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## Health for All by the Year 2000 - Where has the WHO gone?

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### Abstract

Enjoyment of the highest attainable standard of health is a fundamental human right of all people<sup>2</sup>. This is seen as an important outcome as well as a goal of sustainable human development. Yet at the dawn of the 21st century massive worldwide disparities in the provision of health care continue to exist; 800 million people still lack access to health services<sup>3</sup>. The rate of development of the first world has been greater than that of the third world so the gap between “haves” and “have nots” is greater than ever; the richest 1.2 billion people in the world account for 82.7% of the total global wealth<sup>4</sup>.

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# Health for All by the Year 2000 - Where has the WHO gone?

Jane Atkinson

*“Tell the Ministry of Public Health it only works for 15% of the entire population. Furthermore, this 15% is made up of mostly the privileged. The broad ranks of the peasants can not obtain medical treatment and also do not receive medicine. The Public Health Ministry is not a people’s ministry. It should be called the Urban Public Health Ministry, or the Public Health Ministry of the Privileged, or even the Urban Public Health Ministry of the Privileged”.*

Chairman Mao Dezhong, June 26, 1965 <sup>1</sup>

Enjoyment of the highest attainable standard of health is a fundamental human right of all people <sup>2</sup>. This is seen as an important outcome as well as a goal of sustainable human development. Yet at the dawn of the 21<sup>st</sup> century massive world-wide disparities in the provision of health care continue to exist; 800 million people still lack access to health services <sup>3</sup>. The rate of development of the first world has been greater than that of the third world so the gap between “haves” and “have nots” is greater than ever; the richest 1.2 billion people in the world account for 82.7% of the total global wealth <sup>4</sup>.

Even within developing countries there are major health disparities. In the past many governments, in striving for very visible development, have invested in building a western style medical system. As a result there are large, sophisticated hospitals often in the capital, or regional centres capable of sophisticated procedures. These services are life-saving, but only benefit a tiny minority of the population. All this time the same country neglects the vast majority who are deprived of the most basic of medical services. The traditional communist dictum of the greatest good for the greatest number is being ignored. Governments do not seem to understand that health is central to the development process.

## The Road to Alma-Ata

It was in fact the aforementioned communists, in China, who first realised that the route to

development was not with fast medical development but in the provision of basic health care that was available to all. Chairman Mao Dezhong, in 1965 as part of his cultural revolution, advocated ‘barefoot doctors’ who would have only three years training but would provide inexpensive, basic health care to all, especially the rural masses <sup>1</sup>.

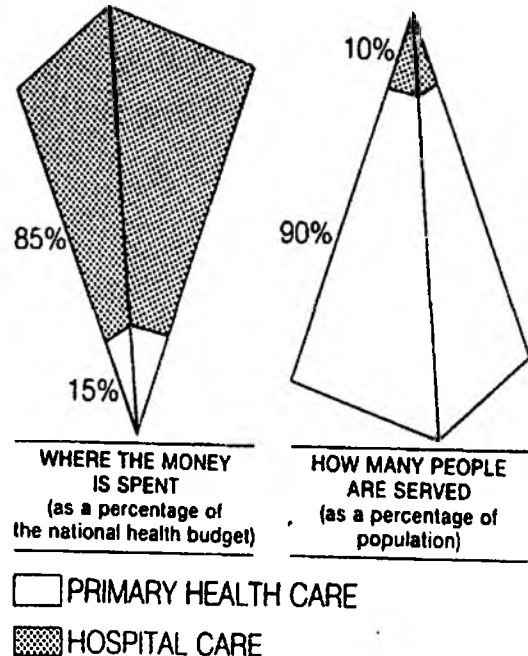


Figure 1: Distribution of health spending in developing countries <sup>1</sup>.

This idea lived on only to re-emerge a decade later at the 1977 World Assembly of the World Health Organisation (WHO). They decided that

their main social target should be “attainment, by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”; this target was summarised as Health for All by 2000 (HFA2000) <sup>5</sup>. Dr Mahler (the Director-General at that time) perceived the outcome of HFA - “people will use much better approaches than they do now for preventing disease and alleviating unavoidable illness and disability and that there will be better ways of growing up, growing old and dying gracefully” <sup>6</sup>.

This was an extension of WHO’s traditional role from setting normative standards and providing technical advice and assistance on medical matters to also include advocacy of health through HFA2000 <sup>7</sup>. This extension was a profound change for the organisation who had previously taken “the approach to health that was largely disease orientated and it studiously avoided political or cultural controversy” <sup>8</sup>.

### **The Declaration of Alma-Ata**

The conference found that the key to obtaining HFA2000 was by the worldwide implementation of primary health care (PHC). This would not be yet another externally led “add-on” programme, it would form an integral and permanent part of the health care systems from the ground up of both developed and developing countries. Thus it would be a reversal of the current hospital/institution based health care system.

PHC consists of nine main areas:

- Health Education
- Environmental sanitation, especially of food and water
- The employment of community or village health workers
- Maternal and child health programs, including immunisation and family planning
- Prevention of local endemic diseases
- Appropriate treatment of common diseases and injuries
- Provision of essential drugs
- Promotion of nutrition
- Traditional medicine

HFA2000 strategy is meant to operate at three levels; locally, nationally and internationally. Ideas should be initiated nationally but planned locally, therefore being most appropriate to the people it aims to serve. Internationally there should be a flow of ideas and strategies co-ordinated by WHO. National self-reliance does imply national initiative but not national self-sufficiency and idea development. HFA was to encompass these five following concepts <sup>5</sup>.

1) **Equity** – This is the foundation of the HFA2000 concept. Every individual must have lifelong access to comprehensive health care regardless of how poor or remote they are.

2) **Comprehensive provision** - Services must be promotive, preventative, curative and rehabilitative.

3) **Sustainability** – The project must be sustainable; financially, culturally and technologically to provide health for all, as well as responsive to changing conditions.

4) **Community involvement** – This promotes self-reliance and reduces dependence.

5) **Integration** – Health, as a sector can not develop in isolation; it both contributes to and is affected by other sectors such as sanitation, housing and education.

### **The Role of WHO**

*“WHO knows everything but does nothing” <sup>9</sup>*

The role of WHO is not to provide the primary health care for HFA2000 but to inspire and assist countries to do so themselves as well as co-ordinating the non-governmental organisations (NGOs) such as UNICEF (who incidentally “knows nothing but does everything” <sup>9</sup>). In this there is a problem, WHO itself is in crisis. It is an underfunded (biennial budget for 1994-5 just \$1.8billion compared to the annual NHS budget of \$60billion), bureaucratic, overspread organisation <sup>7</sup>.

Over the last decade there has been mounting

criticism of the lack of strong leadership and clear strategy; there have even been rumours of corruption<sup>7</sup>. The fact that pharmaceutical representatives are present at many policy-forming meetings has long been considered inappropriate<sup>3</sup>. WHO can not afford to lose its credibil-



*Figure 2: Dr Nakajima – Director-General 1988-1998*

ity, operating as it does through governments. It also needs to be trusted by other NGO's, such as UNICEF, who are more involved on the ground implementing the policies.

Many of the problems have been contributed to by the poor leadership of the recent director-general Dr Hiroshi Nakajima who held the position from 1988-1998. Seen by many as a reserved and a poor communicator, he himself confesses to not being a strong leader<sup>10</sup>. Dr Nakajima attempted to establish "a new paradigm for health" but he embarrassingly failed to explain what this was.

The international loss in confidence, especially by donor countries led to a demand for greater accountability. To gain more control over their donations there has been an increase in the so called 'extra budgetary contributions' for 'special programmes', accounting for 50% of WHO's income, which are outside the direct control of the management. Donors can exert political pressure by threatening to withdraw these funds<sup>11</sup>.

This leads to another problem for WHO: special programmes are generally performance driven, judged by short-term outputs (such as percentage immunity achieved)<sup>11</sup>. They also by-pass WHO's commitment to only working through governments and are generally non-integrated. The programmes are forced to compete with each other for funds so focus on the glamorous, attention-grabbing causes rather than the grass root development so essential for the implementation of HFA2000.

The problems of global initiatives are neatly summarised by Banerji: Firstly, how can one have a 'prefabricated' initiative given the extreme variations among and often within poor countries? Second, selection of health problems for action conformed more to the special interests of the rich countries than the poor. Third, a technocentric approach to problem solving was adopted. Fourth, there is an obvious contradiction in the scientific basis of the claim that the suggested globe-embracing programs are cost-effective given the profound variations among and within countries. Fifth, by their very nature, international initiatives cannot promote community self-reliance. Sixth, there is the key question of dependence and sustainability; 'donors' have used their tremendous influence on the pliable ruling classes of the poor countries to ensure that the ill-conceived, ill-designed, ill-managed global initiatives are given priority over the ongoing work of health organisations. Finally, and above all, these programs are the very antitheses of the Alma-Ata Declaration.

### **Future of WHO**

Much hope was placed on Dr Brundtland the current Director-General. She is originally from a medical background and was Prime Minister of Norway for 10 years<sup>12</sup>. Her main immediate aims as stated in her initial address in July 1998 would be to "pull WHO together by focusing on our core business", "reconnect the organisation through flatter structure, better communication, more transparency and a clearer distribution of roles", and "create an organisational structure not driven by bureaucratic rules but one that promotes performance and results"<sup>13</sup>. All this sounds great and is desperately needed for



Figure 3: Dr Bruntland – current Director-General <sup>12</sup>

revitalising the WHO, but what has happened to HFA2000? In Dr Bruntland's 16 page opening address in July 1998 she referred to HFA only once in reference to "keeping our long term objective of HFA..." <sup>13</sup>. She seems more interested in highlighting the importance of the special programmes especially relating to HIV/AIDS, which are more inclined to by-pass governments and be a "global initiative". WHO has to re-establish its two main roles; firstly to encourage governments and NGOs to work towards health for all, and secondly, to stress the need for partnerships between health and other sectors <sup>3</sup>.

### Future of HFA2000

HFA2000 was not fulfilled; child mortality is no longer dropping, per capita income in sub-Saharan Africa is lower than in the 1960s <sup>3</sup> and the poverty gap has increased by 30% in the past decade <sup>14</sup>. In 1998 WHO re-christened the project Health for All in the 21<sup>st</sup> Century but this new initiative reads like the policy statement for all of WHO's interests. It is made up of Ten Global Health Targets including "reversal of global trends of the five major pandemics" "eradication and elimination of certain diseases" and "implement global and national health information and surveillance systems" <sup>13</sup>. So although HFA

still exists it has become an idealistic phrase rather than an obtainable goal.

This is a tragic state of affairs; the premises on which HFA2000 was launched over twenty years ago still exist. There is still a huge unmet need for provision of basic health care for all people, regardless of how poor or how remote. The individual special programmes are valid but intrinsically focused on a particular population, be it those with HIV/AIDS, or mother and child health. WHO is at risk from losing sight of its philosophy of equity and becoming an organisation of parallel programmes.

*"Before talking of the renewal of the HFA strategy, WHO has to note that it has never been completely implemented. They ought to have elicited the reasons for this sad state of affairs before coming up with yet another 'initiative'."* <sup>16</sup>

### Conclusion

The principle of Alma-Ata was to develop PHC to become an integral and permanent part of the health care systems. To establish HFA2000 was hugely ambitious and although it was not obtained it does not mean it is not possible given time and enthusiasm; development occurs in

small steps rather than great leaps<sup>17</sup>. It has been estimated that \$27 billion would save 8 million lives per year; this seems like a colossal amount of money but it is still \$13 billion less than America's Congress appropriated for its "War on Terrorism" only three days after the September 11<sup>th</sup> attacks; alternatively it could be looked at as being only \$25 per rich-county citizen each year<sup>18</sup>.

WHO is in a unique position to influence the governments of developing countries to raise the status of health on national agendas and to re-structure health systems to focus on primary health care<sup>19</sup>. WHO will always be faced with problems of political instability and conflicts of interest but with perseverance governments will eventually realise that having a healthy population is the only way of obtaining long-term, sustainable, economic and social development.

HFA needs to be separated from WHO's Global Health Targets, maybe even renamed Health by All so it is not considered a passive process<sup>20</sup>. It must be re-established as a major global initiative that operates locally, nationally and internationally involving individuals, communities, NGOs and governments. It may even be appropriate to separate WHO into two sister organisations; one dealing with the shorter-term specific "special programmes", the other striving for the fulfilment of HFA through development of primary health care systems.

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