Editorial

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The battle for health

The founding fathers of WHO some 40 years ago — there were at that time no founding mothers! — had a vision: this was that out of the ashes and ruins of the Second World War a new organization would arise, one that would express the quintessence of all that had occupied the greatest minds working in the health and related fields during the last two hundred years.

At the First World Health Assembly in 1948 the President, Professor Andrija Štampar of Yugoslavia, pointed out that little would be achieved by medical services unless “the existing economic, social and other relations among peoples have been... improved”. He was clearly implying that a revolution was needed in health. It took almost 30 years before the World Health Organization really got down to trying to do something about the “economic, social and other conditions which lie at the heart of most health problems”, as proposed by Professor Štampar.

The immediate priorities of the new Organization, overwhelmingly dominated by the industrialized countries, were more limited: to build up health services in the areas destroyed by the war, and to fight the spread of the big infectious killer diseases. WHO started out with an easy target, yaws. The campaign was an obvious winner because of penicillin, the wonder drug that cured the disease with one shot! In that kind of situation, a massive campaign could largely do the trick — even though yaws has been staging a considerable comeback in Africa. Malaria, however, was a different matter. Here we were faced with a complex interaction between man, mosquito and parasite, in a setting where social, cultural, financial, ecological and political forces all played a role. This formidable disease did not fit into the medico-mathematical models of the time, however much the World Health Assembly wanted it to.

While the infectious diseases were diminishing rapidly in the industrialized countries in the 1950s and 1960s, cancer, heart disease, and road accidents became the main killers. These were clearly related to human behaviour, directly or indirectly, as shown by new evidence that socioeconomic and behavioural factors could be important underlying causes of disease. That alcohol was harmful had been well known for centuries, but gradually it came to be realized that tobacco is a major killer, that

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overeating and the consumption of wrong foods have many disease implications, and that exercise is important for health. In the developing countries many infectious and parasitic diseases continued unabated, but diseases affecting the affluent also started

Taking their toll. In trying to tackle them we were no longer faced with bacteria and viruses, but with much more formidable opponents—such as ingrained human behaviour, professional interest groups, and powerful industrial-political complexes. Let us take tobacco promoters as an illustration. They started by refusing to accept the scientific evidence that tobacco kills. Vast amounts were spent on promoting the use of tobacco, especially with youth and women as favourite targets. As the health forces got organized in the industrialized world to oppose such use, the tobacco industry switched over to the largely untapped market of the developing countries and evolved an ingenious strategy of attack in the developed ones: people who were fighting the use of tobacco were branded as enemies of human liberty—the liberty to slowly kill yourself, your family and your friends—and the liberty to push the means to do so onto unsuspecting or ill-informed citizens!

In the 1970s, societal values hardened in the rich countries: the fulfilment of selfish interests was the aim for many, without regard to others like the old and lonely, the weak and unsuccessful, and established family structures; the “old and wise” became the old and useless. Traffic became more brutal, fanned by advertisements that encouraged the image of the automobile as an aggressive animal. Instead of being a partner in a warm and nourishing society, man became a loner in his private world centred around himself. Drugs, alcohol, tobacco, overeating, sexual frenzy, violence and withdrawal from society became the means to cope for many.

Towards the end of the 1970s it became clear that the battle for health had to take on new dimensions. All sectors of activity had to be confronted with their responsibility in health and the public had to be informed about healthy behaviour and about the dangers, for example, of agribusiness, which was often overselling products contributing to the increase in cardiovascular disease and certain cancers; of industries that polluted our water, soil and air with impunity; and of the media, which often promoted unhealthy behaviour and urged overconsumption. In the developing countries the essential elements of primary health care had to be provided to everyone without exception, in spite of financial constraints, and in the developed countries overconsumption and inappropriate health care technology had to be checked.

The Alma-Ata Declaration in 1978 heralded a new era in health. The concept of primary health care and the global health-for-all strategy to implement it are now rapidly gaining ground. Of course, there are always some who say, “Why don’t you repeat the spectacular success of smallpox eradication by concentrating on a few more diseases and getting rid of them once and for all?” The answer is that the “one shot” approach did work for the sustained smallpox eradication
programme, but this kind of single victory cannot have a lasting effect on the total health situation which is dependent on a vast host of factors (including socioeconomic ones) and on a system able to provide continuous promotive, preventive and curative health care to the total community. What is needed to ensure health is therefore a long-term perspective for the development of health systems based on primary health care, as was agreed in Alma-Ata by everyone concerned. Results are not immediate but they are durable and will ensure sustained improvement. However, “quick fixes” are easier to sell, both to national administrations and to their foreign collaborators. Unfortunately, too many foreign health parachutists are still descending on developing countries to perform quick fixes that leave little or nothing behind in the long run. Some bilateral development agencies are becoming acutely aware of this, as evaluation often shows that ill-planned, vertical programmes have squandered huge amounts of capital and have had little or no impact. The least developed countries are heavily dependent on international collaboration for their health development, so it is essential that any outsiders should not be primarily concerned with furthering their own interests, but should behave as genuine partners.

Health for all—an empty slogan?

In villages, towns and districts, people are waking up to the fact that they can contribute to their own health destiny. They organize themselves, discuss the matters, set their own health priorities and get going. Political commitment to the global strategy has been endorsed by most countries, and the traditional health sector has started to take into account political trends, economic and social development plans, and social movements. The first evaluation report—a unique, frank self-assessment by countries of their progress—was presented to WHO’s 166 Member States at the World Health Assembly in May 1986. It shows that the new concepts of health and the new approaches to reach them have been accepted in every country: it shows great successes, but also many obstacles and problems that remain to be solved. Such a public discussion would have been inconceivable 20 years ago and proves that health for all is starting to have effect beyond that of a mere slogan.

Is money the real problem?

Some say health for all is too expensive. But is it a matter of lack of funds or a matter of priorities? The historic US/USSR treaty on intermediate range ballistic missiles in December 1987, although covering only 4% of the world’s nuclear arsenals, was symbolically a spectacular step in the right direction. A fraction of the savings accrued would be sufficient for the primary health care needs of the developing countries, and there would still be enough left to dramatically boost vital research in the fields of cardiovascular diseases, cancer, AIDS, human reproduction, disorders of the aged, and tropical diseases. If such an international health fund were to be set up, it would be a worthy repetition of the lead that the USA and the USSR took in the

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fight against smallpox, a collaboration which was an outstanding example of what can be accomplished by mankind when nations work together towards a common goal.

Wanted: leadership for health

Clearly, there are other needs for human action besides health. But until lately, the health sector has been a weak partner in the social process: partisan political and economic pressures have been far stronger than the health voice; and the present economic crisis has dramatically strengthened the hands of those who use narrow economic criteria in setting policies for development. This must change—and it is changing, largely as a result of WHO’s action. Though ministries of health and health professions in general have traditionally had little say in the orientation of development policies, times are changing: in 1986 the technical discussions of the World Health Assembly were on “Intersectoral action for health”, and in 1988 the subject is “Leadership for health”. These are signs that the advocates for health are joining forces to provide the leadership needed to give socioeconomic development the human dimension so essential to its success.

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As WHO embarks on its fifth decade, there are grounds for optimism: health is moving in the right direction in spite of major obstacles. The cartoon reproduced here was drawn by the Danish cartoonist Storm P. in 1947. Now, 40 years later, we can say that the hands are out of the pockets: people everywhere are becoming more aware of what they can do for their own health; individuals, whole communities, governments, nongovernmental organizations, industry, consumer associations, and other partners in development are increasingly assuming their social responsibilities. Hands all over the world must join together to work for a healthier life and must not be allowed to idle in pockets: hands out for health!