

Editorial

Reflections on health-for-all developments and prospects

Hussein A. Gezairy MD, FRCS¹

The founders of the World Health Organization (WHO) were indeed aiming at insuring health for all individuals and peoples when they formulated the WHO constitution shortly after the end of the Second World War. They had the wisdom to postulate in the year 1946 that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" [1]. That fundamental concept was the foundation upon which WHO was established. In the early years of WHO, remarkable efforts were made at the national, regional and global levels which lead to unprecedented improvements in the world health situation. However, 30 years after the founding of WHO, both WHO and the United Nations Children's Fund (UNICEF) called for new approaches that would end the inequitable distribution of health resources between and within countries [2]. Towards that end, they convened the International Conference on Primary Health Care at Alma-Ata in September 1978, bringing together representatives from 140 countries, to exchange information and experiences and to devise new directions for future international health work.

Primary health care was considered the key to attaining for all peoples, levels of health that would permit them to lead so-

cially and economically productive lives [2]. The main elements of primary health care, as indicated by the conference, were health education, the promotion of proper nutrition, adequate safe water, basic sanitation, maternal and child health care including family planning, immunization programmes, endemic disease prevention and control, treatment of common ailments and injuries and the supply of essential drugs [3]. The conference emphasized that each country had to interpret and adapt primary health care within its own social, political and developmental context. However, all health systems should provide promotive, preventive, curative, rehabilitative and emergency care. Governments were urged to coordinate the work of different ministries in health-related fields, and to delegate responsibility and authority to intermediate and community levels [2]. They were recommended to work out well-defined goals and action plans to ensure that primary health care be accessible to the entire population [2].

These were some of the basic aims and directions prescribed by the conference and immediately translated into action both by Member States and by WHO. A global sense of interdependence and complementarity emerged, which led to increased support to deprived countries and to the underserved populations within countries. In a few

¹Regional Director, World Health Organization Regional Office for the Eastern Mediterranean, Cairo, Egypt.

years, there was a marked shift from a situation of prevailing injustice and maldistribution of health care, to more human services, based on the ethical principles of human rights. In order to maximize the moral depth of health care as inspired by the health-for-all initiative, the World Health Assembly, in the year 1984, invited Member States to consider including the spiritual dimension in their strategies for health for all [4]; an aspect which will be reflected in the definition of health, to be defined as a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease and infirmity.

In the years that have passed since Alma-Ata, health for all through primary health care has proved to be an eminently sound, ethically correct and cost-effective way to improve the health and quality of life of individuals and communities alike. Evidence shows that there have been substantial improvements in health status all over the world and much of that improvement can be attributed to the implementation of the principles and concepts of primary health care. Of course, progress has been uneven. There have been many instances where improvement in health should have been much faster, and there have also been some instances where certain indicators have deteriorated. However, it is heartening to observe that the more countries work with the original health for all principles, the more it becomes clear that what in the seventies were sometimes statements based on ideology and ethical values have turned out to be observable achievements confirmed by research evidence [5].

It is worthwhile at this juncture, to recall a few innovative programmes that embody the spirit and principles of health for all.

- The basic development needs (BDN) approach has been actively supported and endorsed in countries of the Eastern

Mediterranean. This approach requires the involvement of many government and nongovernment sectors (e.g. social, economic, health) and the founding of partnerships between the numerous levels and actors concerned with its implementation. BDN provides people with resources and technical support to attain their basic needs including health, income, education, environment and social development. It is based on active community involvement and encourages communities to take greater responsibility for themselves. It strongly advocates and implements strategies that facilitate access to essential social services, appropriate technology, information and credit, with the explicit aim of promoting fair distribution of resources to achieve equity at the grass-roots level [5]. The BDN approach is a realistic workable model that puts the principles of health for all into real practice.

- Another example is the recently established Roll Back Malaria initiative. In May 1998 this initiative was launched with its emphasis on partnership, evidence-based action, political mobilization and participation of the community. The core objectives are to reduce malaria morbidity and mortality, to prioritize effective malaria action within health sector development, to base actions on research evidence making a stronger linkage between scientific studies and the provision of services, to ensure that those leading the movement back their leadership with strong advocacy and media relations, and innovative approaches in order to widespread "grass-roots" action including community mobilization and empowerment and more effective means to improve the capability of primary health care providers in the private sector [6].

- A third example to be cited is the world-wide mobilization against the tobacco epidemic which resulted in the loss of at least 3.5 million human lives in 1998 and is expected to cause at least 10 million deaths a year by 2030, if the pandemic is not controlled, with 70% of the deaths occurring in developing countries. A global effort has been initiated by WHO to bring together all national, regional and international powers to combat the tobacco scourge. Furthermore, a WHO framework convention on tobacco control is being formulated with support from Member States, organizations of the United Nations System, other intergovernmental, nongovernmental and voluntary organizations, and the media [7].
- Last but not least are the significant improvements that have taken place since Alma-Ata in various health indicators in the Eastern Mediterranean Region. For example, female life expectancy increased from 57 years in 1985 to 65.6 years in 1996 and male life expectancy increased from 56 years to 62.3 years; and the total adult literacy increased from 38% to 63% during the same period. The infant mortality rate dropped from 97.5 to 75 per 1000 live births, and under-5 mortality from 132 to 115 per 1000 live births.

The health-for-all movement is progressing with renewed vigour and variable features in response to the changing world in which we live. Needless to say, components of human life are continuously changing. Lifestyles and requirements are now quite different from those in the past and will indeed be different in the future. Alertness and open-mindedness are needed to keep abreast of the unavoidable changes

encountered and allow new perspectives. That is why a new regional health-for-all policy and strategy for the 21st century has been formulated [8].

WHO's goals for the future are to build healthy populations and communities and to combat ill-health. To realize those goals four strategic directions provide a broad framework for focusing WHO's technical work [9].

- Strategic direction 1: reducing excess mortality, morbidity and disability, especially in poor and marginalized populations.
- Strategic direction 2: promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioural causes.
- Strategic direction 3: developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair.
- Strategic direction 4: framing an enabling policy and creating an institutional environment for the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

These four directions are interrelated, and their success will depend upon the fullest cooperation of all those concerned everywhere.

These are some reflections on the progress of health for all since its inception in 1978. The overall goal of protecting and promoting the health of all the people of the world has not changed from the very beginning. However, the instruments used have changed and will continue to change, albeit with wider steps and at a faster pace.

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The objective of the World Health Organization (hereinafter called the Organization) shall be the attainment by all peoples of the highest possible level of health.

Source: Constitution of the World Health Organization, Chapter I, Article 1.