Formulating strategies for health for all by the year 2000 (report of the Programme Committee of the Executive Board)................. 1

The CHAIRMAN reminded members that the document requested by the Programme Committee relating to the United Nations General Assembly resolution on health as an integral part of development would be available later, at which time they might wish to discuss that aspect of the item.

Dr BRYANT, introducing the item as a member of the Programme Committee, said that it had been considered in the light of the Director-General's report - document EB65/PC/3/WP/4, attached to the Committee's report (EB65/4) - which gave background information and reported on progress by Member States in formulating national strategies and on progress at the regional and global level, including the global and regional support system for strategy formulation. Under the timetable (paragraph 134 of Annex 2 in document WHA32/1979/REC/1), Member States were scheduled to submit their reports on national strategies by June 1980.

The report described the progress of Member States in the area of political commitment, then outlined the obstacles encountered. It then referred to intersectoral collaboration and reviewed ways in which headquarters support had been called upon by the countries. The concepts of country health programming and national health development centres were proving their value in formulating and implementing strategies. One of the areas of particular importance identified by countries was that of monitoring progress towards health for all, and that brought up the question of the kind of indicators or measures to be used. Two major WHO study group meetings had considered that particular question. The Organization had also been attempting to facilitate the exchange of information on those matters in various countries.

The document then outlined progress in regional and global strategy formulation, and reported on progress in each region.

The Global Programme Committee had met twice to review the support that might be required, and had established a Programme Development Working Group to assist in developing an operational plan for WHO support of strategies in the next two decades.

The purpose of the Global Health Development Advisory Council was to obtain support from expert sources outside the Organization in the overall development of the programme. Another group in the process of formation was the Health 2000 Resources Group, concerning which the Board would soon receive an explanatory document.

The report then referred to international meetings which had had a bearing on efforts to attain the target and showed the influence exercised by WHO on thinking with regard to appropriate approaches to health for all.

The Programme Committee's reaction to that report was set out in document EB65/4. It had drawn attention to the need to move from political commitment to specific action. It had recognized the need for clear understanding of the true meaning of health for all by the year 2000 and of how progress towards its achievement should be monitored. It had also recognized that economic development did not necessarily make a positive contribution to health, and that there was an urgent need to improve social justice and equity in many countries.

The Committee had identified a number of typical obstacles to efforts to attain the goal, commended the role played by the Secretariat, emphasized the importance of interregional exchanges, and discussed the importance of indicators that could capture the dynamic and continuing nature of health development, and means of influencing health development. It had discussed the contribution of other organizations, especially UNICEF, and the resources which
could be called upon. It had also considered the resolution on health as an integral part of development, which had been unanimously adopted by the United Nations General Assembly; the Board would discuss that under a separate agenda item.

The Committee had seen the evolution of the concept of the health for all movement as the full meaning and possibilities became apparent to the various countries and organizations. New support systems were being developed in WHO, and the concept was pervading the Organization and its programmes. Various international organizations were becoming aware of the idea and at last beginning to appreciate its possibilities. At the country level, the movement was spreading, particularly among the less developed countries, and some of the more developed nations were awakening from their apathy to the realization that perhaps they did not possess health for all and that the situation might be deteriorating through overdevelopment. He wondered, however, if those most interested in the concept were not too quick to see positive developments and insufficiently aware of the vast areas where there was no progress at all. It was therefore extremely important to be informed of the true situation by Regional Directors and the Director-General himself.

Dr NAKAJIMA (Regional Director for the Western Pacific) explained that that Region consisted of a large variety of countries with different degrees of economic and social development. However, all those countries had unanimously agreed to cooperate to achieve the objective of health for all by the year 2000.

With expanded terms of reference, the Sub-Committee on the General Programme of Work had been working on the formulation of strategies for health for all by the year 2000, had reviewed country reports and documents, and had submitted a report to the 1979 session of the Regional Committee. Members of that sub-committee would visit selected countries which had shown particular interest in strategy formulation during the latter part of March 1980. A progress report was also expected from countries by May 1980. The sub-committee was to convene a meeting in June 1980 and prepare a progress report to be submitted to the 1980 session of the Regional Committee in the light of experience gained during the visits of its members, guidance provided by the Executive Board, and proposals from countries.

At the same time the Regional Office had formed a special multidisciplinary task force which would visit each country for a certain period and work with national personnel to prepare the country's individual strategy.

Heads of State and Ministers of Health, even though they were not medical professionals, had expressed particular interest in the concept, and Ministers of Health had held a special meeting to discuss intercountry technical cooperation on pharmaceutical supplies in the South Pacific. During that meeting the discussion had centred on the formulation of a strategy for health for all by the year 2000, particularly in the light of technical cooperation among developing countries. During the various discussions, particular attention had been paid to the nature and type of indicators and measures for the formulation of strategies as well as monitoring and evaluating their progress. The type of indicators presented various problems, since some would be politically sensitive and might or might not affect the health situation of the country. The health information study group was therefore examining the different types of indicators from the health, political and socio-economic development aspects.

Dr KAPROI (Regional Director for Europe) explained that the hesitation in some European countries about the relevance of the goal of health for all by the year 2000 was rapidly disappearing in view of the gradual recognition that in certain areas and populations health was deteriorating owing to various aspects of so-called development.

In the Region, both national and international action would be undertaken to improve health wherever possible, and one of the most important elements of the resolution on health for all by the year 2000 adopted at the last session of the Regional Committee was a request to the Regional Director to pursue studies at regional level in order to provide information on important aspects of health development in the Region between now and the year 2000.

A special Task Force had already been established to collect all the statistical and other information needed to weigh up the different possibilities. Another development in Europe was that health policy was to be discussed at the meeting of Ministers of Health of 21 countries to be arranged in Madrid in 1981 by the Council of Europe in cooperation with
WHO; at another level, following the Alma-Ata Conference the question of how the primary health care approach to health for all could be furthered in each social and economic situation had been discussed in Brussels in November 1978 at a meeting of family practitioners from member countries of the European Economic Community.

The Regional Office was strongly encouraging interest and cooperation throughout the Region in the preparation of the strategy for health for all, paying special attention to the few countries where the coverage was not yet complete.

Dr ACUÑA (Regional Director for the Americas) drew attention to paragraph 27 of the Director-General's report to the Programme Committee which quoted the resolution adopted by the last session of the Regional Committee for the Americas, in which it had recommended to Member countries that at the thirty-fourth session of the United Nations General Assembly they "support initiatives aimed at recognizing the goal of health for all in the year 2000 in which health is considered as one of the components of development and an integral part of the international development strategies". Such action from the health sector, designed to involve the highest political levels, was vital to the success of the policy of health for all by the year 2000.

In addition to the reports before the Board, he had available a table summarizing the progress in the countries of the Americas up to 31 December 1979 which listed countries, activities, information on national strategies, problems encountered, and the support being given by WHO to each particular country. If the Board so wished, it could be translated for distribution.

Dr TABA (Regional Director for the Eastern Mediterranean) said that the policy of health for all had been approved by all Member States in the Region. The questions referred to in the report mainly emphasized what countries considered should be the nature of the cooperation supplied by WHO in formulating the strategy for the following two decades. The Regional Office had obtained a reasonably good response to those questions, and had consulted the Regional Consultative Committee. This committee had already discussed the item and had reported to the Regional Committee, which had made some complementary recommendations which would be put before the Regional Health Development Advisory Committee, a multisectoral body to advise the Regional Director on major health programmes. The main objectives were that countries should determine their own priorities and work out how they could help each other. Technical cooperation among developing countries was very important in the Region because some countries had much more experience than others. The Eastern Mediterranean Region had been a pioneer in primary health care. With regard to the statement by the Regional Consultative Committee that more attention should be paid to the question of how priorities could be even more effectively set in the organizations - and, once set, adhered to - the advice of the Regional Health Development Advisory Committee could be very helpful.

Dr QUENUM (Regional Director for Africa) said that he would explain how the African Region tried to implement the political decisions of government bodies from the health development point of view during the discussion on agenda item 11. The main regional activities concerned with working out national and regional strategies to attain the important goal of health for all by the year 2000 were set out in the document before the Board (EB65/4). He was, however, ready to reply to any specific questions raised by members.

Dr KO KO (Director, Programme Management, Regional Office for South-East Asia) said that, in addition to the various activities outlined in the report and mentioned by Dr Bryant, he would like to draw attention to a few other points. The first was that, in addition to the various meetings and activities carried out prior to the Alma-Ata Conference, there had been a follow-up meeting in 1978, and in December 1979 there had been a regional meeting on health for all, at which senior government officials had participated in discussing the principles and work plans for the formulation of a strategy for health for all. In those activities, the Region had much appreciated the cooperation of different bodies in the United Nations system especially UNICEF and UNDP.

The second point to which he wished to draw attention was that at the various meetings health for all had formed the basic theme of the discussions. At its last session the Regional Committee had adopted a resolution confirming its commitment to health for all by
the year 2000, and agreeing to the work plan submitted to it. A number of other resolutions on such matters as technical cooperation among developing countries and the new international economic order had also supported the health for all programme. Other meetings such as those of the advisory committee on medical research and the Heads of Medical Research Councils had stressed the importance of relating their activities to those for the preparation of the strategy for health for all.

In connexion with the work plan, various activities, which would vary with the country, were expected to be undertaken by countries before May 1980 in preparation for the strategy. Those activities would take the form of national seminars or conferences, meetings, departmental assignments or consultations. For some countries - for example, Burma, Maldives and Nepal - the strategies would be formulated through country health programming conducted early in 1980. Those activities would be supported by visits from the staff of the Regional Office and short-term consultants, or a financial contribution if financial support was required. It was planned to convene regional consultations to study and collate all the strategies in June 1980 and, if necessary, in mid-1981.

Plans had been made for the establishment of the Regional Health Development Advisory Committee, but it had been decided to await the outcome of the national activities and also to take guidance from the session of the Global Health Development Advisory Committee before actually establishing it.

A national health development centre was being established in Thailand and would be operational early in 1980, and the possibility of setting up such centres was being explored in other countries, in particular Sri Lanka and Indonesia.

Mr PADOLECHIA (United Nations Industrial Development Organization) said that during the next few days at its third General Conference, in New Delhi - UNIDO would be reporting to the international community on the achievements of the strategy for development whose guidelines had been laid down in 1975 in Lima, and it was expected that a new strategy up to the year 2000 would be developed.

Therefore, in the framework of the principles and scope of the strategy concept promoted by WHO of "Health for all by the year 2000", he was privileged to confirm, on behalf of UNIDO, the continuous interest and support of his organization for the work and initiatives of WHO, which had culminated in the recent cooperative agreement focusing on industrial production policies and projects relating to pharmaceuticals and the utilization of natural resources. The efforts of the two organizations would be combined to mobilize the industrial capabilities of all countries, in particular the developing ones, for the production of essential drugs and medicinal plants. For one of the most important points for the achievement of health for all by the year 2000 was the production and effective availability of essential drugs, for the health benefit of the population. Cooperation between UNIDO and WHO was expected to continue to expand in accordance with the respective institutional mandates.

The CHAIRMAN invited comments on the report of the Programme Committee and on the statements made.

Dr CHRISTIANSEN (alternate to Dr Mork) thanked the previous speakers for the information they had provided. He had been especially interested to hear of the proposed meeting of European Ministers of Health in Madrid in 1981 and hoped to receive more information on that matter.

While recognizing the crucial importance of formulating strategies, he maintained that any debate in the Executive Board could not be conclusive, since strategies now being formulated would only culminate with the adoption of the global strategy at the 1981 World Health Assembly. Any strategies formulated would continue to evolve in response to the setbacks, successes, unforeseen developments, and emerging forces of which history was made. Although the various meetings planned were all indispensable landmarks in the development of strategies, the strategies themselves would continue to evolve.

Meanwhile, the first need, in his view, was a much clearer understanding of what was meant by health for all, in both the developed and the developing countries. The Programme Committee had clearly stated that socioeconomic progress, although initially beneficial to
health improvement, might, if uncontrolled, lead to a deteriorating health situation. Yet, when deteriorating health conditions in developed countries were discussed, opinions suffered from insufficient evidence and lack of appropriate indicators; data on infant mortality rates, crude death rates, morbidity rates, average numbers of doctors and hospital beds per 1000 or 10,000 inhabitants were insufficient, and might be misleading. He was therefore happy to learn that an illustrative list of health indicators was being developed and would be distributed to the Board. He would be grateful to learn from the Secretariat about progress in the preparation of the list.

A second need was for a much greater effort to identify and overcome obstacles to health for all. The Programme Committee had discussed that question in detail, and he would have hoped that the discussion would have been more fully reflected in its report. In developed countries more attention would have to be paid to obtaining a greater involvement of health personnel, politicians and other personalities, and of the communities themselves, in health matters; to overcoming resistance to necessary administrative reforms; to improving planning management and the evaluation capacities of the national health authorities by developing comprehensive health information systems and using them appropriately; and to encouraging the reorientation of personnel and financial resources.

An intersectoral approach, at both the national and international levels, was called for, and in that connexion he referred to paragraph 15 of the Programme Committee's report. As the document relating to the United Nations resolution referred to in that paragraph had not yet been received, he suggested postponing the debate on that question until it was available. He would be pleased to learn how soon that would be. He hoped that by that time the documents on the Health 2000 Resources Group and the Global Health Development Advisory Council would also be available so that all might be discussed together.

The establishment of national health councils for the promotion of an intersectoral approach to health was a subject of great interest. In Norway Dr Могк had taken steps to establish a body which might develop into such a council. A meeting had been held in Oslo at the beginning of January 1980 at which national health councils and questions related to most of the items on the Board's agenda had been discussed by representatives of the health ministries of the five nordic countries. Although he was not speaking on their behalf, he would like the Board to be aware that many of the ideas he was now expressing were shared by others who were far more experienced in those matters than himself.

Dr SHWE TIN had expressed doubts at the Board's previous session as to whether country health programming existed in many countries, particularly the developing countries; however, he had not received a satisfactory answer on that point. Without country health programming it would be difficult to implement the strategy for health for all by the year 2000.

He also wondered how the concept of health for all should be defined. Did it mean that all should be healthy - which was unlikely - or that a health system should be available to all? The official concept, as expressed in resolution WHA30.43, was "the attainment .... of a level of health that will permit them to lead a socially and economically productive life". But that was a very general statement and meant, in effect, that countries could interpret it as they wished. A more precise definition was needed.

Moreover, it was not sufficient for WHO to wait and see what happened as regards implementation of the strategy. Representatives of WHO headquarters and regional offices should go out into the field, see what was happening, and engage in discussions. They should stimulate further action.

He had doubts about the usefulness of national health advisory committees; the bigger the machinery, the more difficult it often was to achieve anything. He would like to issue a note of warning to health ministries that they should enlist only those services which were really necessary.

Dr VENEDIKTOV said that he would not dwell on the significance of the concept of health for all by the year 2000. The documentation available was copious and self-evident, and a detailed discussion could be held on any one aspect.

He wished to stress, however, that there could now be no going back on the decision taken. The response to the Declaration of Alma-Ata had been tremendous, and WHO had taken a step of unprecedented importance for the whole world. Members of WHO, though as individuals they might not live until the year 2000, would have to keep their promise.
Radical changes would have to be made in health care in all countries of the world. The task was tremendous, involving all sections of society in all countries and the whole United Nations system. That was already largely reflected in the strategy document, but certain modifications were required - particularly in the light of the Board's discussion and the United Nations General Assembly resolution of 29 November 1979. He reiterated his support for the general plan of work and his appreciation of the work being done by the Secretariat and of the documentation provided. He was pleased to note the references to several meetings that had been held, but would warn against the danger of attaching too much importance to meetings rather than to effective action.

He fully supported the view of Dr Christiansen and Dr Shwe Tin that it was essential to have a clearer understanding of what was meant by health for all. Dr Bryant had referred to a minimum acceptable level of health. To whom was it to be acceptable - to the population at large, to the medical profession, or to ministry officials? The aim should be to achieve the "highest attainable standard of health" referred to in WHO's Constitution. Each country should determine realistic goals, according to the prevailing situation. It was essential to establish easily applicable means of monitoring progress. A dynamic model profile might be developed, to provide for each country not merely statistics but information on the nature of morbidity, mortality, etc. The work of United Nations demographers on mortality curves provided a good example.

Regarding the establishment of indicators for monitoring progress, the experience already gained by some countries - for example the Soviet Union - might well be valuable to others, and avoid unnecessary work.

He reiterated that the tasks of WHO and those of countries, although closely linked, were distinctly different. He would not make detailed proposals in that respect at the moment, but would merely stress the urgent need to work out a system for monitoring progress. At the meeting of the Programme Committee Dr Kruisinga had referred to Member States' constitutional obligation to report regularly to WHO regarding health, and the Director-General had stressed the importance of receiving such information; that was in fact an indirect reply to those who criticized delegates for making long statements to the Health Assembly about the health situation in their countries.

On the basis of the population forecasts for 2000, estimates should be made of future requirements regarding health personnel, centres, medicaments and equipment.

The strategy document should include a clearer definition of the concept of technical cooperation among developing countries (TCDC).

WHO should take active steps not only to propagate the idea of health for all, but also to indicate practical measures to be taken in pursuit of that aim. In that connexion, the booklet on formulating strategies for health for all by the year 2000 should be brought up to date regularly and distributed as widely as possible among countries and international organizations. There was also an urgent need for practical guidelines to help health administrators in the organization of primary health care; it should not be a blueprint or textbook, but a practical handbook. That aspect should be covered by the organizational study on training in public health.

He felt that it would be difficult to draft a resolution on the subject that would not be a mere repetition. On the other hand, a report from the Board annexing the reports of the Programme Committee and the Director-General and relevant details from the regions would be far too long. He therefore proposed that a working group be set up to prepare a brief report that would incorporate the main ideas from those various sources.

Professor AUJALEU expressed his appreciation of the statements he had just heard and of the reports of the Programme Committee and of the Director-General. The latter gave clear indications of how progress towards the aim of health for all by the year 2000 might be made.

He had, however, been surprised and even saddened by the criticisms levelled at the industrialized countries in paragraph 48 of the Director-General's report and by some of the French terms used. The use of "se targuer", for instance, was almost insulting.

Turning to the Programme Committee's report, he was pleased to note that the four speakers who had preceded him had at last stressed the need for a clearer definition of what
was meant by health for all, a matter which had long preoccupied him. The expression "health for all" was too vague. The attainment of a level of health permitting people "to lead a socially and economically productive life" was already better. The concept of accessibility to health services was much too limited for health services alone did not produce good health. After much thought he suggested that "each individual should enjoy a level of health enabling him in his community to lead the type of life that he would like to lead". The Executive Board should perhaps have started with a definition but it was not too late to produce one now. A definition was important, not for Board members, who knew what they were talking about, but for the outside world and for the sake of WHO's reputation. The goal of the year 2000 could be left out of it for the time being - in the eyes of the world that date was a long way off.

Dr CHEIKH ABBAS said that the Executive Board was now laying the foundation stone of a construction which at first seemed to him almost too audacious. The work of the Secretariat and of the Programme Committee and the promise of political commitment had, however, persuaded him that the task was feasible.

He was now assailed by a second doubt. Although States might have understood WHO's aims, those aims seemed likely to remain remote from the people for a long time yet. He therefore begged the Director-General to make every endeavour to enlist the concern of the people themselves - for they after all were the main ones concerned - to understand and to feel commitment, through the Press and any means of propaganda available. The argument that WHO must not interfere in the affairs of others no longer applied, for it was well known to all that WHO'S aims were purely scientific and its Director-General had no political pretensions.

As Dr Venediktov had said, WHO must assume its responsibilities.

Dr PATTERSON said that the report did credit to the Programme Committee and to the Director-General, and showed that initial enthusiasm for the target of health for all by the year 2000 had been maintained.

She observed none the less, first, that attention and resources had focused on primary health care to a degree which was not without its dangers. 'While entirely in favour of the strategy, which she believed essential to most countries in the world, she had learnt from experience that increased coverage led to the discovery of diseases of which there had been little previous awareness. Of such newly discovered diseases, some 10-15% required sophisticated treatment, for which the resources were not available in countries of limited means once they had devoted all they had to primary health care. Health care had to be seen comprehensively, with due emphasis on secondary and tertiary care.

Secondly, she was convinced that there was a need for more information on criteria and indicators, budgeting and monitoring, in order to strengthen the links in the processes of implementation and make it more effective. She hoped it would be possible to achieve a clearer definition of the whole programme.

Dr RIDINGS said that the Programme Committee had posed the question of translating political commitment into real action. The obstacles in the way of the desired action were, as stated in paragraph 7 of the report, those associated with inadequate infrastructure; obsolete health legislation; inadequate administrative skills and insufficient involvement of health professionals in primary health care. To those problems there should be added, in many developing countries, a lack of health personnel and low morale and commitment to the new programmes on the part of health officials. The Programme Committee's conclusion was that there was a need for retraining and for research. In his own view that would not be enough without a determined effort to strengthen the economies of developing countries so that they could increase their numbers of health professionals. Accordingly he had reservations regarding the national health development networks.

On the other hand he warmly welcomed the interest shown by UNIDO in the Organization's work, and hoped that such links would be intensified.

Dr GOMES SAMBO (alternate to Dr Fernandes) said that he was encouraged to see how much progress had already been made. At the same time there were a number of points he wished to stress.
First, he felt it was time to take a more practical and concrete view of political commitment. Political commitment had to be based on a concept of man in society and on the establishment of better working conditions and the abolition of unjust conditions of production. In his view it was incumbent on WHO to encourage Member States to frame national health policies in such a way as to benefit the greatest possible number of people. As many as possible should be in a position economically to obtain health care, and to that end the Organization should be encouraging mass health policies.

Secondly, intersectoral collaboration was of great importance, and he therefore believed that coordinating machinery such as that provided by national health councils should be encouraged. Political leaders often came to regard health problems as secondary in the economic sphere; he hoped for a change of attitude on their part, and such councils might serve as a catalyst.

Lastly, he wished to express the hope that paragraph 12 of the report should be more closely studied. The problem of indicators was important, and it was essential to solve it, despite its complexities.

Professor DOGRAMACI said that all Member States had accepted the challenge of commitment to health for all by the year 2000, but there appeared to be a general realization that to make progress it was necessary to have a clearer idea of what was meant by health for all. The first step was to arrive at a more realistic definition of indicators. There were at present two worlds, one in which one infant in four died before its first birthday, and another which suffered from the ills associated with affluence. By the year 2000, 60% of the population would consist of those born from 1980 onwards. It was on that part of the population that resources should be concentrated. Suggestions had been made for definitions of health for all. "Better health" would have been easier to understand. Another possible definition, on the basis of Professor Aujaleu's remarks, was "desirable" rather than "acceptable" health. Another alternative would be "optimal" or "minimum possible health. It must be remembered that in some parts of the world, however, not even the barest minimum level was attained. It was of those areas, areas where virtually nothing had yet been done, that he would like to hear more.

Dr KRUISINGA endorsed the congratulations expressed by previous speakers on the excellence of the report, and also thanked Dr Bryant for his introduction. He wished to associate himself with the remarks made by the Programme Committee.

He fully shared the view of Dr Venediktov regarding the need to view strategy formulation as a dynamic process. In that connexion, he wished to identify five essential tools for the furtherance of the strategy. They were, first, a clearer definition of health for all, such as Professor Aujaleu had rightly been asking for in recent years. Second, well-defined criteria, indicators and cost-effectiveness analyses; in that regard the very interesting paper on criteria for resource allocation among countries in the South-East Asia Region (Annex 3 to document EB65/PC/WP/2) deserved to be taken into account. Third, an intensification of interagency cooperation at United Nations level and a recognition of the interdependence of health planning and development with social and economic planning at country level. He commented that among those involved in central planning there was insufficient knowledge of disciplines other than their own; it was essential that economists, health and social experts acquire a greater awareness of each other's fields. Fourth, there was a need for scientific study as a basis for developing indicators, since precise knowledge in that field was lacking. Fifth, there was a need to stimulate contact between the Organization and regions and countries, and he suggested that the means of attaining it were to hand, if only Articles 61 and 65 of the Constitution of WHO were in fact applied. Those articles provided for annual reporting to the Organization by each Member of action taken and progress achieved in improving the health of its people, and also for the transmittal upon the request of the Board of such additional information pertaining to health as might be practicable. What was required was a two-way flow of information to enable appropriate measures to be taken.

He recalled the policy decisions taken since the Alma-Ata Conference and approved by the United Nations Resolution of 29 November 1979, and he stressed the relevance of Article 65.
Referring to Professor Aujaleu's remark concerning the criticisms of the industrialized countries expressed in paragraph 48 of the Director-General's report to the Programme Committee, he voiced his own agreement with those criticisms, which he considered to be justified in some countries.

Lastly, he wished to hear more from Dr Venediktov of the type of report he had in mind to serve as a conclusion of the present discussion.

Professor DE CARVALHO SAMPAIO endorsed the previous speaker's congratulations on the document and his thanks to Dr Bryant for his comprehensive presentation of it. He concluded from what had been heard that there were good grounds for optimism.

He stressed the need to maintain the climate created after the Alma-Ata Conference. He agreed that more data were needed to determine indicators, so that goals might be more precisely defined. In that connexion, he pointed out that many countries spoke of political commitment, but were unwilling to make funds available; it appeared to him that amounts and percentages of funds actually spent on health afforded very good indicators. Secondly, he underlined the significance of intersectoral cooperation for primary health care and the importance of keeping channels of communication open. Thirdly, he saw a need for a change of attitude in the health professions. Some retraining was called for, and to that end a major step would be for WHO to have close and direct contact with Ministers of Education, and not only via Ministries of Health. For example he took the view that Ministers of Education should also be invited to the meeting of Ministers of Health to be arranged by the Council of Europe in Madrid in 1981.

Lastly, he added a word of thanks to the Director-General for his leadership, and wished the programme every success.

Dr BARAKAMFITIYE emphasized that the formulation of strategies for health for all by the year 2000 was one of the essential means for achieving that goal. Since the objective had been approved, further steps had been taken and, in his view, country health programming was a fundamental element, as were also programme budgeting and the Seventh General Programme of Work. At the regional level, efforts had been made to formulate regional strategies based on national strategies. Following the twenty-ninth session of the Regional Committee for Africa, the African Health Charter had been adopted as a formal political framework for the wishes expressed by individual Member States.

Several speakers had referred to problems of definition and he wished to put a practical question to the Secretariat. Many bodies and mechanisms had been set up or were being established, but how did they function at the country level? Their interrelationship was not always obvious and for that reason he welcomed the suggestion made by Dr Shwe Tin that Secretariat officials should study the question on the spot and assist countries to coordinate such bodies and so to benefit from cooperation, not only with WHO, but also with other non-industrialized countries, as well as with the industrialized countries. The officials concerned would be acting in the spirit of permanent consultation that characterized agreements between WHO and Member States, and not, of course, reviving the former practice whereby WHO experts did the work of national officials.

Dr GALEGO PIMENTEL thought that the introductory statement and the explanations by the regional directors had facilitated a better understanding of the efforts being made to formulate strategies for health for all by the year 2000.

The present moment was a crucial one and careful consideration should be given to the way to proceed. The regions were formulating regional strategies which would lead to the formulation of a global strategy to be submitted to the Executive Board session in January 1981. Regional strategies stemmed from national strategies and, although both regional and national strategies differed from region to region and from country to country, a minimum of uniformity was necessary. If that uniformity were lacking, the ensuing global strategy might be unproductive. In her view, the Executive Board could decide upon a certain minimum uniformity in the formulation of national strategies.
To that end it was necessary to decide exactly what was meant by health for all. Some speakers considered that it meant medical care coverage, but that was not her view. Medical care, through primary health care, was important, but it was not the only element; prevention, health promotion and rehabilitation must also be taken into account. Once a country had reached a satisfactory level of primary health care, it would be unable to go on - there would be problems it could not deal with - unless primary health care was integrated within a system providing the other levels of care.

Another problem that would arise as primary health care coverage developed was the increased need for pharmaceutical products and in that connexion she had been very interested in UNIDO's report on its cooperation with drug manufacturing countries. The coordinated work of that organization and WHO promised to become very satisfactory and she hoped that it would be strengthened and extended.

In view of the interdependence of socioeconomic development and health, she warmly supported the establishment of intersectoral consultative bodies at the national, regional and global levels; for it was not possible to consider progress in health without taking into account man's social and economic environment.

Indicators were recognized as being of the utmost importance both in formulating strategies and putting them into effect and in evaluating results. But they must move with the times and be replaced as progress was made at the country, regional and global levels. Cost-effectiveness indicators were also necessary since projects could not be drawn up nor could strategies be put into action without knowledge of budgetary requirements and some means of assessing their effectiveness.

She agreed with previous speakers that, in view of the difficulties countries could have in planning even one year ahead, regional officials should go out to countries and help them formulate strategies. In her Region, the Ten-year Health Plan was ending and the Region was evaluating the plan and using that evaluation in the formulation of strategies. When establishing plans for twenty years, it was very useful to be able to evaluate one that had been used for ten years in a region.

Dr QUENUM (Regional Director for Africa) thought it might be useful to explain to the Executive Board the context in which the difficult task of formulating national, regional and global strategies had been tackled in the African Region. The goal of health for all by the year 2000 could be divided into two elements.

Firstly, why health and why for all? Such a concept already existed in WHO's Constitution and it was the basic right of every human being to health and the satisfaction of his basic needs. There was general agreement that health for all meant that there should be constant improvement of the state of health of the total population and that every individual should have access to primary health care, supported by secondary and tertiary levels of care, within a comprehensive health system. However, "health for all" would be interpreted differently in each country in the light of its social and economic characteristics, health status and morbidity patterns of its population, and state of development of its health system. The Region had worked on a clearly defined basis in order to clarify a certain number of concepts. Its ideas of social justice and equity required that health be for all. The concept of health for all was revolutionary in so far as it entailed a radical revision of patterns of thought and action. To achieve that objective efforts would have to be made to further interaction between the various sectors and to mobilize individuals, families and communities. It was through primary health care that the necessary progress could be made, but primary health care would be meaningless unless it was integrated in the national health system. The eight fundamental components of primary health care had been identified and they corresponded to the basic needs that health development would have to meet in the coming decades. Health research and training of the necessary manpower had also to be included in the overall picture.

Secondly, why the year 2000? Once a social goal had been set a time-limit was required and it was considered that, if that ideal of social justice - the new health order - was not achieved by the year 2000, then WHO would have failed in its task. If the vicious circle of social injustice was to be broken, a great deal had still to be done, but to go beyond the year 2000 would amount to failure. And so every effort was being made, for the formulation and effective implementation of the regional strategy.
Professor SPIES said that the discussions had shown that attempts were being made to reach the heart of the problem. The statement made by the Regional Director for Africa had been helpful and constructive. The debate had increasingly focused on problems of definition, the need for a comprehensive approach to health care, and for monitoring and indicators. WHO's general definition of health was in itself revolutionary, but a more directly binding and challenging definition was required. Although it was difficult to establish average criteria when formulating strategy, there should be flexibility and mutual assistance among countries and regions thus enabling common values to be defined.

He agreed with Dr Patterson on the need for a comprehensive approach to health care. For instance, breast-feeding policy - on which so much stress was laid in Annex A to the Director-General's report - could not alone improve health, if both mother and child were undernourished, even if breast-feeding was prolonged, nor could clean water - mentioned in paragraph 6 of the Programme Committee's report - without other measures.

With regard to the formulation of national strategies and the ideas on which they might be based (paragraph 6 of the Programme Committee's report), all could perhaps agree that, as the comprehensive approach would require, the criteria to be set for the monitoring process should include, not only the provision of health care for the target groups listed, but the reduction of their numbers through the elimination of the risk - a form of action which had not been given sufficient prominence and without which a better level of health could not be achieved in reality.

As regards the obstacles that national strategies would need to address (paragraph 7 of the Programme Committee's report), he was acquainted with the health and epidemiological statistics of some, even very powerful Member States, where all parameters had to be shown in two columns, one for whites and another for coloured people. No approach was suggested to overcome the kind of special obstacle that different groups with very different social levels constituted.

Dr Kruisinga's reference to the problems of affluent countries had prompted some thoughts about Professor Doğramaci's statement that there were two worlds. But there might in fact be three, as a country with a mortality rate below 1.5% did not necessarily suffer from problems of affluence and was not necessarily short of social carriers for technological progress. Even in Europe, with its high level of economic development, there were differing levels of social development. But by comparison with the problems facing the developing countries, the problems of affluence were minor in the sense that they could be overcome, most of the parameters being known. However, disparities in economies and development levels could only be tackled through technical cooperation between developing countries and between developing and developed countries, with the support of WHO.

Criteria and indicators could be divided into three main categories. The first related to the translation of political commitment into action - there had been notable progress in furthering political commitment by Member States - and would include economic planning, health development, services, health manpower and the development of other basic conditions for primary health care. The second category should focus on the specific basic conditions for primary health care and the Alma-Ata Declaration, so that every country would have criteria for continuous monitoring and evaluation. The third category would include those for health and would relate to problems such as the birth rate, mortality, the quality of life for older and handicapped persons and diseases of particular relevance in the country. In the first instance, it would not be possible to combine such criteria with statistics, but the statistics would follow.

The question of criticism was extremely important for every Member State and close scrutiny of a country's own problems would help to determine special priorities, even in highly developed countries.

Professor XUE Gongchuo said that it was undeniable that the formulation of global and regional strategies for health for all by the year 2000 depended to a large extent on the quality of national strategies. The present formulation of national strategies was the key problem and they were largely dependent on internal policies. Nevertheless, those countries that had become members of WHO had accepted the goal of health for all by the year 2000, as well as the principles enabling that goal to be achieved. Therefore, the prior conditions permitting WHO to carry out its activities without interfering in internal affairs had been met.
The areas in which WHO and the regional committees could act were the following: on request by a Member State, they could give advice on the formulation of national strategies; together with countries having well-defined national strategies, they could study the experience gained by those countries and could draw conclusions; in countries with similar political, economic or social conditions, they could organize exchanges of information on the formulation of strategies; they could organize seminars on problems raised in the Programme Committee, thus anticipating future problems; should there be delays in formulating strategies, they could identify problems and seek appropriate solutions.

Paragraph 4 of the Programme Committee's report (document EB65/4) was of the utmost importance since disarmament and détente were essential prior conditions for the attainment of health for all. They should not remain mere words, but should be acted upon.

The meeting rose at 12h35.