of decentralization. In some countries there are shifts of responsibilities to district health management or to local government and sometimes new forms of public management (executive agencies, area health boards, autonomous provider institutions) are established. In other countries, decentralization has focused particularly on establishing new relations with the private and voluntary sector. Decentralization has often been confined to the health system, but has sometimes been part of broader public sector reform.
- Though the effects of decentralization are difficult to measure because of, inter alia, the lack of data and often fragmented implementation, decentralization is not a magic bullet. There is no clear evidence that it has increased equity or strengthened the focus on primary health care. Though some health system functions may be better performed, it is also evident that other functions, such as the operation of drug programmes and research, may benefit from centralization.
- Experience indicates that regulatory frameworks and special implementation units help to facilitate the process of decentralization. Diversity and existing local structures have to be respected, and local capacity developed. In addition, solutions have to be found for the often neglected dimension of employment structures and the workforce.