

# Health 2000

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## The meaning of "health for all by the year 2000"

"Health for all by the year 2000" has now become the official target for all WHO Member States. But what does this idea mean? And what are its ramifications? WHO's Director-General explains.

Globally, there has been in recent years some improvement in the world's health. Statistics prove it. Yet a new-born child in some African countries has only a 50-50 chance of surviving through adolescence, four-fifths of the world's population have no access to any permanent form of health care, and only one in three persons in developing countries has reasonable access to safe water and adequate sanitation.

Our latest assessment of the world health situation shows that the reduction of mortality rates has been slowing down. In some countries, crude mortality rates have levelled out and in a few they have actually increased. Infant mortality rates remain high in all developing countries, and the rate of improvement has begun to slacken. Mortality rates in those areas where they are already relatively low are becoming lower at a faster rate than in those areas where mortality rates are high.

Health services are clearly failing to reach out to those who do not have access to them. Over five million children annually defecate themselves to death. This number is equal to the number of children born every year in the USA, the United Kingdom, France, the Netherlands, and Sweden put together, where diarrhoeas are little more than a nuisance. More than half of all child deaths can be traced to the vicious complex of malnutrition and diarrhoeal and respiratory diseases. All these deaths are unnecessary and it is the fail-

ure to control such diseases of poverty that is holding back further reductions in mortality rates. Where these diseases have been controlled the effects have been dramatic. Cross-national data from Latin America show that as the proportion of deaths caused by infectious and parasitic diseases drops from approximately 22% to 6% of all deaths, life expectancy jumps from 45 to 68 years—almost equal to that in the affluent countries.

The threat posed by such major diseases as malaria, schistosomiasis, filariasis, trypanosomiasis, leishmaniasis, cholera or leprosy either has not lessened in recent years or has actually increased. Nearly a quarter of the world's population remains infected with worms.

### The Imperative for Change

The scope for improving the human condition is therefore great and the action required is urgent. Four-fifths of the population still do not have access to health services on a permanent basis, and nations cannot extend their existing health services to cover the entire population at a price they can afford. Health for all, therefore, remains a dream, and it will remain so as long as the dream is formulated in purely technocratic terms—drugs, nurses,

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vaccines, hospitals, doctors, and X-ray equipment. If the dream is to be turned into a reality, existing health care strategies will have to be vigorously transformed. They have outlived their usefulness. Indeed, the health systems in most developing countries are beset with problems.

Firstly, there are too few resources being invested in the health sector. The public health services of the 67 poorest developing countries, excluding China, spend less in total than the rich countries spend on tranquilizers. The total expenditure on health services in the Third World, including China and including the private health sector, is just over half the sum that the world spends every year on cigarettes. Most developing countries allocate less than 1% of their gross national product to the government health services on which the poor depend. In many developing countries again, the annual *per capita* expenditure on pharmaceuticals is less than US \$1, which is not sufficient to meet even the most essential drug needs of the community. The 2-3% of GNP that most developing countries spend on health care, represents as little as \$4-6 *per capita*. If these countries were to increase their health spending in real terms by as much as 10% per annum, in the year 2000 they would still be spending only about US \$40 *per capita*, or less than 5% of the amount spent in the USA in 1979-80.

Secondly, the few resources that are available are usually spent on meeting the needs of only 10-15% of the population.

Thirdly, the richer countries are attracting doctors from the poorer ones. Over three-quarters of the world's migrant physicians can be found in just five countries—Australia, Canada, the Federal Republic of Germany, the United Kingdom, and the USA. Though it is eight times more expensive to train a physician than a medical auxiliary, many countries still continue to stress the training of the former.

Fourthly, the ordinary people have little control over their own health care. Yet, if health does not start with the individual, the home, the family, the working place, and the school, we shall never get to the goal of health for all. Even in the industrial countries, self-

care, self-responsibility, and self-coping in the individual, the family and the community represent 50-60% of all care. Unfortunately, health professionals are rarely willing to trust people to such an extent that they acquire the power to make the decisions that have to do with their own health.

So the world now agrees that we should have a new strategy that can take us to our goal of health for all. But what does health for all mean?

### What is "Health for All"?

"Health for all" means that health is to be brought within reach of everyone in a given country. And by "health" is meant a personal state of wellbeing, not just the availability of health services—a state of health that enables a person to lead a socially and economically productive life. "Health for all" implies the removal of the obstacles to health—that is to say, the elimination of malnutrition, ignorance, contaminated drinking-water, and unhygienic housing—quite as much as it does the solution of purely medical problems such as a lack of doctors, hospital beds, drugs and vaccines.

"Health for all" means that health should be regarded as an objective of economic development and not merely as one of the means of attaining it.

"Health for all" demands, ultimately, literacy for all. Until this becomes reality it demands at least the beginning of an understanding of what health means for every individual.

"Health for all" depends on continued progress in medical care and public health. The health services must be accessible to all through primary health care, in which basic medical help is available in every village, backed up by referral services to more specialized care. Immunization must similarly achieve universal coverage.

"Health for all" is thus a holistic concept calling for efforts in agriculture, industry, education, housing, and communications, just as much as in medicine and public health. Medical care alone cannot bring health to hungry

people living in hovels. Health for such people requires a whole new way of life and fresh opportunities to provide themselves with a higher standard of living.

The adoption of "health for all" by a government implies a commitment to promote the advancement of all citizens on a broad front of development, and a resolution to encourage the individual citizen to achieve a higher quality of life.

The rate of progress will depend on the political will. The World Health Assembly believes that, given a high degree of determination, "health for all" could be attained by the year 2000. That target date is a challenge to all WHO's Member States.

### The Strategy for "Health for All" — Primary Health Care

The basis of the "health for all" strategy is primary health care. The Alma-Ata conference<sup>2</sup> described primary health care as:

essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

The three prerequisites of primary health care are thus a multisectoral approach, community involvement and appropriate technology, and it is on primary health care that all health programmes and the health infrastructure should be built. This strategy turns the individual, the family and the community into the basis of the health system, and it turns the primary health worker, as the first agent of the health system that the community deals with, into the central health worker.

### Essential surgery for primary health care

I know that textbooks of surgery and lists of surgical procedures are not lacking, but what I am suggesting is an internationally agreed list of essential surgical procedures in support of primary health care that would help countries to decide on their own list and related training and equipment. I am afraid you will accuse me of wanting to lower your standards. Not at all. What are the criteria for these standards? If they are purely technical, I am sure you will know how to preserve technical quality in any proposal. But I return to the social criteria, particularly the criterion of a more equitable distribution of surgical resources. The alternative for most people in the world is either the kind of selected essential surgery I am advocating or absolutely nothing at all.

— H. Mahler in an address to the Twenty-second Biennial World Congress of the International College of Surgeons, Mexico City, 29 June 1980.

But health for all by the year 2000 will be nothing but a mirage unless health services are made accessible to each and every member of the community. This entails a thorough reorientation of the existing health systems in each country to be accomplished through what is called within WHO "managerial process for health development" and through health systems research.

Each of these points is of such fundamental importance that it warrants separate consideration.

### The multisectoral approach

Health does not exist in isolation. It is influenced by a complex of environmental, social, and economic factors ultimately related to each other. The health of the poor is largely the result of a combination of unemployment (and underemployment), poverty, a low level of education, poor housing, poor sanitation,

<sup>2</sup> *Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, September 1978.* Geneva, World Health Organization, 1978.

malnutrition, and lack of the will and initiative to make changes for the better. It would be unrealistic to expect any substantial health improvements in these populations unless these constraints are first removed or alleviated.

Thus health management has to be considered along with such things as producing more or better food, improving irrigation, and marketing products. Even where infant mortality is high, diarrhoeal and respiratory diseases rampant, and no organized health service available, health and disease may come low on the list of perceived needs, following an equitable system of laws, land tenure reforms, improved agricultural production and marketing, family planning programmes, good nutrition, and health education. This is not illogical. Action undertaken outside the health sector can have health effects much greater than those obtained within it.

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The protagonists of every sector are usually convinced of the supreme needs of their particular sector, and public health protagonists are no exception to that rule. But they have to be vigilant and they have to participate actively in the overall allocation of resources to social goals. Public health protagonists must be equipped to defend their cause, which, quite apart from its humanitarian aspect, should be to facilitate the generation of human energy and creativity in an amount adequate to enhance social and economic efforts, which will in turn enhance health.

Ideally, the resources of the diverse sectors should be applied in harmony, and in the correct blend in order to achieve their common social goals. This implies a joint definition of such goals and a common appreciation of the means of attaining them. Health activities can serve as an important level for social awareness and therefore can act as a lever for social development. The protagonists of public

health will be convincing in promoting social development, including health, only if they are imbued with the social purpose of community health.

The intersectoral perspective should not be limited to just primary health care. It should permeate the entire system of health planning.

Despite all that has been said about the difficulties of intersectoral planning, it is possible to secure the involvement of other sectors. If actual health requirements from other sectors are clearly specified, there is a much better chance of gaining the collaboration of the administrators in those sectors than if you merely piously attempt to convince them of the philosophy of multisectoral work.

### Community involvement

We come now to the most challenging part of our work, namely the inability of most health services to respond properly to the needs of communities. We often refer to "coverage" by the health services and, with obvious pride, we say that such and such a facility has been established to cover such and such an area where so many thousands of people live. We do not seem to realize that coverage, to be valid, must relate to productive contact between the health service and people for specific needs, and that our normative statements may easily become a distortion of reality. The reality is that, of the people to whom the facility is said to be available, only the minority who live closest to it actually use it. The majority are excluded. Concepts like accessibility and acceptability are seldom considered.

But a simple extension of conventional health services, no matter how far-reaching into the community, is unlikely to produce the necessary improvement. Health is not a commodity that is given. It must be generated from within. Similarly, health action cannot and should not be an effort imposed from outside and foreign to the people; rather it must be a response of the community to problems that the people in that community perceive, carried out in a way that is acceptable to them and properly supported by an adequate infrastructure.

### Assessing the usefulness of high technology

What surgical interventions are really beneficial? What diagnostic radiology is essential? What laboratory tests provide essential information, and what only marginally useful information? What radiotherapy in fact prolongs life? What drugs are effective and harmless? What psychotherapy is personally helpful and socially useful? What electronic equipment for cardiac patients is really life saving? Think of the enormous savings you could make, not to speak of the alleviation of human suffering, if you could discover a simple test to predict which patients are really likely to benefit from intensive coronary care. Think of the enormous increase in efficiency you could bring about by rationalizing the use of expensive radiological and laboratory equipment.

— H. Mahler in an address to the Congress of the American and Canadian Hospitals Associations, Montreal, Canada, 29 July 1980.

The spirit of self-reliance—at the individual level, the family level, the community level, and the national level—will be fundamental to any strategy for achieving health for all. Self-reliance sets people free to develop their own destiny. It is the essence of primary health care.

The approach that is being adopted to attain health for all is based on the fundamental understanding that it is there, where people live and work, that health is made or broken. People must therefore understand what health is all about, and it is the duty of those who know to help others to understand. People must grasp that ill-health is not inevitable and that, to bring about better health, account must be taken of a number of factors of a political, economic, social, cultural, environmental, and biological nature. Strengthened by this understanding, people will be in a better position to exploit those factors that are favourable to health and to combat those that are detrimental. But to gain such an under-

standing a minimum level of health is essential. So health and social awareness must go hand in hand, the one leading to the other and each progressively reinforcing the other. The process briefly described is known as community involvement, or, as somebody has expressed it, "health as if people mattered".

Such involvement requires communities to assume greater responsibilities in defining their needs, identifying solutions, mobilizing local resources, and developing the necessary local organizations. It is defined as a series of simple activities, by no means all of a medical nature, aimed at meeting the essential health requirements of individuals, families, and the community, and at improving the quality of life.

Such community involvement can have a broader influence than the local organization of health care. It can be instrumental in bringing about the commitment of community leaders to support the health reforms required, and through them it can stimulate the political commitment of the government to introduce and sustain these reforms.

### Appropriate health technology

The 134 Governments represented at the Alma-Ata Conference unanimously agreed that:

The time has come for all levels of the health system to review critically their methods, techniques, equipment and drugs, with the aim of using only those technologies that have really proved their worth and can be afforded. For primary health care this is vital because there has been a tendency to concentrate on medical technologies that are more appropriate for hospital use than for front-line care. The scope and purpose of primary health care, and the technical capacity of those who provide it, make it more important than ever to have appropriate technology available.

In the reorientation of health programmes towards community development and participation, towards primary health care in both its sectoral and intersectoral expressions, and towards greater social relevance, it is necessary to grasp the concept of "appropriate technology".

With the growth of health services has come a disproportionate increase in expenditure directed towards the few, selected not so much by social class or wealth but by medical technology itself. In some places where it has been examined it has been identified as an increasing expenditure on persons in the final months or years before death, an expenditure that does not measurably increase life expectancy or make humanly tolerable the closing episodes of the lives of elderly people.

In other countries the increased expenditure on the few has been linked to the "upgrading" of health care interventions to higher and higher levels of specialization.

As health care becomes more sophisticated, it comes to be justified more and more by the actions themselves rather than by the results achieved and by whether a problem is solved.

Problems change, societies and priorities change, and they will keep on changing. Society's instruments for action must keep changing too. New interventions will continue to be evolved as our knowledge and understanding grow. New types of action must lead to changes in the role of health workers.

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The "health for all" target requires first and foremost a scientifically sound health technology that people can understand and accept and which the non-expert can apply. The identification or generation of such technology forms part of the revolution in community health. We just cannot afford to continue the indiscriminate use of the present methods, machines, and medicines, so many of which have never undergone the critical evaluation of a controlled trial let alone a proper cost-effectiveness analysis. We must break the chains of dependence on unproved, oversophisticated, and overcostly health technology by developing another kind of tech-

nology that is more appropriate because it is technically sound, culturally acceptable, and financially feasible.

For instance, it makes good social, economic, and professional sense to take the technology nearer to the consumer whenever there is a chance. For example, making rehydration salts for babies available to mothers in every home is likely to be more useful than expecting the mother to take the baby to a special centre and have this service done for her. There should be no secret either in the way in which diarrhoeal disease occurs or in its treatment. There appears to be no possible reason why the knowledge and the skills required to deal with it should not be spread to every household at risk. This is what is meant by "demystification" of medical technology, which is vital to bring about community involvement.

WHO is promoting appropriate technology, focusing first of all on primary health care in the community. Later on it will concern itself with appropriate technology in the referral services.

Appropriate health technology has enormous professional, commercial, and therefore political implications, and we may often find ourselves in opposition to the medical and allied professions and industries. To succeed, we shall need to work together more than ever before, whatever our professional expertise. We must succeed if we really mean to reach the main world health target on time. Again—let there be no mistake—this applies not only to developing countries; the most affluent countries also have much to gain and nothing to lose by joining in this effort.

#### **Reorientation of existing health systems**

These, then, are the absolute prerequisites to reach health for all by the year 2000: multi-sectoral approach, community involvement, appropriate health technology, and total health services coverage, including the remotest parts of the country and the poorest members of society.

But, even this strategy cannot lead to success by itself; it can become effective only if it is seen as part of an honest, determined, and

**The help required**

The 80% [of the cost of primary health care] ultimately to be covered by the developing countries would include such items as staff salaries and related costs, current supplies and maintenance and repairs of buildings and equipment, and the repayment of loans. This would leave a net transfer from the developed countries of between 16 thousand million to 40 thousand million dollars over the next 20 years. This amounts to between 800 million dollars and 2 thousand million dollars a year. These sums represent between about one quarter per cent and just over one half per cent of the total outlay on health services in the industrialized countries.

— H. Mahler in the text submitted to the Brandt Commission, 1979.

continuing process of reorientation of the existing health systems so that they are capable of meeting the specific challenges of the 1980s, the 1990s, and the first decades of the third millennium.

It is particularly important to ensure that the health system as a whole evolves in accordance with the direction and content of the new policies, strategies, and plans of action and that primary health care and its support do not become a parallel system that is a "poor relation" to the existing system. In ensuring adequate support to primary health care at all levels, governments will have to face the fact that the functions of the existing health system may differ greatly from those required by the new policies, strategies, and plans of action. Governments will have to review the ways in which programmes are being delivered, services organized, institutions operated and coordinated, and resources and energies expended. The aim of this review should be to coordinate efforts in order to give effect to the new policy.

To quote again from the Alma-Ata report:

Primary health care activities in the community are supported by successive levels of referral facilities. These engage more highly trained staff capable of dealing with a pro-

gressively wider range of specialized health interventions that require more sophisticated technology than can be provided at the community level.

Additional thought will have to be given to referral facilities, and especially to the establishments that constitute the link next to primary health care in the health system chain. In particular, there is a need to review the functions, staffing, planning, design, equipment, organization and management of health centres and district hospitals, in order to prepare them for their wider function in support of primary health care. These establishments will have to adopt a new role in response to the needs of primary health care. Since the problems arising will be on a wider scale than the clinical problems of the seriously ill, the range of services provided will have to be correspondingly wider. They will include the continuing training, guidance and supervision of community health workers as well as the education of the community in health matters. These establishments will have to provide guidance on sanitary measures and to disseminate information on disease control methods that are suitable locally. They will have to provide logistic support in supplying pesticides, drugs, and sanitary and medical equipment. They will of course continue to provide specialized clinical outpatient and inpatient care. Their responsibilities will also involve liaison and intervention with other sectors involved in social and economic development at the administrative level concerned. Such extramural involvement is essential to create confidence in the whole system and to avoid overloading the referral institutions with people who do not need their facilities but could be looked after in the community by primary health care.

During recent years the health delivery system has become a neglected child. In keeping with the principle of paying greater attention to the underprivileged, urgent action is needed to change the situation. It is understandable that we should have neglected the health delivery system when the kind of health care it should be delivering was not at all clear. Now that we have agreed at Alma-Ata what that kind of care should consist of, we can turn to the reorganization of the health infrastructure. If countries allow all their programmes to develop separately, using the health infrastructure as a passive receptacle

for them, they will never achieve a balanced delivery system at a cost they can afford. The health infrastructure must therefore play a leading role in forging together the different health programmes into one unified system. And it must do so not only in the big cities—that is difficult enough—but also, and particularly, in rural areas and urban slums.

### Countrywide health programmes

The three components we have discussed come together to form a community health care infrastructure for delivering nationwide health programmes. Planned in cooperation with other development sectors and in consultation with the local community at all stages, the nationwide programmes will be operated by primary health workers making full use of appropriate technology. Referral facilities, hospitals, and other elements of the health system will be called upon when needed to assist the programmes in an auxiliary capacity.

**The spirit of self-reliance—at the individual level, the family level, the community level, and the national level—will be fundamental to any strategy for achieving health for all. Self-reliance sets people free to develop their own destiny. It is the essence of primary health care.**

Commitment to primary health care implies that the health system has to be organized to support and further develop primary health care. In essence this means that the health system undertakes responsibility for meeting the essential health care needs of people in remote and inaccessible areas. Examples from a number of countries have shown that programmes *can* be planned and implemented so that people in such areas are as well provided for as those in more populated regions and that health infrastructures *can* be created that truly serve the needs of the people. In short, the health infrastructure has the duty of delivering nationwide health programmes with well-defined objectives and accepted technology. There must be agreement at the outset

on the action that should be taken by individuals, families, and communities and by the health sector and other sectors to ensure the coverage of the whole population, progressively if necessary.

The level of the health system next to the primary care level must be geared to supporting, training and guiding community health workers, educating the community in health matters, providing specialized clinical care, and cooperating with other sectors concerned with social and economic development.

### Managerial processes for health development

Health technologies, however appropriate they may be, have to be properly applied wherever they are required as part of health programmes, which have themselves to be integrated within health delivery systems. To do so requires managerial competence that is all too often lacking. We have technical specialists of all types in the countries and in WHO. We have far too few specialists in the composite discipline of health development—people who are imbued with the philosophy of health development, who can generate it, plan for it, programme and budget for it, implement it, monitor it, and evaluate it, who can bring to these ends the specialized knowledge of all the other disciplines involved in the health, political, social and economic sciences, and who can marshal, master and summarize the information required for all these activities. This is the recruitment and training challenge that lies ahead of us. We must seek to create this type of person in sufficient numbers within countries themselves if they are to make real progress with their health development strategies. Few—if any—training programmes are today preparing health managers adequately for these tasks.

The management of health development means many things. Its components are country health programming, programme budgeting, programme evaluation, and health information systems support. It is a far cry from the existing state of affairs where limited funds are used on projects that are often unrelated to one another (even though they may

be under the same programme) and totally unrelated to the national health and social priorities. First of all it implies the elaboration of national health policies and their translation into feasible plans, including the sharp definition of priorities. Priority programmes have to be properly formulated. These are national processes designed to stimulate community action, which ensures that health needs become known and arouse appropriate social, technical, and political responses. These national processes must include national health programme budgeting of a kind that reflects social policies. It does this by ensuring the preferential allocation of resources to programmes that have been defined as social priorities and to the services and institutions delivering them. The process as a whole and its individual components have to be monitored and controlled. They have to be evaluated with the aim of constant improvement, and throughout they must receive sound information support.

The managerial process for health development can, therefore, help countries to make better use of their own resources and better use of WHO's resources. It costs WHO very little to promote. Its potential benefits far outweigh the cost, if it is wisely applied. It has been introduced in more than 30 Member States, yet few have followed up the initial efforts by instituting a continuing process. It is expected that as it gains impetus, more large-scale health programmes will emerge for funding and implementation by a combination of national and international agencies.

#### Health systems research

The reorientation of existing health systems and the parallel development of a sound managerial process for health development are essential prerequisites to transform health for all by the year 2000 from an abstract idea into reality. But how can any existing health system be reoriented without a thorough knowledge of how it really works, what its weaknesses and imperfections are, and what changes must be made in what order of priority?

Health systems research—research on how the various parts of a health system work and

#### The most affluent countries have much to gain . . .

Forty-nine million Americans live in areas officially designated as medically underserved, 22 million in urban areas and 27 million in rural areas. Fourteen point nine per cent of people do not have a regular source of medical care. Twenty to twenty-five million Americans have no health insurance—most poor or near poor—and 19 million Americans have inadequate health insurance coverage. An additional 46 million Americans have inadequate insurance against large medical bills. Almost half of all individuals with incomes below the Federal poverty level are not covered by Medicaid.

— H. Mahler in an address to the Congress of the American and Canadian Hospitals Associations, Montreal, Canada, 29 July 1980, quoting from the United States case study for achieving health for all by the year 2000.

on the possible ways of improving it—is an area that demands much more attention if countries are to make real progress in the organization and management of health care. We have been socially unimaginative, too theoretical, and probably too perfectionist in the past. But now that research is recognized as a national undertaking, with WHO acting as promoter and coordinator of the aspects that require international collaboration, there is reason to hope that health systems research will become highly practical and will be closely interwoven with the delivery of health care. On the other hand, it should be fed by and feed into other components of health research, so that a continuum of laboratory, clinical, epidemiological, ecological, and health systems research will be formed, closely related to effective and efficient delivery of health care based on established knowledge.

There is a dire shortage of health systems research workers throughout the world. This is not surprising, because, in spite of initial enthusiasm some 20 years ago, this kind of research has far from gained respectability,

especially among biomedical scientists. However, scientists must accept the responsibility of making sure that the benefits of scientific progress are applied for the wellbeing of mankind as a whole. If conventional scientific

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methods cannot be usefully applied to the operational problems of health care delivery, they must be discarded and new, more socially useful methods will have to be found.

### Cooperation not Confrontation

The goal of health for all was certainly conceived in a climate of political optimism, and that was only a few years ago. At that time there was still a feeling that in spite of ideological differences, in spite of economic enigmas, somehow our world was muddling its way out of an impasse and was going to substitute cooperation for confrontation. Now we can detect unmistakable signs that this is beginning to change, and the world is once again tending to become divided. But we have to continue to find points of cooperation even in areas of confrontation. All the actors in the existing health drama—the governments of the North and the governments of the South, their medical, scientific, and industrial establishments, and the international health bureaucracy—will have to work hard towards reducing the areas of friction and enlarging the areas of cooperation.

### Technical cooperation

Recent years have seen a significant evolution in WHO's approach to its activities in countries. In the 1950s these activities tended to be based on the concept of technical assistance, frequently patterned on the aid project approach. This kind of technical assistance, implying a donor-to-recipient relationship

without mutual exchange, was provided in a fragmentary way by donors without necessarily being highly relevant to the health or socioeconomic development needs of the country concerned.

WHO did some excellent technical work but in a number of rather narrow fields. Then came the reckoning in the 1960s when it was realized that, while it is all very well to engage in malaria control and to carry out work on some other communicable disease, it does not get health down to the people in their local communities.

Times have changed. Countries have expressed an increasing political desire to replace the traditional donor-recipient relationship with a new concept of *technical cooperation*, whereby Member States make use of their Organization to define and achieve social and health policy objectives determined by their own needs. The health programmes resulting from this approach are aimed at promoting national self-reliance for health development. WHO's role in technical cooperation programmes is thus to support national health development.

A number of criteria for defining technical cooperation have been suggested. Technical cooperation can be interpreted to mean activities that have a high degree of social relevance for Member States in the sense that they are directed towards defined health goals and will contribute directly and significantly to the improvement of the health status of their populations through methods they can apply now and at a cost they can afford now. In formulating such activities the important principle in technical cooperation over the next decade—to develop national self-reliance in health matters—must always be kept in mind. The concept of WHO doing something *for* countries has yielded to cooperation *with* countries and the fostering of cooperation *between* the countries themselves so that together a lasting impact is made on health development.

This new approach to technical cooperation is part of the wider process of health development, in which health both contributes to and benefits from social and economic development.

### The North-South dialogue

It is still not certain to what extent the developed countries are prepared to help the developing countries achieve the goal of health for all. The South, having formulated its social target of health for all and its principal tool of primary health care, now has a much better chance of moving towards self-reliance in health. And now it can simultaneously challenge the North by saying that, to achieve our collective goal of health for all, we will do 95-97% of the job ourselves, but will you not let us have the 2-3% of support that is essential for us to make the best of our 95-97%?

And why should the developed world help? Because in the process it would only help itself. Take the case of smallpox eradication. Ironically, it is the rich world that is making, according to a moderate estimate, a saving of about a billion dollars a year. It seems reasonable to say that a least half the profits should go back to the developing countries; they took part in the campaign largely for the sake of the developed countries. In Africa, for instance, the form of smallpox was not very serious. They could live with that. If you have a million children dying from malaria, it is not the most important thing to eradicate smallpox. But because of its commitment to global solidarity, Africa had to eradicate smallpox. This is a good illustration of just how interdependent the nations of the world are in health. No nation lives in isolation today. Health is indivisible.

But probably what the developed countries will gain most is knowledge about how to handle their own health problems by emulating the approaches being developed in the Third World—a kind of reverse transfer of technology. An appreciation of the South's real health problems will have a better chance to emerge once the North gets a feeling for the incredible irrationality that exists in its own health system. This will be an additional factor leading to the true global solidarity necessary to achieve health for all the world's peoples. The developed countries have begun to realize the tremendous benefits they will derive from a new development order. It is already happening, you can open the report of

the Brandt Commission and see that we are realizing for the first time that it is in the interest of affluent countries to generate markets in the developing world. It is the only way that these countries can keep up their growth potential. That is now accepted. There is still a long way to go to translate that into action. But with all these movements taken together it is not unrealistic to aim for health for all by the year 2000.

### The medical Establishment

Any thoughtful observer of medical schools will be troubled by the regularity with which the educational system of these schools is isolated from the health service systems of the countries concerned. In many countries these schools and faculties are, indeed, the proverbial ivory towers. They prepare their students for certain high, obscure, ill-defined, and allegedly international "academic standards" and for dimly perceived requirements of the twenty-first century, largely forgetting

**Appropriate health technology has enormous professional, commercial, and therefore political implications, and we may often find ourselves in opposition to the medical and allied professions and industries.**

or even ignoring the pressing health needs of today's and tomorrow's society.

Most of the world's medical schools prepare doctors not to care for the health of the people but to engage in a medical practice that is blind to anything but disease and the technology for dealing with it. Sometimes even the cynical question is raised: does it really matter what kind of doctors we train?

But society, which, after all, foots the bill for all that happens in health, expects us to prepare doctors to fulfil a social purpose in response to the health needs and demands of the community they are going to serve. The medical school is an integral part of society, an instrument that should prepare for work in and for society. To this end we must first

examine carefully the conditions that graduates will face when they leave medical school and arrange an education programme to prepare them for that role. To do this, we have to ask a few searching questions.

- Do graduates think and behave in terms of “health” rather than of “disease”? That is to say, do they apply techniques of prevention and health promotion and not only those of cure and rehabilitation?
- Do graduates think and behave in terms of the family and community rather than in terms of the individual sick patient?
- Do graduates think and behave in terms of membership of a health team consisting of doctors, nurses, and other health workers as well as social scientists?
- Do graduates think and behave in terms of making the best and most effective use of the financial and material resources available?
- Do graduates think and behave in terms of their country’s patterns of health and disease and its relevant priorities?

If the answer to all these questions is in the affirmative, then the medical school is going some considerable way to preparing a graduate whose training is relevant to the health needs of modern society. If, however, some of the answers are not an unequivocal “yes”, there is urgent need to re-examine the whole philosophy and programme of the school concerned.

Doctors and other health workers, however, tend to adapt to the existing health system even when they are trained for quite different tasks. Therefore, the health system will have to be changed first and the doctors trained for the system.

If we want a system which is accessible to all members of the community, which is concerned with the promotion of health in the whole community, and in which major decisions concerning health are taken and implemented by the community, the doctor will have to become only one component of a team whose every member does what he or she has been trained for and which is oriented towards identifying and solving the priority health problems of the community.

### Health and socioeconomic development

If health for all meant medical repairs by doctors and nurses for everybody in the world for all their existing ailments . . . it would certainly not be a realistic proposition. But it does not mean that. Nor does it mean that nobody will be sick or disabled. It means a different approach by which health is considered in the broader context of its contribution to, and promotion by, social and economic development, so that all people will be able to lead socially and economically satisfying lives. It means that people will use better methods than they do now for preventing disease and disability, and better ways of growing up, growing old and dying gracefully.

— H. Mahler, *World health*, November 1979.

But here we face a dilemma. The existing community of health professionals tends to oppose the establishment of such a health system. Medical colleges are very unimaginative about how to change. The answer lies with national governments.

Fortunately, there is a growing pressure on those responsible for producing health manpower. At every level of manpower development, a revolutionary new thinking must be adopted. Existing health workers need to be reoriented and new categories of workers created. The role of traditional healers and birth attendants needs to be revalued. Individual family members must accept a new responsibility for their own health and the health of their loved ones. But real success will not be achieved until some hard political decisions are made. We should not fool ourselves into romantic dreams of a rapid change in attitudes. We will somehow have to induce in these professions an attitude which makes them see the advantages of at least going beyond the present state of passivity.

Health professionals should welcome the new roles that are being offered to them in addition to the exercise of their clinical skills—those of health leaders, educators,

guides, and generators of simpler and socially acceptable technologies. To fulfil these roles, they will require a combination of sagacity, scientific and technical knowledge, social understanding, managerial acumen, and, above all, political persuasiveness. How long will they continue to evade this exciting challenge?

The health professions are not alone in their conservatism. Classical economics too is in danger of estranging itself from the aims of society by confusing economic growth with development and by constantly demanding economic proof of social benefits. Can these benefits really always be expressed in economic terms? Surely it is the other way round: development has to be proved in social terms. It has to be capable of augmenting the energies of the people, stimulating their creativity, and raising the quality of life. The greatest potential energy in the world is human energy, and health is the fuel that can generate it.

### The scientific community

To achieve our world health target, we shall have to work closely with the scientific community. Scientists are becoming concerned about social relevance and social equity. There is growing disillusion with research that leads not to action but to the need for further research. Take the one million children dying every year in Africa from tropical malaria. It is possible to mobilize enough social commitment among those involved in health research to say that this cannot be tolerated when we have such fantastic scientific tools at our disposal, but many of these tools need sharpening and in this the scientific community has an essential role to play. Now, particularly through WHO's tropical diseases and human reproduction research programmes, we have started to strengthen biomedical research capabilities in the developing countries.

The scientists in many other fields will have to make available their competence and creative capabilities, which are urgently needed to bring simple and practical solutions to the many problems that have remained as yet without an adequate answer. To be really useful their work must become much more

oriented to practical problem-solving. Wernher von Braun once said, "Basic research is what I'm doing when I don't know what I am doing". Without in any way denigrating such "basic research", we must convince the scientists that practical problem-solving and research and development are as important as the highly sophisticated research associated with the image of the "ivory-tower researcher".

### The confrontation with industry

The confrontations with industry are the most difficult to resolve. The pharmaceutical industry, the infant foods industry, the tobacco industry, the medical equipment industry—all affect the health of the people, whether negatively or positively or in both ways. Here WHO can enable Member States who find it politically difficult to handle these confrontations to make use of WHO's neutral platform.

Look, for instance, at drugs. Developing countries found it very difficult to formulate national drug policies because of the resistance of the medical specialists or the general physicians, who were often influenced by the international drug industry. But highly expert physicians assembled by WHO from around the world have said that a concept like essential drugs is perfectly valid. Essential drugs, which can cope with the overwhelming

**The demystification of medical technology is vital to bring about community involvement.**

majority of the problems even in relatively sophisticated societies, number around 200. But for the villager and urban slum-dweller great miracles can be achieved with fewer than 30 well-chosen drugs. Without these drugs, the primary health care programme cannot work. We must be sure we can get penicillin for the child whenever he has pneumonia. It was WHO's neutral role as an arbiter that led to the realization that there is nothing shameful in speaking about essential

drugs. Now the onus is back on the governments. Can they now get their experts together and enforce this concept?

Recent small-scale studies in developing countries have shown that considerable improvements in people's health can take place for as little as 0.5 to 2% of the *per capita* gross national product—or what amounts to a few dollars a year.

In the confrontation over the marketing of infant foods, too, WHO has played a significant role by providing a neutral platform. What we achieved was not a miracle, but when it is compared with the situation 10 years ago it is remarkable that industry, non-governmental organizations, and Member States could arrive at this kind of consensus. Now Member States will have a code of conduct for the marketing of infant foods, which they can adapt to their own conditions.

Providing a neutral platform and creating a consensus is often not enough in these confrontations. With essential drugs, for instance, we are now moving straight into technology, production, patents, trademarks—all the elements of a new international economic order in the widest possible sense. WHO has set the scene, and other bodies like the UN Conference on Trade and Development, the UN Industrial Development Organization and the World Bank should now play their parts. The essential drugs programme, despite its imperfections, has already elicited an encouraging response from a number of developing countries now formulating national drug policies and from Member States in the Western Pacific Region who have got together under WHO auspices to decide on collective purchasing so that they can negotiate with drug suppliers much more strongly than in the past.

Still, the speed of the essential drugs programme is too slow, and WHO, by itself, does not have the necessary social or economic ability to accelerate the process. We need, therefore, to involve UNIDO, UNCTAD, and the drug industry itself as well as Member

States, so as to overcome normal marketing pressures, which impede progress. A startling example of such constraints occurred at one conference when the industry spokesman said that the production of vaccines and sera is so competitive that they were losing interest in it. What conclusion can you draw from that? When you want health for all and want to prevent six million children dying from tuberculosis, whooping cough, diphtheria, measles, and polio every year, then you need to vaccinate 100–120 million children every year. In order to get that you need a vaccine price that is low. But when the price is low, you can't get the products. So the conclusion is that we can no longer treat these vital components of people's health as normal commodities in the market-place. They may have to be taken out of the market-place, and other ways may have to be found to produce these essential drugs. Nothing will work more in this area than the joint efforts of countries to exchange technologies, information, and experiences, and jointly boost their bargaining positions.

### The political will

The concentration on building up health systems based on primary health care for the delivery of programmes aimed at achieving the target of health for all, the reforms needed to ensure effectiveness and efficiency in carrying out these programmes, and the acceptance of the methods of financing them all require major political decisions in countries, and at regional and global levels—in a word, political will.

Can social benefits be expressed in economic terms? Surely it is the other way round: development has to be proved in social terms.

Ministerial departmental policy alone will not be sufficient. Health for all will not be attained without the political commitment of governments and of groupings and communities of governments which see health development as an integral part of socioeconomic development. Expressions of this political

**Africa aims high**

The measurement of progress towards Health for All by the Year 2000 will require a number of sensitive indicators to be used by every country. This problem was considered by the WHO Regional Committee for Africa at its thirtieth session in September 1980, but from a purely regional point of view. The Committee thought that the number of indicators should be limited and that they should be of a kind that can make use of approximate figures. For the measurement of progress in the African Region the Committee proposed the following indicators.

- (1) Number of countries having demonstrated the political will to achieve health for all (through their allocation of resources and development of appropriate managerial processes).
- (2) Number of countries able to show that their health resources are fairly equitably distributed (according to percentage of GNP spent on health, the proportion of that amount going to primary health care, and the degree of equity in the distribution of resources).
- (3) Number of countries providing primary health care coverage (as shown by the existence of a public standpipe or protected well within 15 minutes' walk of each house, by the percentage of at-risk children immunized, and by the availability of essential drugs).
- (4) Number of countries where the nutritional status of children is up to standard (judged by the number of newborns of 2500 grams and over per 1000 births and by the proportion of children who are 50% underweight compared to an agreed standard).
- (5) Number of countries in which the infant mortality rate is less than 50 per thousand.
- (6) Number of countries in which life expectancy at birth is higher than 55 years.
- (7) Number of countries in which the GNP per head is greater than US\$500.
- (8) Number of countries in which the adult literacy rate is greater than 50%.

commitment are to be found in a recent resolution of the United Nations General Assembly<sup>3</sup> and in declarations of groupings of countries such as the Organization for African Unity and the Non-Aligned Movement.

However, ministries of health could exercise important leadership functions, particularly if their functions were reviewed and better geared to leadership. A primary function of an invigorated ministry of health is that of leadership in introducing *new* ideas and *new* policies. In many countries, ministries of health do not seem to have the formal power they require to ensure that adequate attention is paid to health development, but if they dare to exhibit greater leadership in ideas this will lead to a strengthening of their influence in the formulation of social policies at the political level. And such leadership is badly required to promote public confidence.

If political persuasiveness is to be applied to social development, it must be fully backed

by carefully defined policies and by soundly formulated plans and programmes. Political decisions will therefore have to be taken by countries to introduce or strengthen the health development process, an important part of which is an appropriate managerial process. There is also a need for regional strategies for health development. The Regional Committees of WHO will have to display greater leadership than ever in establishing various regional mechanisms for programme development, such as research, development, and training centres to promote regional self-reliance.

Above all, there is a need for the political support of the Health Assembly, the highest constitutional authority of WHO, because the achievement of international health targets by

<sup>3</sup> Resolutions and decisions adopted by the General Assembly during its thirty-fourth session. New York, United Nations, 1980, p. 95 (Resolution 34/38. Health as an integral part of development).

WHO as a whole will require the supreme support of its collective membership. It will even require a readiness to sacrifice part of national health sovereignty in the interest of international health solidarity. This solidarity should manifest itself in such ways as the mobilization of internal and external financial support, the participation of the health institutions of particular countries in international collaborative networks for the attainment of common health objectives and for the regionalization of health technology, and a genuine sharing of experience with other countries.

Most politicians are very uncomfortable with the present kind of health care situation in which the few are eating up the best at the expense of the many.

WHO can provide political support to countries in both words and action—in words, by stating our social targets forcefully to the world and emphasizing our determination to reach them; in action, by giving top priority to those programmes that properly reflect our principles and policies and that are most likely to realize them.

We shall undoubtedly have to face many political problems. Some of them will derive from commercial and professional interests, where they are touched, for example, by the generation of appropriate technology for health, by the adoption of drug policies aimed at providing essential drugs for all and establishing drug industries in developing countries, and by the preferential production of vaccines in certain countries on behalf of the region concerned. Most of all, there will be the political pressures deriving from any attempt to change a planning process from one that aims to meet the needs of a few into one that aims to meet the needs of all.

We cannot expect any politician to close down what is there, because one of the most formidable absolute constraints is that people will never permit anything to be taken away from them. But a perfectly logical political

consequence of adopting primary health care will be to ensure that additional development expenditure does not perpetuate existing bad practices. So provided the political decisions are right we shall get the funds.

While health services are clearly an integral part of a country's social policy and political structure, we must assume that health policies and actions can be changed and improved without a change in the basis of government.

### Is "Health 2000" Realistic?

How much will it cost? Are the costs exorbitant? Recent small-scale studies in developing countries have shown that considerable improvements in people's health can take place for an extra expenditure of as little as 0.5 to 2% of the *per capita* gross national product—or what amounts to a few dollars a year. This is by any standard a reasonable cost—a hundredth of what is spent on health by people in many rich countries. So cost factors should not hinder governments when they consider their plans for meeting their commitment to the target of health for all by the year 2000. Even within their present expenditure for health, most countries could make significant progress towards health for all by the year 2000 by reorienting their health systems, placing the thrust of their effort on primary health care for the whole population rather than on sophisticated hospital and specialist services for privileged minorities in urban areas. However, rich countries not only have the moral duty to support the efforts of developing countries both financially and technically; they also have a clear interest in doing so. Health reform on a global scale rests on the enlightened self-interest of the industrial nations, not on the lukewarm altruism of the élites of these countries. The North-South dialogue must lead to a new economic order in the interest not only of the Third World but also of the industrial countries.

Change is coming and I am sure we shall succeed. We *must* succeed. The children of today, and those who have not yet been born but will comprise more than a third of the people living in the year 2000, will never forgive us if we do not.

ANNEX

The attainment of health for all by the year 2000 was the central issue of the International Conference on Primary Health Care, held at Alma-Ata in September 1978. In view of the importance of that conference for future health strategy throughout the world, the Declaration of Alma-Ata is here reproduced in full.

DECLARATION OF ALMA-ATA

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

## VII

## Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: 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;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

## VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

## IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report<sup>1</sup> on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

## X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

<sup>1</sup> *Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.* Geneva, World Health Organization, 1978.